

## Chapter Five – Townsville, Charters Towers, Rockhampton, and the Prince Charles

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*'The only reason I can think of for suppressing information is for short-term political advantage, and I don't aim that at anyone in particular but I think one of the roles of a Director – General is often seen to be to first protect your Minister. I think that's an unhealthy situation.'*

Dr Andrew Johnson, Townsville

### Limitations on the inquiry into other hospitals

- 5.1 As mentioned earlier, this Commission was limited in the inquiry which it could conduct, and the findings and recommendations it could make with respect to, or arising out of each, the Townsville Hospital, the Charters Towers Hospital, the Rockhampton Hospital, and the Prince Charles Hospital, to the matters in respect of which evidence had been given before Commission No.1 of 2005. They were, for that reason, limited as follows.
- 5.2 Part A: The Townsville Hospital
- The recruitment of an overseas neurosurgeon as a locum Senior Medical Officer.
  - The recruitment of an overseas trained ear, nose and throat surgeon.
  - The employment of a 'psychiatrist' who had obtained registration with forged documents.
  - The management structure of the Townsville Hospital.
  - The implementation of the credentialing and clinical privileging process in the Northern Zone.
- 5.3 Part B: The Charters Towers Hospital
- Matters arising from a Queensland Health report into a tragic death in that Hospital.
- 5.4 Part C: The Rockhampton Hospital
- The Emergency Department of the Hospital.
- 5.5 Part D: The Prince Charles Hospital
- The provision of cardiac services at that Hospital.

## Part A - The Townsville Hospital

### The City of Townsville

- 5.6 Townsville lies approximately 1375 kilometres north of Brisbane, a one and a half hour journey by air.<sup>1</sup> Townsville is the largest city in Northern Australia,<sup>2</sup> and has evolved into a government and business centre for North Queensland. In recent years the city's population has swelled to 155,000.<sup>3</sup>
- 5.7 Approximately 24.2% of the population is over 50 years old,<sup>4</sup> whilst 6.3% of the population is indigenous.<sup>5</sup>
- 5.8 Townsville is also home to the James Cook University, at which Queensland's second Medical School is located.<sup>6</sup> The city is also home to a large air force and army base.
- 5.9 Townsville traditionally has been an industrial port for a variety of products including minerals, beef, wool, sugar and timber.<sup>7</sup> The city also has manufacturing and processing industries, while tourism has been a growing industry in recent years.

### The Hospital

- 5.10 In 2002 the former Townsville General Hospital and the Kirwan Institute for Women were amalgamated and moved to a new, purpose built, state of the art, hospital sited in the Townsville suburb of Douglas. The Townsville Hospital is the tertiary referral hospital for the Northern Zone.<sup>8</sup> It has 452 beds and is the largest provincial hospital in Australia. It provides a comprehensive range of services comparable to a major Brisbane hospital such as the Royal Brisbane and the Princess Alexandra. It has a staff of 3000 including 72 full time specialist doctors and 48 Visiting Medical Officers, along with a number of more junior medical practitioners.<sup>9</sup> It is located adjacent to the James Cook University, has developed close links with the University's Medical School, and is the primary teaching hospital for that Medical School.
- 5.11 As the tertiary referral centre for the Northern Zone it services the region from as far north as Thursday Island, west to Mount Isa, and south to Sarina, a

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<sup>1</sup> <http://www.townsville.qld.gov.au/about/>

<sup>2</sup> <http://en.wikipedia.org/wiki/Townsville>

<sup>3</sup> <http://en.wikipedia.org/wiki/Townsville>

<sup>4</sup> compared to the state average of 28.8% source: <http://www.health.qld.gov.au/wwwprofiles/tville.asp>

<sup>5</sup> compared to the state average of 3.1% source: <http://www.health.qld.gov.au/wwwprofiles/tville.asp>

<sup>6</sup> <http://www.jcu.edu.au/school/medicine/about.html>

<sup>7</sup> <http://en.wikipedia.org/wiki/Townsville>

<sup>8</sup> [http://www.health.qld.gov.au/townsville/Facilities/tville\\_hosp.asp](http://www.health.qld.gov.au/townsville/Facilities/tville_hosp.asp)

<sup>9</sup> [http://www.health.qld.gov.au/townsville/Facilities/tville\\_hosp.asp](http://www.health.qld.gov.au/townsville/Facilities/tville_hosp.asp): Dr Johnson gave evidence that there were approximately 400 doctors employed at the Townsville Hospital, approximately half being overseas trained see T3374 line 39

geographical area one and half times the size of France.<sup>10</sup> As the tertiary referral centre for the Northern Zone it accepts emergency transfers from all other hospitals within the Northern Zone. On occasion it may also accept transfers from the more northern hospitals of the Central Zone. It services a population of more than 600,000. In the 2003/04 year there were 38,456 admissions to the Townsville Hospital.<sup>11</sup>

- 5.12 The Townsville Hospital is 1375 kilometres from the nearest major hospital, the Royal Brisbane Hospital.<sup>12</sup> Obviously this distance makes transferring patients to Brisbane difficult and impracticable. As one witness put it:

Brisbane is closer to Canberra than it is to Townsville, and is closer to Melbourne than it is to Cairns<sup>13</sup>

- 5.13 The remoteness of the Townsville Hospital means that it has little choice but to accept all emergency transfers within the Northern Zone and is generally not in the position of being able to refer a patient on to another tertiary referral hospital.

### **Clinical governance at the Townsville Hospital**

- 5.14 The Townsville Hospital has a different management structure from other public hospitals in Queensland.<sup>14</sup> While it retains the traditional executive of a District Manager, Mr Ken Whelan, an Executive Director of Medical Services, Dr Andrew Johnson, a District Director of Nursing, Ms Val Tuckett, and a Director of Operations, Mr Shaun Drummond, it is below that level that management of the Hospital, in a clinical sense, has been handed, to a large extent, to clinicians.

- 5.15 Unlike the other tertiary referral hospitals such as the Royal Brisbane Hospital, the Townsville Hospital operates what was described as a devolved management structure.<sup>15</sup> Under this structure the Townsville Hospital created 11 clinical institutes, each headed by a clinical director who is a doctor and an operations director who is a nurse.<sup>16</sup> Each director carries a clinical workload and an administrative workload.<sup>17</sup> For example Dr Reno Rossato is the clinical director of the Institute of Surgery and he has a clinical workload as the Staff Specialist Neurosurgeon at the Townsville Hospital. He also has an administrative workload.<sup>18</sup> His evidence was that his duties were roughly 50% administrative and 50 per cent clinical.

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<sup>10</sup> T3414 line 3

<sup>11</sup> [http://www.health.qld.gov.au/wwwprofiles/tville\\_tville\\_hosp.asp](http://www.health.qld.gov.au/wwwprofiles/tville_tville_hosp.asp)

<sup>12</sup> [http://www.health.qld.gov.au/wwwprofiles/tville\\_tville\\_hosp.asp](http://www.health.qld.gov.au/wwwprofiles/tville_tville_hosp.asp)

<sup>13</sup> T3334 line 2

<sup>14</sup> T3328 L51

<sup>15</sup> Exhibit 236 para 8

<sup>16</sup> Exhibit 237 para 8

<sup>17</sup> Exhibit 237 para 8

<sup>18</sup> Exhibit 243 para 11

- 5.16 The Townsville Executive has devolved the management and responsibility for each Institute's operational budget to the two directors of each Institute.<sup>19</sup> Therefore the directors of each Institute have greater control over the day to day running of the Institutes and have the authority to manage resources to meet the clinical needs of patients.<sup>20</sup> Each clinical director has a financial delegation to expend up to \$20,000.00 without any need to seek further approval from the Townsville Executive.<sup>21</sup>
- 5.17 The budget of each Institute is negotiated each year between the Townsville Executive and the directors of each Institute,<sup>22</sup> rather than determined by the Townsville Executive. This process enables the clinicians delivering the services to be involved in the allocation of resources.
- 5.18 An example of how this process operates is that, when Mr Drummond assumed the role of Executive Director or Operations in 2003, the Townsville Hospital was in financial crisis, and the Obstetrics and Gynaecology Department was \$2million over budget in that year. Historically, the Obstetrics and Gynaecology Institute had always been significantly over budget. Upon examination of the budget, in consultation with the directors of the Institute, Mr Drummond formed the view that the budget that had been historically allocated to the Institute was grossly insufficient to meet the clinical need.<sup>23</sup> Staff of the Obstetrics and Gynaecology Institute were frustrated by the fact the budget was inadequate. Understandably, they felt there was little point in attempting to run the Institute within budget as the task was effectively impossible. To address this, the Townsville Executive transferred \$2million from its operational budget to the Obstetrics and Gynaecology Institute.<sup>24</sup> More generally, in that year the Hospital Executive transferred a total of \$8 million from the administrative budget to the clinical institutes.<sup>25</sup> That sum was considerably more than the administrative budget for that year. However, the Executive took the view that through operational efficiencies those funds could be recovered.
- 5.19 The budget allocated to the clinical institutes each year is agreed between the Townsville Executive and the directors of the clinical institutes.<sup>26</sup> This structure gives clinicians significant say over the operation and budgets of their institutes. As much as possible clinicians are involved in decisions about budget allocation and expenditure of funds.<sup>27</sup> Budget negotiations between the Townsville Executive and the clinical institutes may even take place before the annual

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<sup>19</sup> Exhibit 237 para 10

<sup>20</sup> Exhibit 237 para 9

<sup>21</sup> Exhibit 251 para 14; T3573 line 56

<sup>22</sup> T3329 line 1

<sup>23</sup> Exhibit 251

<sup>24</sup> Exhibit 251

<sup>25</sup> T3572 line 8

<sup>26</sup> T3572 line 11

<sup>27</sup> T3536 line 45

budget of the hospital has been agreed by Queensland Health,<sup>28</sup> a process that Queensland Health has found difficult to understand:

I think the largest thing [Queensland Health] struggles to comes to terms with is actually how we set budgets with our clinical institutes when [Queensland Health] haven't given us a budget ... they don't understand how we have done that. If we didn't do that, we are now, in the second month of this financial year and we wouldn't have had resources allocated for the delivery of those clinical services.<sup>29</sup>

5.20 The role of the Townsville Executive has become one of supporting clinicians and advocating to Corporate Office. As described by Mr Whelan, the clinicians work in the business, while the Townsville Executive work on the business acting as an advocate for increased funding and resources for the Townsville Hospital.<sup>30</sup> Under this structure, over the past few years, the Townsville Executive has been able to employ an additional 100 medical and nursing staff within the Hospital's existing budget.<sup>31</sup>

5.21 This structure is unique to Queensland Health<sup>32</sup> and, according to Mr Drummond, from his interactions with Queensland Health, the model appears to be poorly understood by Queensland Health's Corporate Office. This lack of understanding is a source of frustration to the Townsville Hospital. An example of the frustration is that recently, the Townsville Executive sought Corporate Office approval to increase the financial delegations of the clinical directors from \$20,000.00 to \$50,000.00 thus allowing the clinical directors much greater autonomy in purchasing equipment and medical supplies for the hospital.<sup>33</sup> Mr Drummond stated that in his view the Institute directors ought to be permitted to expend up to \$100,000.00. Under the present financial delegations the clinical directors need to have Mr Drummond or Mr Whelan approve what are essentially routine purchases for the hospital, a situation that Mr Drummond considered inappropriate and a poor use of both his and the clinician's time. Mr Drummond gave the example of his being required to approve purchase orders for renal fluids:

Because they're fairly expensive [the Hospital] ... might .. order .. \$12,000 of renal fluids at one time, ... somebody from the Institute of Medicine has to come .. to me to actually get me to [authorise that] ..purchase.... It is an absolutely necessary clinical supply. I wouldn't know whether that was the right quantity or not. I'm not the clinician actually involved in the delivery of that service.... Now, they can't sign that, ..I [will] so [it] can be purchased, but it is a ridiculous exercise in bureaucracy.<sup>34</sup>

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<sup>28</sup> T3536 line 43

<sup>29</sup> T3538 line 59 – T3584 line 8

<sup>30</sup> Exhibit 237 para 10

<sup>31</sup> Exhibit 251 line 42

<sup>32</sup> Exhibit 251 para 18

<sup>33</sup> Exhibit 251 para 18

<sup>34</sup> T3575 line 3

- 5.22 The Corporate Office of Queensland Health rejected the application to increase the financial delegations of the directors of the clinical institutes.<sup>35</sup>
- 5.23 In the way described above, the Townsville Hospital seems to have gone some way towards achieving a balance between clinicians being involved in decision making with respect to clinical issues and fiscal responsibility being achieved by the Townsville Executive. Dr Johnson made the point in his evidence that there is a significant role for a full time medical administrator.<sup>36</sup> That person is responsible for balancing competing considerations across the entire health service district.<sup>37</sup>
- 5.24 In the opinion of Mr Drummond it would be possible to implement a similar model of clinical governance in a smaller hospital,<sup>38</sup> although with fewer institutes. The essential feature of this model is an expansion of the authority and responsibility of the clinicians delivering the clinical services, thus increasing their authority and accountability.
- 5.25 Even if this model is not appropriate to all other regional and rural hospitals it does illustrate the advantage of greater clinician involvement in the way in which a hospital's budget is allocated. This topic is taken up later in this report.<sup>39</sup>

### **The Townsville experience of central control**

- 5.26 Prior to joining the Townsville Hospital both Mr Whelan and Mr Drummond worked within the New Zealand public health system.<sup>40</sup> Both have drawn on their experiences in New Zealand, and the devolved management structure discussed above is a common structure within hospitals in other States of Australia and internationally.<sup>41</sup>
- 5.27 Both Mr Whelan and Mr Drummond were critical of the level of central control exerted by Queensland Health<sup>42</sup> complaining of frustration with the level of bureaucracy.<sup>43</sup> Mr Whelan gave evidence that the level of bureaucracy created frustration at the hospital level, and led to unnecessary conflict between clinicians and the executive.<sup>44</sup> Many decisions had to be referred to Corporate Office, and that led to inevitable delay.<sup>45</sup> Clinicians, frustrated by delay, take out that frustration on the local executive. However, the local executive may not be responsible for that delay.

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<sup>35</sup> Exhibit 251 para 15; T3574 line 25

<sup>36</sup> T3328 line 9

<sup>37</sup> T3329 lines 1-15

<sup>38</sup> Exhibit 251 para 16

<sup>39</sup> see Chapter 6

<sup>40</sup> Exhibit 237 para 1; Exhibit 251 para 2

<sup>41</sup> T3328 L58

<sup>42</sup> Exhibit 237 para 11

<sup>43</sup> Exhibit 236 paras 2 - 6

<sup>44</sup> Exhibit 236 para 4 - 5

<sup>45</sup> Exhibit 236 para 6

5.28 Examples of the frustrations experienced by Mr Whelan and Mr Drummond included:

- Services being provided are based on decisions at Corporate Office and the health agenda of the government of the day, which makes it difficult to provide a health service that is timely and responsive to the needs of the community;<sup>46</sup>
- Hospitals are required to carry any financial deficits from one year through to the next; however they are not permitted to carry through any surplus;<sup>47</sup>
- Inflexibility with respect to funding arrangements, financial delegations,<sup>48</sup> and salary packaging;<sup>49</sup>
- Lack of consultation regarding community needs;<sup>50</sup>
- Lack of consultation concerning directions from Corporate Office on procedures to be performed at Townsville;<sup>51</sup> and
- Excessive delay in decision making by Corporate Office.<sup>52</sup>

### Recruitment of overseas trained doctors in the Northern Zone

5.29 The Townsville Hospital operates as the first point of call for overseas trained doctors being employed in the Northern Zone.<sup>53</sup> In the Northern Zone, practitioners destined for rural and regional hospitals first spend some time working in the Townsville Hospital. The overseas trained doctor will work closely with practitioners from the Townsville Hospital who assess his or her skills and competencies. That assessment might also give consideration to the likely scope of practice that the doctor may have in a regional or rural hospital.<sup>54</sup> If, during that assessment, it becomes apparent that the doctor may not have the necessary skills and experience to perform the duties expected, then remedial action can be taken, for example, further training or changing the position to which the doctor may be appointed.<sup>55</sup>

5.30 The Townsville Hospital is ideally situated to perform an assessment of overseas trained doctors destined to work in rural hospitals because:

- It is a large tertiary referral hospital that provides a complete range of medical services and can assess competencies in a wide range of disciplines;

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<sup>46</sup> T3531 line 15

<sup>47</sup> T3337 line 55

<sup>48</sup> T3574 line 20

<sup>49</sup> T3584 line 10-40

<sup>50</sup> Exhibit 236 para 7

<sup>51</sup> T3549 line 56. This situation refers to a direction from corporate office regarding that only the Princess Alexandra Hospital and the Royal Brisbane Hospital were permitted to carry out oesophagectomies and Whipples procedures. Townsville, which had a competent surgeon who performed numerous such procedures were not consulted. The VMO concerned threatened resignation over this direction

<sup>52</sup> Exhibit 236 paras 5-6

<sup>53</sup> T3334 line 51

<sup>54</sup> T3334 line 5

<sup>55</sup> T3335 line 8

- It faces similar difficulties to those faced by rural and regional hospitals across Queensland, although perhaps to a lesser degree, including
  - remoteness;<sup>56</sup>
  - difficulties attracting suitable medical staff;<sup>57</sup>
  - onerous on-call duties;<sup>58</sup>
  - As a result it is well suited to assess a new doctors' capacity to cope in rural or regional setting.
- It is probable that the doctor will have an on-going relationship with the Townsville Hospital as it will be the tertiary referral centre he or she is most likely to contact for advice. Therefore, time spent in Townsville will assist that doctor in understanding the public health system in Queensland, and establishing appropriate professional support networks.

### **Clinical privileging and credentialing in the Northern Zone**

- 5.31 The Northern Zone has implemented a different model<sup>59</sup> of credentialing and clinical privileging. The deficiencies in the credentialing and clinical privileging process in the Northern Zone were revealed in a report commissioned by Mr Terry Mehan, the manager of the Northern Zone of Queensland Health, into the death of Ms Kathryn Sabadina at the Charters Towers Hospital in 2000 (discussed below).<sup>60</sup>
- 5.32 In the Northern Zone the credentialing and privileging process differs for specialists and rural generalists.
- 5.33 Within the Northern Zone, in addition to those hospitals that provide specialist services, there are a large number of hospitals where the medical staff are largely rural generalists. Before examining the different processes for credentialing and privileging specialists and rural generalists, it is first necessary to say something about the nature of a rural generalist medical practitioner. Presently, there is no recognised speciality for rural generalists. Rather the term is used as an umbrella term for those doctors who practise medicine in a rural or remote setting.<sup>61</sup> A large majority of rural generalists are general practitioners<sup>62</sup> who also perform procedures such as low risk obstetrics and gynaecology, anaesthetics, general surgery, and orthopaedics.<sup>63</sup>

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<sup>56</sup> T3334 line 2

<sup>57</sup> Exhibit 233 Paras 16 - 19

<sup>58</sup> Exhibit 243 paras 8 – 9

<sup>59</sup> that the southern or central zones of Queensland Health

<sup>60</sup> Exhibit 56 page 67

<sup>61</sup> Exhibit 297 para 15

<sup>62</sup> Exhibit 297 para 19

<sup>63</sup> Exhibit 297 para 15 and para 28



- 5.34 For doctors destined to work as rural generalists in the Northern Zone a Rural Credentialing and Privileging Committee<sup>64</sup> ('the Rural Committee') considers the credentials and clinical privileges, meeting every three months to do so. The process involves an assessment of the credentials of the applicant and then, once those credentials are examined, an award of clinical privileges.<sup>65</sup> The nature of the privileges granted will depend on a range of factors including the service capability framework, the qualifications of the applicant, the scope of practice of the hospital, the equipment available at the hospital, and the nature of procedures performed in that hospital.<sup>66</sup> Accordingly, the specific privileges granted to a practitioner will differ between facilities.<sup>67</sup>
- 5.35 It is often difficult to assess a particular practitioner's credentials 'purely on the papers'.<sup>68</sup> In the event that the Rural Committee is unable to adequately assess whether a particular doctor has the requisite skills for the clinical privileges sought, then the Committee may require the applicant to undergo a period of supervised practice with an appropriate specialist.<sup>69</sup> The specialist will then provide a written report to the Rural Committee who can award appropriate clinical privileges.
- 5.36 Another change in the procedures for clinical privileging that was implemented following the report into the death of Ms Sabadina is the process for the award of interim clinical privileges. Interim clinical privileges may be awarded subject to a formal assessment of the practitioner's skills by an appropriate person.<sup>70</sup> Interim clinical privileges for rural practitioners are restricted to general practitioner duties and not for specialty procedures such as obstetrics and anaesthetics.<sup>71</sup> Only after formal assessment by the Rural Committee are any specialist privileges awarded.<sup>72</sup>
- 5.37 For Senior Medical Officers, whether specialist or otherwise, in the Northern Zone, a different procedure for credentialing and privileging is used. Where a public hospital in the Northern Zone provides specialist services,<sup>73</sup> then if the hospital lacks sufficient staff to adequately perform credentialing and clinical privileging then that service may be provided by the another, larger, hospital's credentialing and privileging committee.<sup>74</sup> For example, at present, the Mount Isa Hospital uses the Townsville Hospital's credentialing and clinical privileging

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<sup>64</sup> Exhibit 297 para 32

<sup>65</sup> Exhibit 297 para 33

<sup>66</sup> Exhibit 297 para 33

<sup>67</sup> Exhibit 297 para 33

<sup>68</sup> Exhibit 297 para 36

<sup>69</sup> Exhibit 297 para 37

<sup>70</sup> Exhibit 56

<sup>71</sup> Exhibit 297 para 38

<sup>72</sup> Exhibit 297 para 38

<sup>73</sup> For example, the Mt Isa Hospital

<sup>74</sup> T3416 L1

committee to assess those of its staff that are providing specialist services,<sup>75</sup> whether Senior Medical Officer or specialist.

- 5.38 The Townsville Hospital has sufficient resources and a sufficient number of specialists to provide a broad credentialing and privileging service across the Northern Zone where appropriate. For example, it can call on a wide range of specialists,<sup>76</sup> and it can call on academic staff from the James Cook University Medical School,<sup>77</sup> thus ensuring an appropriately robust and independent credentialing and privileging committee.

### **The emergency department at the Townsville Hospital**

- 5.39 Like all tertiary referral hospitals, the Townsville Hospital has a busy emergency department. The remoteness of the Hospital, however, and the difficulties in transferring patients to Brisbane place significant pressures on the hospital. Evidence was given that, despite the hospital being built only three years ago, it has insufficient beds to meet demand.<sup>78</sup> Dr Andrew Johnson, gave evidence that the hospital needed another 40 beds immediately in order to cope with the demand placed on its services,<sup>79</sup> particularly during peak times of the year.
- 5.40 Dr David Symmons a Staff Specialist in emergency medicine gave evidence of the Townsville Hospital Emergency Department suffering what is described as 'access block'. Access block describes the situation where a patient attends the emergency department and requires admission to the Hospital, yet a bed cannot be found for that patient. Dr Symmons gave evidence that in the first two weeks of July this year, there were 337 patients admitted to the hospital through the Emergency Department. Of those, only 197 were admitted within eight hours, 140 patients waited longer than eight hours, and, of those, 28 patients waited in the Emergency Department for more than 24 hours for a bed to be found.<sup>80</sup> Dr Symmons stated that access block is a direct result of a lack of inpatient beds.<sup>81</sup>
- 5.41 Dr Symmons commented that, in his view, the current elective surgery funding regime is a disincentive to the Hospital cancelling elective surgery and freeing up hospital beds, even in times of extreme access block in the Emergency Department.<sup>82</sup> He considered that the Hospital would be financially punished for cancelling elective surgery even when faced with severe access block in the

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<sup>75</sup> T3416 L29

<sup>76</sup> T3335 line 40

<sup>77</sup> T3392 line 45

<sup>78</sup> T3344 line 16

<sup>79</sup> T3344 line 17

<sup>80</sup> Exhibit 249 para 12

<sup>81</sup> Exhibit 249 para 10

<sup>82</sup> Exhibit 249 para 16

Emergency Department.<sup>83</sup> Consequently elective surgery was given priority and elective surgery patients occupied beds needed for emergency patients.

5.42 Dr Symmons was not critical of the Townsville Hospital Executive regarding access block.<sup>84</sup> He acknowledged that the Hospital Executive had taken steps to address the problems of access block in the emergency department however the problem was ongoing.<sup>85</sup> Access block has caused numerous adverse effects on patients and staff including:<sup>86</sup>

- Increased adverse incidents;
- Increased length of patient stay; and
- Increase in absenteeism, sick leave and overtime for staff.

5.43 Dr Symmons also gave evidence that the Emergency Department at the Townsville Hospital was heavily reliant on overseas trained doctors to fill junior medical staff positions.<sup>87</sup>

### **Recruiting overseas trained doctors to the Townsville Hospital**

5.44 The recruitment of two overseas trained doctors was canvassed before the Commission; Dr Donald Myers, an American trained neurosurgeon who had most recently been practising in the Virgin Islands who was working as a locum Senior Medical Officer, and a Dr Kalavagunta, an ear nose and throat surgeon, who had applied for a position at the Townsville Hospital.

### **The recruitment of Dr Myers, a third neurosurgeon for Townsville**

5.45 At present there are two neurosurgeons practising in Townsville, Dr Reno Rossato, a staff specialist, and Dr Eric Guazzo, who conducts a private practice as well as being a Visiting Medical Officer. Dr Rossato and Dr Guazzo have been sharing a 1 in 2 on call since 1994.<sup>88</sup> Prior to that Dr Rossato was the only neurosurgeon in Townsville and had been since 1979.<sup>89</sup> The neurosurgery unit at the Townsville Hospital has been increasingly busy in recent years.<sup>90</sup> Due to the nature of neurosurgery there is a significant demand for after hours services particularly for head trauma. As a result being on call 1 in 2 is particularly onerous.<sup>91</sup> In recent years a neurosurgeon who practised in Rockhampton, Dr

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<sup>83</sup> Exhibit 249 para 16

<sup>84</sup> Exhibit 249 para 11

<sup>85</sup> Exhibit 249 para 11

<sup>86</sup> Exhibit 249 attachment 'DADS2'

<sup>87</sup> Exhibit 249 para 17 and 18

<sup>88</sup> Exhibit 243 para 7: this means that each doctor is 'on call' for emergencies after hours effectively every second day and every second weekend. In specialties such as neurosurgery, this is particularly onerous as the neurosurgeon is often called on to respond to trauma cases

<sup>89</sup> Exhibit 243 para 7,8

<sup>90</sup> Exhibit 243 para 20

<sup>91</sup> Exhibit 243 para 21 and 22

John Baker, closed his practice and moved to Brisbane.<sup>92</sup> Since that time the Townsville Hospital has taken all emergency transfers for neurosurgery in North Queensland including transfers from the more northern centres of the central zone.<sup>93</sup> Dr Guazzo had serious concerns about the onerous on-call duties and the fact that whilst one neurosurgeon was on leave, the other was on-call continuously for weeks at a time.<sup>94</sup> For some years, Dr Guazzo had also been advocating for a third neurosurgeon to be employed by the Townsville Hospital.<sup>95</sup> Dr Rossato, as the Director of Surgery at the Townsville Hospital, had been attempting to recruit a third neurosurgeon to Townsville for some time.<sup>96</sup>

- 5.46 In May 2004, Dr Guazzo resigned as a Visiting Medical Officer.<sup>97</sup> This led to a potential crisis in the provision of neurosurgery services in North Queensland. Dr Guazzo cited a number of reasons for his resignation including the onerous on-call duties, and that he felt that there had been a lack of consultation with him over the operations of the neurosurgery unit in the Townsville Hospital.<sup>98</sup> After negotiations with Dr Johnson, Dr Guazzo agreed to return to the Townsville Hospital as a Visiting Medical Officer although with reduced on-call responsibilities and a promise of greater consultation.<sup>99</sup>
- 5.47 In the intervening time, Dr Rossato had taken steps to recruit an additional neurosurgeon to the Townsville Hospital.
- 5.48 Dr Donald Louis Myers was referred to the Townsville Hospital by Wavelength Consulting Pty Ltd. Dr Myers resume<sup>100</sup> was provided to Dr Rossato in late December 2004. Dr Myers is an American trained neurosurgeon, who passed his American Medical Board Exams in 1980.<sup>101</sup> In 1984 he was certified as a neurosurgeon by the American Board of Neurological Surgery.<sup>102</sup> He practised as a neurosurgeon in various hospitals in Philadelphia until 2001.<sup>103</sup> Dr Myers gave evidence that in 2001 there was a medical indemnity crisis in Philadelphia, and he decided to retire from his practice.<sup>104</sup> Dr Myers moved to the US Virgin Islands where he took up a neurosurgery practice although, due to resource constraints, his practice was limited in some respects.<sup>105</sup>

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<sup>92</sup> Exhibit 243 para 21

<sup>93</sup> Exhibit 243 para 21

<sup>94</sup> Exhibit 242 para 12

<sup>95</sup> Exhibit 242 para 5

<sup>96</sup> Exhibit 243 para 23

<sup>97</sup> Exhibit 242 para 13

<sup>98</sup> Exhibit 242 para 14

<sup>99</sup> Exhibit 242 para 14

<sup>100</sup> Exhibit 243 attachment RGR-1

<sup>101</sup> Exhibit 241 para 3

<sup>102</sup> Exhibit 241 para 4

<sup>103</sup> Exhibit 241 para 7

<sup>104</sup> Exhibit 241 para 7 and 8

<sup>105</sup> Exhibit 241 para 9 and 10

- 5.49 Initially Dr Rossato reviewed Dr Myers' application and considered that his experience and training suited him for employment as a neurosurgeon at the Townsville Hospital.<sup>106</sup> Dr Rossato had some concerns about the recency of his practice.<sup>107</sup> However, following an interview<sup>108</sup> and contacting two referees,<sup>109</sup> he considered that Dr Myers was suitable for employment as a staff specialist neurosurgeon at the Townsville Hospital, and made him an offer in those terms.<sup>110</sup> Following a visit to Townsville during which he met both Dr Rossato and Dr Guazzo; Dr Myers, for various reasons, chose not to accept that offer.<sup>111</sup>
- 5.50 In an attempt to encourage Dr Myers to join the Hospital on a more permanent basis, Dr Rossato negotiated for Dr Myers to join the Townsville Hospital as a locum Senior Medical Officer for a period of three months from June to September 2005.<sup>112</sup>
- 5.51 Dr Myers was appointed as a locum Senior Medical Officer in neurosurgery.<sup>113</sup> However, this appointment was not without some controversy. Concerns were raised about the recency of Dr Myers' experience due to the nature of his practice in the Virgin Islands.<sup>114</sup> Dr Guazzo believed Dr Myers to be a well qualified and capable neurosurgeon. However, he had some concerns about the process of his appointment,<sup>115</sup> specifically:
- That he, as the second neurosurgeon at the Townsville Hospital,<sup>116</sup> was not consulted with respect to the recruitment;
  - Dr Myers' recency of practice, particularly his familiarity with some emergency neurosurgery procedures carried out in Townsville;<sup>117</sup>
  - The level of supervision of Dr Myers that may be required given his recency of practise;<sup>118</sup>
  - That Dr Myers had, at least initially, been placed on the 'on-call' roster, without supervision;<sup>119</sup> the lack of supervision was, on Dr Guazzo's view, inappropriate until some assessment of Dr Myers' skills had been made.
- 5.52 It also seems apparent that Dr Myers was to be employed under an area of need application as a Senior Medical Officer, yet would be effectively practising as a

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<sup>106</sup> Exhibit 243 para 28 - 30

<sup>107</sup> Exhibit 243 para 30

<sup>108</sup> Exhibit 243 para 32

<sup>109</sup> Exhibit 243 para 33 - 35

<sup>110</sup> Exhibit 243 para 36

<sup>111</sup> Exhibit 241 para

<sup>112</sup> Exhibit 243 para 43

<sup>113</sup> Exhibit 243

<sup>114</sup> Exhibit 234 para 43

<sup>115</sup> T3450 line 26

<sup>116</sup> Exhibit 234 para 45

<sup>117</sup> Exhibit 234 para 43

<sup>118</sup> T3454 L 26

<sup>119</sup> T3454 L17, although Dr Rossato stated that this was done in error.

neurosurgeon, without any review by the Royal Australasian College of Surgeons.

- 5.53 All of these concerns were, in my opinion, well founded. Dr Myers should not have been employed on this basis. He should have been employed only on a probationary basis in circumstances in which close supervision could have been provided at all times. His skill, judgement and general competence should have been appropriately assessed by a credentialing and privileging committee before he commenced employment.
- 5.54 Dr Johnson approved the area of need application for Dr Myers, although he had not been previously involved in the recruitment process.<sup>120</sup> Dr Johnson had believed that Dr Myers was to be subject to the supervision of Dr Rossato and Dr Guazzo at least until such a time as his level of competence could be confirmed. However, as it transpired, Dr Rossato was to be on leave during the first three weeks of Dr Myers' tenure,<sup>121</sup> and Dr Guazzo, was unwilling to formally supervise Dr Myers although he did offer collegiate support.<sup>122</sup>
- 5.55 Upon Dr Myers' arrival at the Townsville Hospital Dr Johnson spoke at length with him and during that conversation Dr Johnson formed the view that:
- Dr Myers had a great deal of insight into his limits and recent experience in neurosurgery;<sup>123</sup>
  - Dr Myers admitted that some of his skills were 'rusty' and he needed to refresh his skills in some areas;<sup>124</sup>
  - Dr Myers had not had access to the latest equipment in the Virgin Islands and would need to familiarise himself with the equipment at Townsville;<sup>125</sup>
  - Notwithstanding his lack of recent experience in some areas, Dr Myers was otherwise an impressive candidate, and his personal insight was impressive and, more importantly, the mark of a competent surgeon.<sup>126</sup>
- 5.56 In the event, Dr Johnson was not satisfied that the Townsville Hospital could allow Dr Myers to practise independently until such time as his skills had been appropriately assessed by Dr Rossato and Dr Guazzo.<sup>127</sup>

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<sup>120</sup> Exhibit 234 para 41

<sup>121</sup> Exhibit 234 para 45

<sup>122</sup> Exhibit 234 para 46 and T3452 L9

<sup>123</sup> Exhibit 234 para 51

<sup>124</sup> Exhibit 234 para 52

<sup>125</sup> Exhibit 234 para 52

<sup>126</sup> Exhibit 234 para 54

<sup>127</sup> Exhibit 234 para 53

### *Employment as a Senior Medical Officer*

- 5.57 The employment of Dr Myers as a locum Senior Medical Officer resulted in his being employed, at least initially, without the Royal Australasian College of Surgeons being involved in either assessing his qualifications<sup>128</sup> or granting him deemed specialist status. Dr Johnson gave evidence that, in the past, the Townsville Hospital has employed locums as Senior Medical Officers rather than as deemed specialists,<sup>129</sup> the reason being that often the assessment process for deemed specialist status may take longer than the period of the locum itself.<sup>130</sup> Dr Johnson's evidence was that, in his experience, it can take between three and six months for an assessment by the various colleges, and often the locum appointment was for a much shorter period.<sup>131</sup>
- 5.58 Therefore it was impractical to apply for a deemed specialist review for most locum appointments.<sup>132</sup> However, that can never be a reason to circumvent a necessary patient safeguard. Doctors should not be able to work as a specialist without first being assessed as competent to do so by the relevant specialist college. The alternative is to permit them to perform any specialist work under close supervision; and then only after an adequate process of credentialing and clinical privileging which should define the limits of their work.

### *Supervision of Dr Myers*

- 5.59 Dr Myers was subject to constant supervision whilst he worked at the Townsville Hospital. He was granted no independent clinical privileges.<sup>133</sup> During the first three weeks of his employment whilst Dr Rosatto was away, Dr Myers was not permitted to perform any clinical work.
- 5.60 He has since performed clinical work under the supervision of Dr Rossato or Dr Guazzo.<sup>134</sup> He has also performed neurosurgery under the supervision of both Dr Rossato and Dr Guazzo. Dr Myers has assisted Dr Guazzo perform surgery at a private hospital in Townsville in an effort to give him an appreciation of the nature of practising medicine in Townsville generally. Both Dr Guazzo<sup>135</sup> and Dr Rossato<sup>136</sup> have been impressed with Dr Myers and both support him seeking specialist accreditation with the Royal Australian College of Surgeons.

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<sup>128</sup> T3353 line 7

<sup>129</sup> T3353 line 9

<sup>130</sup> T3353 line 20

<sup>131</sup> T3353 line 25

<sup>132</sup> T3353 line 34

<sup>133</sup> Exhibit 243 para 49

<sup>134</sup> Exhibit 241 paras 22 - 25

<sup>135</sup> Exhibit 242 para 32 and T3542 line 25

<sup>136</sup> Exhibit 243 para 52

- 5.61 The Townsville Hospital has also forwarded to the Royal Australasian College of Surgeons the relevant paperwork for deemed specialist recognition of Dr Myers.<sup>137</sup>

*General comments on the recruitment of Dr Myers*

- 5.62 It is clear on the evidence that the staff of the Townsville Hospital hope that Dr Myers might be convinced to become a permanent neurosurgeon<sup>138</sup> at the Hospital. The Commission had the benefit of receiving evidence from Dr Myers.<sup>139</sup> Dr Myers thought that the arrangements in place were an excellent way for him to assess the type of practice offered at the Townsville Hospital and for the Townsville Hospital to assess his skills and experience.<sup>140</sup>
- 5.63 It seems that the experiment with Dr Myers has worked well for both the doctor and the Townsville Hospital. But it was not without serious risk. I shall discuss this problem further and suggest some solutions in Chapter 6.

**Recruitment of Dr Kalavagunta**

- 5.64 Another issue that was raised before the Commission was the recruitment of an ear nose and throat surgeon named Dr Kalavagunta. Dr Kalavagunta was offered a position as a specialist ear nose and throat surgeon.<sup>141</sup> Dr Andrew Johnson and Dr Andrew Swanton, then the Director of ear nose and throat surgery at the Townsville Hospital, were on the selection panel.<sup>142</sup> The position was offered to Dr Kalavagunta subject to him being granted deemed specialist status by the Royal Australasian College of Surgeons.<sup>143</sup> Dr Lindsay Allen, a Visiting Medical Officer in ear nose and throat surgery, and the only ear nose and throat surgeon at the Hospital during this time had some concerns about the appointment and was not consulted by the Townsville Hospital during the recruitment process.<sup>144</sup>
- 5.65 Dr Allen had a significant workload as the sole provider of ear nose and throat surgery at the Townsville Hospital.<sup>145</sup> The Townsville Hospital was attempting to recruit an additional ear nose and throat surgeon as quickly as possible to reduce the demands placed on Dr Allen.<sup>146</sup> However, the Townsville Hospital made it clear, at least to Dr Kalavagunta, that any appointment was subject to

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<sup>137</sup> Exhibit 234 para 49

<sup>138</sup> Exhibit 234 para 54

<sup>139</sup> Exhibit 241 and T3428 to T3434

<sup>140</sup> Exhibit 241 para 26

<sup>141</sup> T3348 line 10

<sup>142</sup> T3348 line 8

<sup>143</sup> T3348 line 25

<sup>144</sup> Exhibit 235

<sup>145</sup> T3349 line 10

<sup>146</sup> T3349 line 12



him obtaining deemed specialist recognition from the Royal Australasian College of Surgeons.

5.66 Dr Kalavagunta was not granted deemed specialist recognition by the Royal Australasian College of Surgeons.<sup>147</sup> Consequently he was not appointed to the position. Dr Kalavagunta did not commence employment with the Hospital and, in fact, had never left his home country.<sup>148</sup>

5.67 Dr Lindsay Allen was critical of the delay in the recruiting process,<sup>149</sup> and concerned about the fact that the process took several months for the position to be advertised. Dr Johnson gave evidence that it may take up to nine months from the time a need is identified to the appointment of a medical officer, particularly if that doctor is an 'area of need' application. It may take even longer to have an applicant granted deemed specialist status. The delay in recruitment eventually led to the resignation of Dr Allen, the remaining ear nose and throat surgeon.<sup>150</sup> Until suitable staff can be recruited, the Townsville Hospital no longer offers ear nose and throat surgery.<sup>151</sup> As Dr Johnson put it:

We have no ENT services at the Townsville Hospital which is an absolute travesty. We're a tertiary hospital and can't provide one of the basics. Part of that is an issue of the recruitment processes, part of it's an issue of local shortage of specialists ENT practitioners, and certainly the new requirements for supervision and support through the Area of Need process complicate the issue even further.<sup>152</sup>

5.68 It is unfortunate that the Townsville Hospital can no longer provide ear nose and throat surgery. However, that seems preferable to having a service provided by a overseas trained doctor who has not been approved by the Royal Australasian College of Surgeons and cannot be fully supervised by a Fellow of that College.

5.69 While the delay taken to recruit a specialist to assist Dr Allen is unfortunate, the approach of the Townsville Hospital in this case is to be commended in ensuring that a proposed recruit would be either a fellow of the relevant Royal College or has been granted deemed specialist status by the appropriate College<sup>153</sup> before his appointment to an unsupervised position at the Hospital.

### **Vincent Victor Berg**

5.70 Vincent Victor Berg ('Berg') was employed as a Resident Medical Officer at the Townsville Mental Health Unit between January 2000 and January 2001. He

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<sup>147</sup> T3348 line 3

<sup>148</sup> T3848 line 38

<sup>149</sup> Exhibit 235

<sup>150</sup> T3350 line 45

<sup>151</sup> T3350 line 46

<sup>152</sup> T3350 line 47

<sup>153</sup> T3348 line 30

had previously worked as an 'observer' for a period of months at the Gold Coast Hospital Mental Health Unit.<sup>154</sup>

- 5.71 In his Curriculum Vitae Berg stated that under his previous name of Tchekaline Victor Vladimirovich, he had completed a combined medical degree and post-graduate qualification in psychiatry of the Voronezh State University in the former USSR<sup>155</sup>, now the Russian Federation. Berg claimed to have enrolled in this degree in September of 1969 and been awarded the degree of Doctor of Medicine in Psychiatry in May 1977.<sup>156</sup> He then claimed to have continued his post-graduate study in psychiatry between May 1977 and December 1978.<sup>157</sup>
- 5.72 Berg also claimed that he had been a staff member and lecturer at the Voronezh State University between January 1978 and April 1982.<sup>158</sup>
- 5.73 Berg claimed that in 1982, he was ordained as a priest in the Russian Orthodox Church and was subsequently ordained as a bishop in June 1986. As a result of his religious activities Berg claimed that in August 1986 he had been arrested and imprisoned by the KGB until released in 1988. He was then not permitted to practise officially as a psychiatrist or priest, although claims that he continued to do both secretly. He fled the USSR in 1992.<sup>159</sup> Berg was granted refugee status in Australia in August 1993.
- 5.74 Between August 1999 and November 1999 Berg worked as an unpaid clinical observer at the Gold Coast Hospital. Berg had no clinical duties while working at the Gold Coast Hospital. His work as an observer was a means by which Berg could have his skills assessed with a view to obtaining future employment as a psychiatrist.<sup>160</sup>
- 5.75 Berg then applied to join the rotational training scheme conducted by the Royal Australian and New Zealand College of Psychiatrists.<sup>161</sup> However he was not considered suitable for that scheme due to his lack of recent experience in psychiatry.<sup>162</sup> Nevertheless, Dr John Alexander Allan,<sup>163</sup> the Director of Integrated Mental Health Services at the Townsville Hospital, considered that Berg might be suitable for a vacancy that existed in the Townsville Mental Health Unit.<sup>164</sup> At the time, the Townsville Hospital was short staffed and Dr Allan was aware that those who had observed Berg at the Gold Coast Hospital had given

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<sup>154</sup> Exhibit 254 Statement of Dr John Allan

<sup>155</sup> Exhibit 234

<sup>156</sup> Exhibit 238, medical based file, Curriculum Vitae of Vincent Berg

<sup>157</sup> Curriculum Vitae of Dr Vincent V Berg dated which is annexure AJJ-1 to Exhibit 234, Statement of of Dr Andrew Johnson

<sup>158</sup> CV of Vincent Berg Exhibit 234 annexure AJJ-1

<sup>159</sup> Exhibit 235 annexure AJJ-1

<sup>160</sup> Exhibit 245

<sup>161</sup> This is a scheme where psychiatric registrars rotate through various mental health units as part of their training.

<sup>162</sup> Exhibit 245

<sup>163</sup> Dr Allan was on the board of the rotational training scheme

<sup>164</sup> Exhibit 245

him favourable references.<sup>165</sup> Dr Allan contacted two of his referees who advised that there were some adjustment and cultural issues that Berg needed to address but there was nothing that caused them particular concern.<sup>166</sup>

5.76 On 27 April 2000 Berg was granted conditional registration by the Medical Board of Queensland as a medical practitioner for twelve months, on a temporary basis, under s17C(1)(a) of the *Medical Act 1939 (Qld)*.<sup>167</sup> That registration was for the period 4 January 2000 until 3 January 2001. That registration was to enable him to undertake post graduate training at the Townsville Hospital. Berg was not granted registration under the 'area of need' program.

5.77 Section 17C(1)(a) was in the following terms:

**Graduates from non-accredited institutions – post graduate training:**

A person who is a graduate of medicine from an institution which is not accredited by the Australian Medical Council may be registered on a temporary basis to enable the person to undertake a period of postgraduate study in medicine approved by the board

5.78 By s17C(1)(a) the Medical Board was obliged to satisfy itself, before registering Berg, that he was a graduate of medicine from an institution not accredited by the Australian Medical Council. It now seems likely that Berg was not a graduate of the institution from which he claimed to have graduated. It is not clear what the Medical Board did to verify the genuineness of the certificates which he produced but it appears that it took them at their face value.

5.79 Berg then commenced a one year contract as a Resident Medical Officer in psychiatry at the Townsville General Hospital. He commenced in that role on 3 January 2000. Berg saw patients between January and October 2000 in his capacity as a Resident Medical Officer. It must be noted that Berg was supervised by several consultant psychiatrists during his practice at Townsville.<sup>168</sup>

5.80 Not long after Berg commenced duties, Dr Allan began to develop concerns about his clinical practice and performance.<sup>169</sup> Dr Allan considered that Berg was difficult to supervise and would also ignore directions given to him by his supervisor. Dr Allan also noticed that Berg had some psychiatric knowledge but that there were real concerns about his clinical judgment:

Berg felt that he already knew everything about psychiatry. He was difficult to supervise. He was unwilling to take direction. There were also situations where he would ignore directions given to him by his supervisor. I was also aware that

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<sup>165</sup> T3473 line 23 - 35

<sup>166</sup> Exhibit 245 para 20

<sup>167</sup> Exhibit 238, Medical Board of Queensland File of Vincent Berg

<sup>168</sup> Exhibit 245 Statement of Dr Allan, annexure 'JAA-2' confidential audit

<sup>169</sup> T3473 line 45 - 3475 line 14

there were concerns about him practising independently where he had less supervision, especially after hours when on call<sup>170</sup>

- 5.81 Berg was insistent that his Russian training should entitle him to specialist registration as a psychiatrist in Queensland<sup>171</sup> and maintained that he was a fully qualified psychiatrist.
- 5.82 By August of that year Dr Allan's concerns about Berg's performance were such that the he, on behalf of the Townsville Hospital, issued a show cause notice asking him to respond to several allegations about his clinical practice.<sup>172</sup> Berg then took several months sick leave and did not return to work at the Townsville Hospital until late 2000. Berg performed no clinical work at the Townsville Hospital between October 2000 and January 2001.
- 5.83 Drs Allan and Johnson had by that time resolved not to extend Berg's contract and Berg ceased employment in Townsville at the end of his contract on 7 January 2001.<sup>173</sup> His conditional registration expired on 3 January 2001.<sup>174</sup>

#### *Berg attempts to gain specialist registration*

- 5.84 In July 2001, some months after he ceased employment at Townsville, Berg submitted his qualifications to the Australian Medical Council in an attempt to have his specialist qualifications recognised by the Australian Medical Council.<sup>175</sup> The Australian Medical Council referred Berg's application to the Royal Australian and New Zealand College of Psychiatrists ('the College of Psychiatrists') for assessment.
- 5.85 As part of that assessment process the College of Psychiatrists took steps to verify the authenticity of Berg's qualifications. The College of Psychiatrists had concerns because Berg's qualifications were in a different name: Tchekaline Victor Vladimirovich. Berg explained that he had changed his name on arriving in Australia. The College of Psychiatrists contacted the Voronezh State University in an effort to confirm his claimed qualifications.

#### *Doubts emerge about Berg's claimed qualifications*

- 5.86 An officer of the College of Psychiatrists contacted Sergey Zapryagaev, a professor and provost of the Voronezh State University.<sup>176</sup> Professor Zapryagaev advised that the Voronezh University had no record of a degree being awarded to Tchekaline Victor Vladimirovich, and no one by that name had ever worked as a staff member of the University. He also advised that the Voronezh State

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<sup>170</sup> Exhibit 245 para 24

<sup>171</sup> T3475 line 15 - 42

<sup>172</sup> Exhibit 245 Statement of of Dr Allan at annexure 'JAA-1'

<sup>173</sup> Exhibit 245 Statement of of Dr Allan and Exhibit 235 Statement of Dr Johnson

<sup>174</sup> Exhibit 238 Medical Board file on Berg

<sup>175</sup> Exhibit 238 Medical Board file, letter from Berg to the AMC dated 23 July 2001

<sup>176</sup> Exhibit 238 Medical Board File, email from Sharon Rayner to Professor Zapryagaev dated 7 September 2001

University had no such educational program in 1977 as the one that Berg claimed to have completed. The email from Professor Zapryagaev to the College of Psychiatrists read:

Voronezh State University did not produce the diploma 'Medical Degree in Psychiatry' number 723438. Moreover, [the] University had no such educational program in 1977.<sup>177</sup>

- 5.87 In that e-mail Voronezh University also asked the College of Psychiatrists to provide a copy of Berg's certificates so that it might determine their authenticity. The College of Psychiatrists then sent a copy of Berg's certificates directly to the Voronezh State University. In a further email from Mr Zapryagaev to the College of Psychiatrists, having examined the certificates he advised that both Berg's degrees were very rough forgeries.<sup>178</sup>
- 5.88 The College of Psychiatrists requested that the Voronezh University confirm by letter that the documents were forgeries and that the Voronezh University did not produce the degrees.<sup>179</sup> The Voronezh University provided that written confirmation.
- 5.89 This course of correspondence establishes that there is prima facie evidence of fraud by Berg.

#### *The College of Psychiatrists informs the Medical Board*

- 5.90 On 16 October 2001, the College of Psychiatrists wrote to the Australian Medical Council advising them of what it had discovered about Berg's claimed qualifications.<sup>180</sup> A copy of that letter was also sent to the Medical Board. However neither the Medical Board, the Australian Medical Council, nor the College of Psychiatrists contacted the Townsville Hospital to inform them of what it had discovered about Berg.
- 5.91 Berg did not give evidence before this Commission and, although invited to make submissions he has not yet done so. However, exhibit 238, the Medical Board's files contains a letter from Berg dated 30 October 2001. Berg wrote to the Mr Ian Frank of the College of Psychiatrists regarding the suggestion that his qualifications were forgeries. He claimed that the action by the College of Psychiatrists in contacting the Voronezh State University was in violation of international agreements concerning refugees. He also claimed that he had not given his permission for the Australian Medical Council or any other party to contact 'authorities' in the Russian Federation as that contact posed a serious risk to his safety.<sup>181</sup>

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<sup>177</sup> Exhibit 238

<sup>178</sup> Exhibit 238

<sup>179</sup> Exhibit 238 Medical Board File relating to Vincent Berg

<sup>180</sup> Exhibit 238 Medical Board File relating to Vincent Berg

<sup>181</sup> Exhibit 238 Medical Board File of Vincent Berg, letter to Ian Frank dated 30 October 2001

5.92 Berg also said in this letter that he considered that by contacting the Voronezh University without his permission the College of Psychiatrists and the Australian Medical Council had committed an unlawful act, although his letter does not identify the basis of that claim.

5.93 As to the course of study that he claimed to have undertaken he advised that:

[the course] I was selected to undertake [was] an exclusive course, which was designed to prepare highly qualified physician-psychiatrists for work in some special government departments, such as the Ministry of Foreign Affairs, Ministry of Defence, Ministry of Internal Affairs, and the KGB ... I am not in a position to tell you more about this course, but can only stress again that it was a special course, and no authority in the Russian Federation would ever disclose any information about this course and its students even within Russia, particularly to a foreign country.<sup>182</sup>

5.94 Berg claimed that the information from the Voronezh State University was false and that by providing it the Russian authorities were attempting to further persecute him.

5.95 In early December 2001, Berg contacted the Medical Board seeking a certificate of good standing from the board.<sup>183</sup> Following some further correspondence between the Medical Board and Berg, on 10 January 2002 the Medical Board issued, directly to Berg, a Certificate of Good Standing. That certificate was valid for three months and bore the notation:

The Board has not been able to verify the qualification on which Dr Berg's registration was granted.<sup>184</sup>

5.96 On 29 January 2002 Berg applied to the Medical Board of Western Australia for conditional registration under an area of need.<sup>185</sup> He was granted provisional registration. The Medical Board of Western Australia subsequently discovered, through the Royal Australian and New Zealand College of Psychiatrists, the doubts about the veracity of Berg's claimed qualifications.<sup>186</sup> Berg's conditional registration in Western Australia was then cancelled on 28 February 2002. The Medical Board of Western Australia then sent a facsimile to its counterparts in all other Australian jurisdictions setting out the above history and providing the following information:

Dr Berg has subsequently advised the Medical Board of Western Australia that he will be returning to Queensland (State in which he was previously registered). It is the Board's understanding Dr Berg will not be pursuing registration in Western Australia.

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<sup>182</sup> Exhibit 238 Medical Board File, letter Vincent Berg to Ian Frank dated 30 October 2001

<sup>183</sup> Exhibit 238 email from Vincent Berg to the Medical Board dated 23 December 2001

<sup>184</sup> Exhibit 250 Statement of Michael Demy-Geroe, attachment MDG-17

<sup>185</sup> Exhibit 238 Medical Board file on Vincent Berg, facsimile from Medical Board of Western Australia to the Medical Board of Queensland dated 13 March 2002

<sup>186</sup> Exhibit 238 Medical Board file on Vincent Berg, facsimile from Medical Board of Western Australia to the Medical Board of Queensland dated 13 March 2002

Should Dr Berg apply for registration within your jurisdiction, please contact me for further background concerning this matter<sup>187</sup>

*Dr Allan discovers the doubts about Berg's past*

- 5.97 The Townsville Hospital learned of the concerns about Berg's qualifications only when Dr Allan attended a function hosted by the College of Psychiatrists in Melbourne. That function was held in November 2002, some 13 months after the College of Psychiatrists had written to the Medical Board and the Australian Medical Council about Berg.<sup>188</sup> During that function, a colleague of Dr Allan's asked him 'whatever happened to that Doctor who was not a doctor?' After some discussion Dr Allan realised that his colleague was referring to Berg.
- 5.98 Upon his return to the Townsville Hospital Dr Allan then advised Dr Johnson, the Executive Director of Medical Services about what he had been told by his colleague in Melbourne. On 28 November 2002, Dr Johnson telephoned the Royal Australian and New Zealand College of Psychiatrists seeking confirmation from the college about Dr Berg's qualifications. On the same day Dr Johnson wrote to the College seeking written confirmation regarding the validity of Berg's qualification.<sup>189</sup>
- 5.99 The College of Psychiatrists replied to Dr Johnson in a letter dated 2 December 2002<sup>190</sup> advising that it had information that Berg's qualifications were forgeries. The College of Psychiatrists also advised that on 16 October 2001 it had written to the Australian Medical Council and the Medical Board of Queensland advising them of the discrepancies identified in Berg's qualifications. Dr Johnson then wrote an email to the then General Manager of Health Services, Dr Steve Buckland advising him of the problem.

*Concerns expressed by the Townsville Hospital*

- 5.100 Dr Buckland's recollection was that he was advised by his media advisor that Dr Johnson and Dr Allan intended to hold a public meeting about Berg. Dr Buckland telephoned Dr Johnson to discuss the proposed public meeting. Dr Buckland recalled that, at the time, he had real concerns about the proposed meeting as, in his view, giving information such as this to patients during a public meeting may have an adverse effect on them.<sup>191</sup> In his evidence Dr Buckland stated that, at the time, no decision could be made about communicating to patients until such time as all the affected patients had been identified.

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<sup>187</sup> Exhibit 238 Medical Board file on Vincent Berg, facsimile from Medical Board of Western Australia to the Medical Board of Queensland dated 13 March 2002

<sup>188</sup> Exhibit 245 Statement of Dr Allan, T3481 line 12 - 27

<sup>189</sup> Exhibit 234 annexure 'AJJ-2'

<sup>190</sup> Exhibit 234 annexure 'AJJ-3'

<sup>191</sup> Exhibit 336 at paras 208-210

- 5.101 On 4 December 2002 Dr Peggy Brown, the then Director of the Mental Health Unit in Queensland Health, who had been in Townsville on unrelated business at the Townsville Hospital, met with Dr Johnson.<sup>192</sup> Dr Brown's recollection is that Dr Johnson briefed her on the matter and that an audit of all patients was being performed, he also advised her that the Townsville Hospital intended to make a public disclosure. Dr Brown had some concerns about making a public disclosure as proposed by Dr Johnson.
- 5.102 On 5 December 2002 Dr Brown met with Dr Buckland when she apparently discussed her concerns about the potential risk to mental health patients against the public benefit of any such disclosure.<sup>193</sup> Dr Brown did not provide any written advice to Dr Buckland with respect to Berg.
- 5.103 On 6 December 2002, Mr Ken Whelan the District Manager of the Townsville Health Services District wrote to the Medical Board of Queensland as follows:

I write to express my significant concern at the Medical Board's handling of matters surrounding Vincent Victor Berg.

It has come to my attention that the Medical Board was made aware in January 2002 that Vincent Victor Berg allegedly did not hold the primary medical qualifications he claimed in order to obtain registration in Queensland.

I am advised that you noted this was the case and did not seek to notify the Townsville Health Service District, which had been his sole employer during the period of his registration. It needs to be noted that Queensland Health employed Mr Berg on the belief that his preliminary registration had been granted by the Medical Board.

We are now faced with the task of identifying all patients seen by Vincent Berg over the period of his tenure with the Townsville Health Service District to identify whether there has been any adverse outcomes for patients.

The time delay in finding out this information, which was only identified as an incidental remark in discussions with the College of Psychiatrists, has led to significantly increasing the difficulty for the District and has potentially left patients at risk over a much longer period than was necessary.

I seek your explanation for the failure to notify the Townsville Health Service District and your undertaking that procedures will change within the Medical Board to ensure that we are notified of any significant issues in the future in a timely manner.

Further I seek your assurance that the Medical Board will be reporting this matter to the Police for investigation as a criminal offence.<sup>194</sup>

- 5.104 The Medical Board, in a letter dated 28 January 2003, replied as follows:

It is regretted that Townsville Health Service District were not notified when the Board became aware that Mr Berg did not hold recognised qualifications to enable him to be registered to undertake postgraduate training in psychiatry.

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<sup>192</sup> Exhibit 376 part C para 15

<sup>193</sup> Exhibit 376 part 3 para 20

<sup>194</sup> Exhibit 248 Statement of Ken Whelan annexure KDW-2



As a result of your concerns, a process has been put in place to ensure that employing authorities are notified if it is subsequently found that a person, who has been registered, in fact did not hold recognised qualifications<sup>195</sup>

- 5.105 Missing from this reply is a response to Mr Whelan's request that the matter be referred by the Medical Board to the Queensland Police Service for investigation. The Medical Board did have further interaction with Berg in later months, a matter that is discussed below.
- 5.106 At some time in early December 2002, Mr Whelan contacted Dr Buckland to seek his advice on whether the matter should be reported to Queensland Health's Audit and Operational Review Branch. Dr Buckland advised Mr Whelan to contact Mr Michael Schaefer the Director of the Audit and Operational Review Branch.<sup>196</sup>
- 5.107 On 9 December 2002, Mr Whelan wrote an email to Mr Michael Schaefer in the following terms:

Steve Buckland suggested I contact you about the following.

Back in January 2000 to January 2001 this district employed a NON training registrar in Psychiatry named Victor Berg the story is a long one but the short version is that this chap was apparently a Russian who attained refugee status in Australia. He was given provisional registration from the Australian [sic] Medical Board and was employed in this district as a psych reg. Apparently when he left here he was even given references from existing specialists.

The down side is the district has now found out that apparently this chap is not and never has been a doctor. Dr Andrew Johnson my Med Super found this out accidentally when discussing another case with the college. Apparently this chap is still in Australia but not in Queensland.

I have some clinical staff reviewing all the patients he saw to try and establish the extent of the problem. I guess the good news is because he was a registrar his work was supervised but it does raise the question about how a non doctor could work with specialists for a year and not be sprung.

The question I guess is impersonating a doctor is no doubt a criminal offence but given the person is no longer in Queensland is this a matter for us? Queensland Police? Or the Medical Board to follow up. I am led to believe that as a public servant if we suspect criminality we have an obligation to report?

For obvious reasons we are keeping this strictly confidential at present we need total control of the facts before the media get involved.

Your advice would be appreciated<sup>197</sup>

- 5.108 On 10 December 2002, Mr Max Wise, who had been delegated the responsibility of replying to Mr Whelan's email advised:

Impersonating a doctor is in fact a criminal offence and therefore constitutes 'suspected official misconduct' under the Crime and Misconduct Act 2001. This also means that his actions should be reported to the Audit Branch...

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<sup>195</sup> Exhibit 238 Medical Board File on Berg

<sup>196</sup> Exhibit 336 para 217

<sup>197</sup> Exhibit 248 attachment KDW-1

We have an 'in-house' Queensland Police Detective working in Audit, so I will allocate the matter to him. I will also make the necessary inquiries with the Medical Board'.<sup>198</sup>

- 5.109 On 11 December 2002 Mr Whelan replied to Mr Wise advising him to contact Dr Johnson if any further information was required.<sup>199</sup>
- 5.110 On 17 December 2002 Mr Schaefer and Mr Wise wrote to the Crime and Misconduct Commission reporting the suspected official misconduct.<sup>200</sup>
- 5.111 Mr Whelan had no recollection of referring the matter to the Audit and Operational Review Branch.<sup>201</sup> At the time Mr Whelan had recently arrived in the country and suffered a serious illness in early January 2003. A copy of Mr Whelan's email to Mr Schaefer was not kept on file at the Townsville Hospital. Mr Whelan explained that he was not familiar with Queensland Health policies concerning the retention of documents such as emails in hard copy and therefore failed to keep a hard copy of this email.<sup>202</sup>

#### *Action taken by the Hospital*

- 5.112 Dr Johnson and Dr Allan had real concerns about the patients that had been treated by Berg during his time at the hospital. Dr Allan, a psychiatrist of 17 years experience, felt that there was a strong possibility that as Berg may have had no qualifications every clinical decision that he had made was potentially invalid.<sup>203</sup> Dr Allan then performed an audit of the charts of all patients that may have come into contact and been treated by Berg during his time at the Hospital.
- 5.113 Dr Allan completed his audit of patient charts in early January 2003. He identified 259 patients that Berg had come in contact with and possibly may have treated. Of those patients Dr Allan identified one patient who had died as a result of a fall at the Charters Towers Rehabilitation Unit. Dr Allan had concerns that Berg had changed this patient's medication which may have caused disziness in the patient resulting in the fall and subsequent death.
- 5.114 Dr Allan also identified 10 patients that were at the highest clinical risk who he thought required immediate follow up. He identified a further 40 patients who, in his opinion, required clinical follow up as a matter of urgency.<sup>204</sup> As a part of his audit Dr Allan prepared a communications plan and draft media release as he, along with Dr Johnson, felt that it was necessary to contact the patients to advise them what had occurred. Obviously this proposal resulted in the distinct possibility that the 'story' would find its way into the media. Dr Johnson and Dr

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<sup>198</sup> Exhibit 248 attachment KDW-2

<sup>199</sup> Exhibit 248 attachment LDW-3

<sup>200</sup> Exhibit 239 Queensland Health Investigation File T3563

<sup>201</sup> Exhibit 248 para 47

<sup>202</sup> Exhibit 245 Statement of Dr Allan

<sup>203</sup> Exhibit 245 Statement of Dr Allan, annexure JAA-2

Allan proposed to advise the media of what had occurred and what steps the Hospital was taking to address the concerns it had about the clinical treatment by Berg.<sup>205</sup>

- 5.115 The audit, the communications plan, and the draft media release were then annexed to a briefing note to the Minister dated 9 January 2003. That briefing note went up the chain of command and was received by Dr Buckland on 13 January 2003.

#### *Reaction by Dr Buckland*

- 5.116 Dr Buckland wrote on the brief:

This brief is incomplete – while the RANZCP opinion is provided, the Medical Board of Queensland position and view must be included as it significantly alters the slant of this issue<sup>206</sup>

- 5.117 Dr Buckland ordered that the brief be returned to the Townsville Hospital for review and completion.

- 5.118 The revised briefing note was received by Dr Buckland late January 2003.<sup>207</sup> That briefing note outlined the planned strategy for clinical follow up and also included the following comments:

#### Other Action Required

Many clinical staff maintain that there exists an ethical obligation on Queensland Health to inform patients that they have been receiving care from a person whose qualifications to provide that care have been found to be invalid. This raises serious concerns about the potential for adverse public comment. Direction is sought from GMHS as to whether any of the patients subject to this audit are to be informed of the validity of Vincent Berg's claimed qualifications.

- 5.119 On 31 January 2003, Dr Buckland noted his advice on the brief as follows:

...I have had this discussion on at least 4 separate occasions with medical and management staff including Drs Allan and Johnson. My instructions have been clear and have not altered. The process is appropriate, ethical and clinically sound, given that the client base have a mental illness. Any at risk patients have been identified and managed.<sup>208</sup>

#### *Rejection of the proposed Communications Strategy*

- 5.120 The communications strategy prepared by Dr Allan and Dr Johnson was never put into action following the direction from Dr Buckland.<sup>209</sup> Dr Buckland stated

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<sup>205</sup> Exhibit 245, 234, T3360 line 2 – 30, T3481 line 17 - 3483 line 5

<sup>206</sup> Exhibit 336 annexure SMB 62

<sup>207</sup> Exhibit 336 Statement of Steve Buckland, annexure SMB 63

<sup>208</sup> Exhibit 336 Statement of Steve Buckland, annexure SMB 63

<sup>209</sup> Dr Buckland admitted that it was likely that the Director-General and Minister for Health would accept his advice on this issue. T5526 line 25

that the decision not to go to the media was a difficult one. However his decision was, he said, based on the following considerations.<sup>210</sup>

- There was a risk posed to a large number of patients that they may be adversely affected by the media coverage of Berg. That risk included stopping medication, withdrawing from the therapeutic relationships and suicide.
- This risk was to all psychiatric patients not simply those treated by Berg.
- The vast majority of patients treated by Berg had been identified and reviewed.
- Informing those patients who had been treated by Berg would inevitably lead to media coverage and the inherent risks above.

5.121 While these considerations may be reasonable, I remain concerned about the decision for the following reasons:

- Dr Buckland appears to have made his decision soon after the matter arose, and perhaps based purely on Dr Brown's verbal advice given in the meeting of 5 December 2002;
- The decision ignored the opinion of Dr Allan, as provided in the briefing note of 13 January 2003. He was a psychiatrist of long experience and standing within the profession. Dr Allan was arguably the best person to assess the potential impact on patients in Townsville, as he had been the Director of Mental Health in Townsville since 1985;<sup>211</sup>
- In the context of other reports located by this Commission,<sup>212</sup> it is not unreasonable to draw an inference that the Berg matter was kept confidential to avoid adverse publicity rather than for legitimate clinical reasons;<sup>213</sup>
- Finally, the statement that, 'in exceptional circumstances, it is appropriate for a medical practitioner not to disclose information where it may cause greater harm to disclose that information,'<sup>214</sup> proceeds on the assumption that mental health patients are not entitled to the same rights of informed consent as other patients.

5.122 The decision was no doubt a difficult one. On the evidence there were a number of factors that would support a decision to release the information and there were some which justified maintaining confidentiality with respect to

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<sup>210</sup> Exhibit 336 paras 224-228

<sup>211</sup> Exhibit 245

<sup>212</sup> See the reports identified as the Lennox Report (Exhibit 55), The North-Giblin Report (Exhibit 38), The Johnson-Farlow Report (Exhibit 56), The Miller Report (Exhibit 126)

<sup>213</sup> T3365 line 21

<sup>214</sup> Exhibit 336 para 223

Berg. But it is difficult to avoid reaching a conclusion that one of the reasons which motivated Dr Buckland's view, from the very first, was a desire to avoid publicity.

#### *Police involvement*

- 5.123 At 9:37 am on 23 January 2003, Mr Whelan sent an email to a local police officer, Christopher Reeves.<sup>215</sup> In that email Mr Whelan asked for advice on a number of matters. Firstly, he sought some information on the whereabouts of Berg as Dr Allan had expressed some concern for his personal safety if the matter became public. Secondly, he enquired about any other assistance or advice that the Police might be able to provide.
- 5.124 At 12:50pm Mr Reeves sent an email to Mr Whelan that advised, among other things, that Berg appeared to have committed the offence of fraud, and that the Crime and Misconduct Commission should be advised as it would appear that Berg's conduct could amount to official misconduct. He also advised that the Queensland Police Service does require an official complaint to be made to it before the Police Service could investigate Berg's activities.<sup>216</sup>
- 5.125 On the same day at 2:19pm following an earlier telephone conversation between Mr Whelan and Mr Terry Mehan the Northern Zonal Manager, Mr Whelan sent an email to Mr Mehan summarising what he had discussed with the local police.

#### *Further reaction of Dr Buckland*

- 5.126 At 3:31pm the following day Mr Whelan sent an email to Mr Mehan seeking his advice and help on how he should handle the matter further. At 3:42pm Mr Mehan forwarded Mr Whelan's email to the General Manager Health Services, Dr Buckland.
- 5.127 At 3:51pm that day, some 20 minutes later, Dr Buckland replied to Mr Mehan in the following terms:

The fact that the Medical Board registered Dr Berg means that he has not misrepresented himself to Queensland Health. If he has misrepresented himself to the Medical Board, that is an issue for the Board and not QH.

There seems to be some inability for Dr Johnson et al to brief properly. QH does not register medical practitioners. We employ them. Dr Berg was registered by the Board when we employed him. Our issue is about the quality of his performance. In discussions with the Board they refuse to acknowledge that he was not registrable. Game set and match.

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<sup>215</sup> Exhibit 236 Statement of Mr Ken Whelan annexure KDW-4

<sup>216</sup> Exhibit 248 Statement of Ken Whelan, annexure KDW-4

Therefore there is no official misconduct and no need to report. The QPS should be given these facts<sup>217</sup>

- 5.128 The statement that, because the Medical Board refused to acknowledge that Berg was not registrable, there was no official misconduct by him was plainly wrong. There was, as Dr Buckland must have known, prima facie evidence that his so called qualifications were forgeries. This statement tends to support the suspicion expressed in paragraph 5.122 in this chapter above. It is also contrary to the advice that Dr Buckland apparently gave Mr Whelan in early December, a mere seven weeks earlier.
- 5.129 That email was then forwarded to Mr Whelan at 4:27pm that day. Mr Whelan took that email as an instruction that he was to take no further action to refer the matter to the CMC or the Queensland Police Service.<sup>218</sup> Dr Allan recalled that he was instructed by either Dr Johnson or Mr Whelan that he was not to contact the media; nor was he to advise any patient about the fact that Berg was not a qualified medical practitioner.<sup>219</sup>

#### *The Townsville Hospital contacts patients*

- 5.130 In any event, the Townsville District Health Service did contact the majority of those patients that had been identified as being 'high risk'.<sup>220</sup> Dr Allan had initially prepared a 'script' to be used when contacting patients. He was unable to use that script as he had been instructed that he was not to inform patients about Dr Berg's qualifications. However, in contacting those patients Dr Allan testified that he felt considerably constrained in what he could say:

When speaking to the ... patients I was very constrained in what I would tell those patients and the questions that I could ask those patients as I was unable to discuss all aspects of Mr Berg. That made it difficult for me to perform a meaningful analysis of their care and treatment.<sup>221</sup>

- 5.131 Nevertheless, while one may be reasonably confident that the vast majority of patients had been identified and reviewed there remained a risk that some patients were not assessed and reviewed especially when one has regard to Berg's apparent tendency to practise independently without supervision.

#### *Termination of investigations by the Police and CMC*

- 5.132 Notwithstanding Dr Buckland's email of 23 January 2003, the apparent fraud had been referred to the Crime and Misconduct Commission by Mr Michael

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<sup>217</sup> Exhibit 236

<sup>218</sup> Exhibit 236 para 45

<sup>219</sup> Exhibit 245 para 45, 46 Statement of Dr Allan

<sup>220</sup> Exhibit 245 para 50 Statement of Dr Allan

<sup>221</sup> Exhibit 245 para 50

Schaefer, the Director of the Audit and Operational Review Branch of Queensland Health.<sup>222</sup>

- 5.133 Several months later on 4 June 2003, Detective Sergeant Wayne Pennell of the Queensland Police Service contacted the Townsville Hospital to enquire whether the hospital wished to take any further action with respect to Berg. Dr Johnson advised that the hospital did not wish to proceed with any action against Berg.<sup>223</sup> The administration at the Townsville Hospital remained unaware that the matter had, in fact, been referred to the Crime and Misconduct Commission on 17 December 2002.
- 5.134 The Crime and Misconduct Commission had been advised by Audit and Operational Review that the matter had been referred to the Queensland Police Service, and in any event Berg was no longer residing in Queensland.<sup>224</sup> It is also apparent that the Crime and Misconduct Commission were advised that Berg was no longer a current employee of Queensland Health.<sup>225</sup> The Crime and Misconduct Commission, appropriately, referred the matter back to the Audit and Operational Review branch of Queensland Health for further investigation.
- 5.135 On 28 January 2003, Mr Max Wise, the manager of Audit and Operational Review Branch wrote an email to Mr Robert Walker of the Crime and Misconduct Commission in the following terms:
- The matter has been reviewed by QH's in-house QPS officer, who has not identified any Criminal Code breaches in relation to Mr Berg's application for registration – therefore no investigation is proposed.
- Following discussions with the medical registration board it has also been established that that agency does not intend initiating prosecution proceedings due to a lack of evidence to establish it was misled by Mr Berg. However, steps have been taken such that it is now 'practically impossible' for Mr Berg to obtain registration as a medical doctor in Australia.
- The Department intends taking no further action in relation to this matter and will now proceed to [close] the file.<sup>226</sup>
- 5.136 The Audit and Operational Review Branch of Queensland Health did not identify any criminal offences associated with Berg's registration. It reached this conclusion without contacting any staff member of the Townsville Hospital during the course of its investigation.<sup>227</sup> There are no witness statements or notes of interviews within the Queensland Health Investigation File. The only contact was with Mr O'Dempsey of the Medical Board.

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<sup>222</sup> Exhibit 239 Queensland Health Investigation File into Vincent Berg

<sup>223</sup> Exhibit 234 annexure AJJ-7 and T3366 line 12 - 23

<sup>224</sup> Exhibit 239 Queensland Health Investigation File into Vincent Berg letter from the CMC to Mr Schaefer dated 3 January 2003

<sup>225</sup> Exhibit 239 Queensland Health Investigation File into Vincent Berg, letter to Ms Couper

<sup>226</sup> Exhibit 239

<sup>227</sup> T3363 line 2 - 10

5.137 Upon completion of the investigation the investigator prepared a memorandum dated 20 January 2003 that concluded:

A perusal of the Queensland Criminal Code fails to find any criminal offence relation to ... Berg attempting to gain registration as a Doctor/Psychiatrist. There is also some doubt as to whether or not he actually committed an impersonation of a doctor, as during his employment in Queensland, he was a Clinical Observer at the Gold Coast Hospital and undertaking training at Townsville General Hospital. Even so, there is still no known offence of impersonating a doctor under the Queensland Criminal Code.<sup>228</sup>

5.138 In my opinion these conclusions are wrong for several reasons:

- First, there is prima facie evidence (though possibly inadmissible), evidence of offences that Berg may have committed that are discussed below;
- Secondly, the conclusion that there was doubt whether Berg 'committed an impersonation of a doctor due to the fact that he was undertaking training at the Townsville General Hospital' ignores the fact that Berg was registered and employed as a medical practitioner and was undertaking training in order to achieve specialist registration. Therefore, he was a doctor employed by Queensland Health.
- Thirdly, while there is no specific offence of impersonating a doctor under the *Criminal Code*, s502 creates the offence of attempting to procure unauthorised status which is discussed below.

5.139 The memorandum also concluded that Berg was no longer within Queensland and therefore it would not be in the public interest to continue investigations.

5.140 The file was submitted for closure on 30 January 2003. That closure was approved by the Crime and Misconduct Commission, and Queensland Health for the following reasons:<sup>229</sup>

The Matter was assessed by the Queensland Health – QPS Liaison Officer, who was not able to identify any breaches of the Criminal Code. However, providing misleading information in relation to an application for registration is a breach of the legislation as administered by the OHPRB.<sup>230</sup> Inquiries with the OHPRB indicate that no prosecution was contemplated by that agency due to an inability to establish that the qualifications were in fact forgeries. Mr Berg's present whereabouts are also unknown to the OHPRB<sup>231</sup>

5.141 The Medical Board's file reveals that as recently as 28 April 2003, some months after the file was submitted for closure, the Medical Board was corresponding by email with Berg. In that email correspondence, Berg provided a postal address at the Gold Coast.<sup>232</sup> There is also nothing on the

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<sup>228</sup> Exhibit 239 Queensland Health investigation file

<sup>229</sup> Exhibit 239 QH investigation file Memorandum to Director-General dated 30 January 2003

<sup>230</sup> Office of Health Practitioner Registration Boards

<sup>231</sup> Exhibit 239 QH investigation file

<sup>232</sup> Exhibit 238 email from Vincent Berg to the Australian Medical Council



Queensland Health Investigation file that shows that any attempts were made to locate Berg prior to closing the file.<sup>233</sup>

*Evidence of offences committed by Berg*

5.142 Whether or not there is sufficient evidence to justify a referral of Berg's conduct to the Commissioner of the Police Service depends on whether there is sufficient evidence that the qualifications he submitted to the Medical Board are forgeries. In my view, the correspondence from the Voronezh State University and the e-mail communications between the College of Psychiatrists and Professor Zapryagaev are sufficient evidence to establish, subject to that being proven in a satisfactory way, a prima facie case that they are forgeries for the following reasons:

- The Voronezh University has said that no one with the name of 'Tchekaline Victor Vladimirovich', Berg's alleged former name, had graduated as a Doctor of Medicine in Psychiatry;
- The Voronezh University had never employed anyone with the name of 'Tchekaline Victor Vladimirovich'; and
- Perhaps most compelling, that at the relevant time the Voronezh University did not offer the course that Berg claimed to have completed.

5.143 My concerns are sufficient to warrant a referral to the Commissioner of the Police Service for further investigation of Berg for the following criminal offences:

- Fraud – s408C Criminal Code;
- Forgery and uttering – s488 Criminal Code;
- Attempts to procure unauthorised status – s502 Criminal Code;
- Assault – s245 Criminal Code.

5.144 Section 408C of the *Criminal Code* provides for the offence of fraud:

**Fraud**

A person who dishonestly—

...

(d) gains a benefit or advantage, pecuniary or otherwise, for any person;

...

Commits the crime of fraud.

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<sup>233</sup> Exhibit 239

- 5.145 If Berg's qualifications were forgeries then his registration as a Medical Practitioner under the *Medical Act 1939* was achieved by fraud. It would be open to a jury to conclude that Berg dishonestly gained a benefit or advantage, pecuniary or otherwise, from another person.
- 5.146 In my view, achievement of registration by the Medical Board of Queensland gave Berg a benefit or advantage, which was both pecuniary and non-pecuniary. The pecuniary advantage was that he was entitled to employment by the Townsville Hospital as a Principal House Officer. At the time that allowed him to earn a salary of at least \$58,917.00.<sup>234</sup> Clearly that amounted to a significant pecuniary benefit. The other advantages that Berg gained by registration were associated with the fact that he could hold himself out as a doctor. That would, in my view, amount to a considerable advantage in his standing within the community.
- 5.147 I am satisfied that there is sufficient evidence to warrant further investigation by the Queensland Police Service with respect to the offence of fraud by Vincent Berg.
- 5.148 Section 488 of the Criminal Code creates the offence of forgery and uttering. That section provides (relevantly):
- Forgery and Uttering**
- A person, who, with intent to defraud –
- (a) forges a document; or
- (b) utters a forged document
- commits a crime.
- 5.149 The term 'forge' is defined in section 1 of the *Criminal Code* as follows:
- 'Forge' a document means make, alter or deal with the document so that the whole of it or a material part of it –
- (a) purports to be what, or of an effect that, in fact it is not: or
- (b) purports to be made, altered or dealt with by a person who did not make, alter or deal with it, or by or for some person who does not, in fact exist;
- (c) purports to be made, altered or dealt with by authority of a person who did not give that authority; or
- (d) otherwise purports to be made, altered or dealt with in circumstances in which it was not made, altered or dealt with.
- 5.150 If the certificates that Berg held himself out as holding were not issued by the Voronezh State University then clearly those documents fall within paragraph (a) of the above definition in that they purport to be certificates of the Voronezh State University, when in fact they are not.

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<sup>234</sup> Regional Health Authorities – Senior Medical Officers and Resident Medical Officers Award – State – 1995. s3.4

- 5.151 The other element of the offence that will need to be established is that Mr Berg forged the document with intent to defraud. The intention to defraud is interpreted as acting with deliberate dishonesty to the prejudice of another person's proprietary right.
- 5.152 I am satisfied that the evidence is sufficient to warrant a referral to the Queensland Police Service for further investigation of Vincent Berg for the offence of forgery and uttering under s488 of the *Criminal Code*.
- 5.153 Section 502 of the Criminal Code creates the offence of attempts to procure an unauthorised status. That section provides:
- Attempts to procure an authorised status**
- Any person who –
- ...
- (c) by any false representation procures himself, herself or any other person to be registered on any register kept by lawful authority as a person entitled to such a certificate, or as a person entitled to any right or privilege, or to enjoy any rank or status;
- .....
- is guilty of a misdemeanour, and is liable to imprisonment for 3 years.
- 5.154 This section has not been subject to judicial consideration to my knowledge. However, s502(c) would appear to apply specifically to the matter of Vincent Berg. He made a false representation in that he represented that he had medical degrees from the Voronezh State University. The information summarised above, subject to proof in a satisfactory form, is prima facie evidence that he held no such degrees. As a result of that false representation, he procured himself to be registered on the register kept by the Medical Board. As a result he was then entitled to enjoy the rights and privileges of being a medical practitioner within the State of Queensland. Accordingly, it would appear there is sufficient evidence to warrant a referral to the Commissioner of Police for further investigation of Berg for the offence of 'attempts to procure an authorised status'.
- 5.155 Finally, although there is little evidence before the Commission of the nature Berg's practice, it would seem likely that during the course of his treatment of patients whilst at the Townsville Hospital he may have administered medication and touched individuals during the course of their treatment in circumstances where the patients may have only consented to that touch on the assumption that Berg was in fact a doctor.
- 5.156 In my view that raises the question of whether or not Berg's conduct in any particular circumstance may have amounted to an assault as defined in s245 of the *Criminal Code*. That definition is as follows:

### Definition of Assault

(1) A person who strikes, touches, or moves or otherwise applies force of any kind to, the person of another, either directly or indirectly, without the other person's consent, or with the other person's consent if a consent is obtained by fraud, or who by any bodily act or gesture attempts or threatens to apply force of any kind to the person of another without the other person's consent, under such circumstances that the person making the attempt or threat has actually or apparently a present ability to effect the person's purpose, is said to assault that other person, and the act is called assault.

(2) In this section –

'applies force' includes the case of applying heat, light, electrical force, gas, odour, or any other substance or thing whatever if applied in such degree as to cause injury or personal discomfort.

5.157 During the course of his treatment of individuals at the Townsville Mental Health, Berg may have committed an assault in two ways:

- He may have applied force in the sense that he touched persons in circumstances where their consent was obtained by fraud; the fraud being that Berg represented himself as being a qualified psychiatrist when in fact he held no such qualification.
- He may have administered medication in such a way that it may amount to the extended definition of 'applies force' within s245(2) of the *Criminal Code*. It will need further investigation on behalf of the Queensland Police Service in order to establish whether or not Berg administered 'any other substance' that may have caused injury or personal discomfort to any particular patient. If there is evidence of that, then it may be that Berg has committed an assault.

### Recommendations with respect to Berg

5.158 Accordingly I recommend that the matters relating to Berg be referred to the Commissioner of the Police Service for investigation of the following possible offences committed by Berg:

- Fraud – s408C *Criminal Code*;
- Forgery and uttering – s 488 *Criminal Code*;
- Attempts to procure unauthorised status – s502 *Criminal Code*;
- Assault – s 245 *Criminal Code*.

## Part B: Charters Towers

### Charters Towers

5.159 Charters Towers, a town of approximately 10,000 people, lies 135 kilometres south west of Townsville and is 1350 kilometres distant from Brisbane. Once a major gold mining centre, Charters Towers had a population of over

27,000<sup>235</sup> and was the largest inland city in Queensland. Nowadays, the main industries in Charters Towers are mining, beef and tourism.<sup>236</sup>

## The Hospital

- 5.160 The Charters Towers Hospital is the sole public hospital in Charters Towers, although there is also present in the town a tertiary psychiatric facility, the Charters Towers Rehabilitation Centre.<sup>237</sup> The Charters Towers Hospital, a 25 bed facility, provides a range of services to the local community including accident & emergency, a variety of outpatients sessions and support services including pharmacy and radiography. It also provides some specialist services such as obstetrics, a weekly ante-natal session. Visiting surgical and paediatric services are also offered weekly.<sup>238</sup>
- 5.161 The Charters Towers Hospital is a rural hospital,<sup>239</sup> staffed by general practitioners. The medical staff of a hospital such as the Charters Towers Hospital are best described as rural generalists.<sup>240</sup> Rural generalists are usually general practitioners who have some procedural expertise in fields such as anaesthetics, obstetrics, orthopaedics, general surgery, or a combination of procedural skills. Being by their nature generalist practitioners, such doctors would ordinarily perform low or medium risk procedures within their area of expertise and skill.<sup>241</sup> In a rural hospital such as the Charters Towers Hospital, the Medical Superintendent, or Director of Medical Services (as they are now known), has a clinical workload in addition to his or her administrative responsibilities.<sup>242</sup>
- 5.162 In 2004, the Charters Towers Hospital had 1522 admissions and provided services to a further 40,892 patients.<sup>243</sup> In 2000, the time of the events subject to examination by the Coroner and under consideration here, the Hospital was staffed by Dr Izak Maree, the Medical Superintendent, Dr David Row, a Senior Medical Officer, and Dr Derek Manderson, a Principal House Officer. Access to specialist support was by telephone to the Townsville Hospital, the nearest tertiary referral hospital.<sup>244</sup>
- 5.163 The tragedy subject to the Coronial Inquest, and investigation by Queensland Health, surrounded the treatment of a patient by Dr Izak Maree.

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<sup>235</sup> [http://www.queenslandholidays.com.au/townsville/charters\\_towers.cfm](http://www.queenslandholidays.com.au/townsville/charters_towers.cfm)

<sup>236</sup> [http://www.queenslandholidays.com.au/townsville/charters\\_towers.cfm](http://www.queenslandholidays.com.au/townsville/charters_towers.cfm)

<sup>237</sup> [http://www.health.qld.gov.au/wwwprofiles/charters\\_ctowers\\_rc.asp](http://www.health.qld.gov.au/wwwprofiles/charters_ctowers_rc.asp)

<sup>238</sup> [http://www.health.qld.gov.au/wwwprofiles/charters\\_ctowers\\_rc.asp](http://www.health.qld.gov.au/wwwprofiles/charters_ctowers_rc.asp)

<sup>239</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p29)

<sup>240</sup> Exhibit 297

<sup>241</sup> Exhibit 297 para 21

<sup>242</sup> Exhibit 56; Exhibit 297 para 11

<sup>243</sup> [http://www.health.qld.gov.au/wwwprofiles/charters\\_ctowers\\_rc.asp](http://www.health.qld.gov.au/wwwprofiles/charters_ctowers_rc.asp)

<sup>244</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p10)

## The appointment and employment of Dr Maree

- 5.164 By the middle of the year 2000, the position of Medical Superintendent at the Charters Towers Hospital had been vacant for some time.<sup>245</sup> The Charters Towers Hospital had been, unsuccessfully, attempting to recruit an Australian trained and registered doctor to the position.<sup>246</sup> In May 2000, an international recruitment firm was engaged, and through this firm Dr Maree became a candidate for the position.<sup>247</sup> Dr Maree was a South African trained doctor who claimed some considerable experience in obstetrics and also experience in anaesthetics.
- 5.165 The selection panel for the position of Medical Superintendent comprised the outgoing Medical Superintendent, the District Manager and the Human Resources Manager of the Charters Towers Hospital.<sup>248</sup> Having reviewed Dr Maree's resume, the panel conducted a telephone interview of Dr Maree and resolved to offer the position to Dr Maree, subject to checking with his referees.<sup>249</sup> Dr Maree's referees confirmed the experience he claimed in his resume.
- 5.166 In considering whether or not the appointment of Dr Maree to the position of Medical Superintendent, should have been made, the Coroner relied on evidence given to him by Dr Andrew Johnson, the Executive Director of Medical Services at the Townsville Hospital, who stated that, based on Dr Maree's resume, qualification, and references: 'he would have gained a position in any facility [similar to Charters Towers Hospital] around the country'.<sup>250</sup>
- 5.167 Dr Maree, as the Medical Superintendent of the Charters Towers Hospital, had both an administrative workload, and a clinical workload. However, his primary role was the provision of clinical services.<sup>251</sup>
- 5.168 During the months he was employed at the Charters Towers Hospital, Dr Maree treated a variety of patients,<sup>252</sup> performed ward rounds and on-call duties. He also performed procedures in obstetrics<sup>253</sup> and administered anaesthetics,<sup>254</sup> as would be expected in a rural hospital such as Charters

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<sup>245</sup> According to the Coroners findings, the position had been vacant since sometime in 1999 see:

<http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p24)

<sup>246</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p24)

<sup>247</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p24)

<sup>248</sup> T3407 L22

<sup>249</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p24)

<sup>250</sup> T3407 L29

<sup>251</sup> Exhibit 56 para 9

<sup>252</sup> Exhibit 56

<sup>253</sup> particularly caesarean sections; see Exhibit 56 para 51

<sup>254</sup> Exhibit 56 para 52

Towers.<sup>255</sup> As the Medical Superintendent, Dr Maree was also the clinical leader of the Charters Towers Hospital.<sup>256</sup>

### Dr Maree's clinical privileges

5.169 Dr Maree exercised extensive clinical privileges at the Charters Towers Hospital. During his time as Medical Superintendent he practised in the following areas:

- Obstetrics including caesarean deliveries;<sup>257</sup>
- General surgery, such as tubal ligation;<sup>258</sup>
- Accident and Emergency;<sup>259</sup>
- Anaesthetics;<sup>260</sup> and
- General Medicine.<sup>261</sup>

5.170 Dr Maree was never granted clinical privileges by a credentialing or clinical privileging committee,<sup>262</sup> and exercised what was described by the coroner as 'implied' privileges only. Nor were his credentials examined by an appropriate credentialing and privileging committee.

### Ms Sabadina attends the Charters Towers Hospital

5.171 Ms Kathryn Sabadina, mother of two, lived with her parents at Charters Towers.<sup>263</sup> Ms Sabadina and her children had been living in Charters Towers for some time.<sup>264</sup> Ms Sabadina was a loving and dedicated parent to her two children, one of whom required 24 hour care due to a disability. At the time of her death she had become engaged to her long term partner.

5.172 On 13 December 2000, Ms Sabadina attended her local dentist, Dr Lingard, complaining of a toothache. Under a local anaesthetic Dr Lingard, removed the pulp of the offending tooth and applied an antibiotic dressing. Some days later, whilst visiting Townsville, Ms Sabadina's face became swollen and she was in severe pain. Her fiancé contacted Dr Lingard who advised him that Ms Sabadina should see a doctor and obtain some medication. On Saturday 16 December 2000, Dr Lingard received a further call from Ms Sabadina's fiancé who told him that Ms Sabadina was still in severe pain and her face remained

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<sup>255</sup> Exhibit 56 para 9

<sup>256</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (page 27)

<sup>257</sup> Exhibit 56 para 34

<sup>258</sup> Exhibit 56 para 37

<sup>259</sup> Exhibit 56 para 37

<sup>260</sup> Exhibit 56 para 42, although Dr Maree only performed 4 general anaesthetics

<sup>261</sup> Exhibit 56 para 49

<sup>262</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (page 27)

<sup>263</sup> Exhibit 56 para 58

<sup>264</sup> Exhibit 56 para 58

swollen. She had attended the Townsville Hospital the previous evening and received an injection for the pain. Ms Sabadina and her fiancé agreed to return to Charters Towers and see Dr Lingard. At 3:00pm that day Dr Lingard saw Ms Sabadina and performed about 2 ½ hours of dental work on the offending tooth. Having done all that he believed he could, Dr Lingard prescribed antibiotics.<sup>265</sup>

- 5.173 On Sunday afternoon, 17 December 2000, Dr Lingard, upon his return from a visit to Townsville, received a message on his answering machine from Ms Sabadina's father. It seemed that Ms Sabadina was in severe pain and had been taken to the Charters Towers Hospital for a pain killing injection. When Dr Lingard next spoke to the family, at about 3:00pm, she was sleeping.<sup>266</sup>
- 5.174 Dr Lingard then began to make enquiries about the availability of a general anaesthetic as he decided to perform an extraction of the tooth. He contacted Dr Manderson, a Senior Medical Officer, who was on call at the Charters Towers Hospital. Dr Manderson informed Dr Lingard that Dr Maree was on call after 5:00pm and he might be available to administer a general anaesthetic. Dr Lingard then contacted Dr Maree and explained the situation, as well as giving Dr Maree some of Ms Sabadina's clinical history.<sup>267</sup>
- 5.175 Dr Lingard saw Ms Sabadina at 4:00pm and proposed that the infected tooth be removed under a general anaesthetic. Ms Sabadina attended the Hospital at 5:00pm and was extremely anxious about the impending operation.<sup>268</sup> At 5:40pm Dr Maree began administering the anaesthetic and almost immediately things began going horribly wrong. Her blood oxygen level began to plummet,<sup>269</sup> her heart rate dropped to 40 beats per minute, and Dr Maree had difficulty in ventilating her.<sup>270</sup> Within minutes Ms Sabadina had no measurable pulse or blood pressure. Dr Maree initially suspected that the nasal tube that delivered the anaesthetic gas to Ms Sabadina's lungs may have found its way into her stomach, a common enough complication. However, when satisfied that the tube was in order, he then queried the blood and oxygen readings on the monitor of the pulse oximeter a machine used to measure pulse, blood pressure and blood oxygen levels. He called for another portable pulse oximeter to be brought into the operating theatre in case the original machine was faulty. At 5:45pm Dr Maree decided to abort the anaesthetic. At 5:50pm other nurses were summoned to the operating

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<sup>265</sup> Exhibit 56 para 58

<sup>266</sup> Exhibit 56 para 58

<sup>267</sup> Exhibit 56 para 59

<sup>268</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p7)

<sup>269</sup> it dropped from 97% to 64% see: <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p8)

<sup>270</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p7)



theatre to assist, and over the next 10 minutes Ms Sabadina received doses of adrenaline and hydrocortisone.<sup>271</sup>

- 5.176 Just before 6:15pm Dr Manderson was called and he ran to the operating theatre to provide what assistance he could. Upon his arrival he suggested that Dr Simpson, a senior anaesthetist at the Townsville Hospital, be contacted for advice. After being brought up to speed with events Dr Simpson made a number of suggestions all of which were acted upon by Dr Maree and Dr Manderson, unfortunately to no avail.<sup>272</sup>
- 5.177 Shortly after 6:15pm Ms Sabadina's heart stopped beating. The medical team started cardio-pulmonary resuscitation. At 7:20pm the doctors and nurses who had been trying to save her life, ceased their efforts and Ms Sabadina passed away.<sup>273</sup>
- 5.178 The death was immediately notified to the Queensland Police Service and an investigation ensued.<sup>274</sup>

### The complaint to Queensland Health

- 5.179 On the next day,<sup>275</sup> Dr Row handed to the District Manager, Mr Peter Sladden, a letter in which he expressed his serious concerns about the clinical competence of Dr Maree.<sup>276</sup> Dr Row provided a copy of his letter to the Medical Board.<sup>277</sup> The gravity of Dr Row's complaint was such that Mr Sladden immediately sought advice from the zonal manager of the Northern Zone, Mr Terry Mehan.<sup>278</sup>
- 5.180 On 20 December 2000, two days after receiving Dr Row's complaint, Mr Mehan appointed Dr Andrew Johnson, the Executive Director of Medical Services at the Townsville Hospital and Dr David Farlow, the Director of Medical Services at the Proserpine Hospital to investigate the matters raised in the complaint.<sup>279</sup>

### The Queensland Health Investigation

- 5.181 The Queensland Health Investigation commenced on 20 December 2000 and concluded in February 2001.<sup>280</sup> Dr Johnson and Dr Farlow determined that 11 separate issues were raised in Dr Row's letter of complaint. Dr Johnson and

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<sup>271</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p9)  
<sup>272</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p9)  
<sup>273</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p10)  
<sup>274</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p10)  
<sup>275</sup> 18 December 2005  
<sup>276</sup> Exhibit 56 para 4  
<sup>277</sup> Exhibit 56 para 4  
<sup>278</sup> Exhibit 56 para 4  
<sup>279</sup> Exhibit 56  
<sup>280</sup> Exhibit 56 para 4

Dr Farlow interviewed 37 witnesses, including several witnesses who gave expert opinions. Dr Johnson and Dr Farlow thoroughly investigated all of the complaints and concerns in Dr Row's letter, drawing various conclusions with respect to the 11 issues.<sup>281</sup> Of the allegations, Dr Johnson and Dr Farlow considered that there was sufficient evidence to support an adverse finding for five of the allegations made by Dr Row. Of the other six they determined that there was insufficient evidence to draw any adverse conclusion with respect to the conduct of Dr Maree.

5.182 The findings of Dr Johnson and Dr Farlow that were of interest to the Commission are that:

- Dr Maree was not entitled to the clinical privileges that he had been exercising; and
- Dr Maree may have acted incompetently with respect to the death of Ms Sabadina;<sup>282</sup>

The other matters canvassed in the report of Dr Johnson and Dr Farlow will not be examined.

### **The Investigators recommendations**

5.183 Following their investigation Dr Johnson and Dr Farlow made a number of recommendations including:<sup>283</sup>

- That the death of Ms Sabadina be referred to the Coroner;
- That their report be provided to the Medical Board of Queensland for further action as the appropriate regulatory body; and
- That the process for credentialing and privileging process in the Northern Zone be reviewed with consideration being given to centralising the privileging and credentialing process in the Northern Zone, particularly for senior medical staff.

5.184 Queensland Health's investigation and response to the complaint was prompt and thorough.

### **The Medical Board's action**

5.185 The Medical Board received Dr Row's letter of complaint shortly after 17 December 2000.<sup>284</sup> On 19 December 2000, the Medical Board communicated with Queensland Health and was advised that Queensland Health was

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<sup>281</sup> Exhibit 56 para 64

<sup>282</sup> Exhibit 56 para 64

<sup>283</sup> Exhibit 56 paras 66, 67

<sup>284</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p27)

investigating the complaints. The Board was also informed that Dr Maree had been suspended from practice during that investigation.<sup>285</sup>

5.186 The Medical Board received a copy of the investigation report of Dr Johnson and Dr Farlow on 23 February 2001. On 22 March 2001, the Board wrote to Dr Maree asking him to show cause why his registration should not be cancelled. On 27 March 2001, Dr Maree advised the Medical Board that he intended to resign from Queensland Health and he did not intend to practise medicine in Australia again.<sup>286</sup> Dr Maree resigned effective 17 April 2001. On 27 November 2001 for reasons discussed by the Coroner (considered below) the Medical Board decided to discontinue its investigation following Dr Maree's departure.<sup>287</sup>

### The Coronial investigation and inquest

5.187 The Queensland Police Service completed its investigation in late 2003, and the Police Report was forwarded to the Coroner on 25 November 2003.<sup>288</sup>

5.188 Following five days of hearings at which 49 exhibits were tendered, the Coroner delivered his findings of 32 pages on 24 August 2005. The Medical Board and Dr Maree were represented at the Inquest. I have read the Coroner's findings and I adopt them unreservedly.

### The Coroner's findings

5.189 The Coroner found that Ms Sabadina had died as a result of anaphylaxis.<sup>289</sup>

5.190 The Coroner found that Dr Maree did not take reasonable care and did not exercise reasonable skill when administering the anaesthetic for the following reasons:

‘...’

- He did not perform a sufficiently comprehensive examination of the patient before administering the anaesthetic drugs.
- It seems he failed to ensure the patient had sufficient fluids from the outset, or as soon as it became apparent that anaphylaxis may be occurring. Dr Mackay [an expert witness before the Inquest] said the patient would have needed many litres of intravenous fluid as soon as possible.

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<sup>285</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p4)

<sup>286</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p28)

<sup>287</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p28)

<sup>288</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> p4, the Coroner did not investigate the delay in the referral and there is no evidence

<sup>289</sup> Anaphylaxis is a sudden, severe, potentially fatal, systemic allergic reaction that can involve various areas of the body (such as the skin, respiratory tract, gastrointestinal tract, and cardiovascular system). Symptoms occur within minutes to two hours after contact with the allergy-causing substance, but in rare instances may occur up to four hours later. Anaphylactic reactions can be mild to life-threatening. (source:

<http://www.foodallergy.org/anaphylaxis.html>)

- He failed to regularly monitor the patient's blood pressure.
- He failed to give staff sufficiently clear and definite instructions concerning the quantities of the drugs when they were suddenly required to prepare them.
- He did not know how to monitor the level of carbon dioxide in the exhaled breath of the patient. Difficulties he had experienced previously when administering anaesthetic with this equipment should have alerted him to his lack of a complete understanding of its operation and the dangers that posed.
- He did not recognise that he could immediately test the accuracy of the pulse oximeter readings indicating that an emergency situation was developing by merely clipping the lead to his finger or that of a nurse and instead wasted time in sending for another.
- He apparently did not recognise the symptoms of anaphylaxis as soon as could reasonably be expected and therefore failed to respond as quickly as could reasonably be expected.
- He administered Vecuronium, a relatively long lasting paralysing drug, when he could not have been sure that he had established an airway.
- He administered too small an amount of that drug to have any significant effect on the patient.
- Almost immediately after administering Vecuronium, he administered neostigmine and atropine to counteract the effects of the Vecuronium apparently unaware or not sufficiently caring that the countervailing properties of the neostigmine would not be effective for 20 to 25 minutes - far too late to assist the patient.
- Not only was the neostigmine unlikely to be of any benefit, it was a dangerous drug to administer to a patient suffering a low heart rate and falling blood pressure, even when accompanied by atropine.
- He failed to administer adrenaline sufficiently quickly to respond to the emergency.
- When it should have been apparent that the patient's low blood pressure and pulse rate would make the intravenous administration of adrenaline ineffective, he failed to take adequate steps to respond to this such as cardiac massage to ensure the adrenaline was circulated to the heart and bronchi. As Dr Mackay put it, 'you don't wait for the monitor to say asystole.'<sup>290</sup>
- He, without good reasons, disconnected the intubation tube from the oxygen supply and sought to ventilate the patient with his own expired breath containing only 14% oxygen when the patient desperately needed 100% oxygen.
- He did not, with sufficient urgency, summon assistance and instead waited nearly 30 minutes to call in another doctor whom he knew was readily available. The expert witnesses testified that Dr Maree should have done this as soon as it became apparent that something was amiss.
- After attempts to resuscitate the patient were abandoned, Dr Maree failed to download from the anaesthetic machine the records that would have

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<sup>290</sup> Asystole is a form of cardiac arrest in which the heart stops beating and there is no electrical activity in the heart. The heart is at a total standstill. [source: [www.medterms.com](http://www.medterms.com)]

enabled a more accurate analysis of what had transpired during the procedure. Further, despite being advised to do so, he failed to ensure that a post mortem sample of blood was promptly taken to enable mast cell tryptase levels to be measured.<sup>291</sup>

- 5.191 While the Coroner found that Dr Maree did not exercise reasonable care and skill, he also did not consider that the evidence necessitated any criminal charges being laid against Dr Maree.

*The Coroners findings concerning Dr Maree's appointment*

- 5.192 When considering the appointment and employment of Dr Maree, the Coroner also identified serious shortcomings at four critical times which might otherwise have served as some guarantee of Dr Maree's clinical competence. They were the appointment of Dr Maree, his registration by the Medical Board of Queensland, his orientation at the Townsville General Hospital, and his credentialing and privileging at the Charters Towers Hospital. I deal with each in turn below.

- 5.193 The Coroner found that the process of appointing Dr Maree was flawed because:

- The selection panel failed to apply appropriate policies concerning appointment on merit;
- The selection panel failed to keep documentation that explained the decision process;
- All the panel did was ask a few general question about Dr Maree's knowledge and experience and recorded their deliberations on a page and a half of notes.
- These shortcomings made it difficult for the request to assess whether an appropriate merit selection process had been followed.

*The Coroners findings on Dr Maree's registration*

- 5.194 The Coroner considered that Dr Maree's registration by the Medical Board represented an opportunity to identify his potential failings. The Coroner's comments regarding the Board's processes:

Because he had secured a position with Queensland Health, the Medical Board granted Dr Maree conditional registration. All that [the Board] required of him was proof that he had such qualifications as would entitle him to registration and to be satisfied that he complied with the provisions of the Medical Act 1939. The Board satisfied itself of these matters by having Dr Maree interviewed by a senior doctor from the Townsville Hospital who then wrote to the Board certifying that Dr Maree met these conditions for registration. It seems this

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<sup>291</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> although the Coroner did state that this was not deliberate (p18 - 20 )

process did not involve any assessment of Dr Maree's suitability for the position he was about to fill nor any review of his level of competence<sup>292</sup>

5.195 Dr Maree was granted conditional registration under s.17C(1)(d) of the *Medical Act 1939*. The Medical Board's file reveals that Dr Maree was registered as an area of need registrant under s.17C(1)(d) of that Act. That section provides:

'A person may be registered for the purpose of enabling an unmet area of need...to be met if the Board is satisfied that the person has suitable qualifications and experience to practise medicine in the area of need.'  
(emphasis added)

5.196 That, in my view, requires the Medical Board to independently satisfy itself of Dr Maree's qualifications and experience. It is clear from the Coroner's findings that the Medical Board relied on an agent of Queensland Health, the prospective employer, to investigate Dr Maree's experience and qualifications. Such a delegation of responsibility was, in my view, inappropriate.

#### *Orientation and induction*

5.197 What was described as an induction, in fact, fell far short of what was appropriate and necessary particularly given that Dr Maree was trained in South Africa.

5.198 Dr Maree had an orientation and induction at the Townsville General Hospital in early September 2000.<sup>293</sup> During the week that was his induction, Dr Maree was introduced to a few people from the Townsville General Hospital with whom he could expect to be in contact during the course of his duties at the Charters Towers Hospital. Notwithstanding that Dr Maree was to have a clinical role in anaesthetics at the Charters Towers Hospital, he did not attend the anaesthetic department at the Townsville General Hospital. He did not have any discussions with any other anaesthetists with respect to the types of equipment that he would be using at Charters Towers Hospital nor was any assessment of his clinical skills conducted. The induction represented another lost opportunity to identify Dr Maree's level of clinical competence, and address any shortcomings that may have been identified.

#### *Credentialing and privileging*

5.199 Finally, had Dr Maree been appropriately credentialed and privileged then that may have alerted his superiors of his limitations.<sup>294</sup> Dr Maree was never subjected to any process of credentialing and privileging. Rather he operated with what the Coroner described as 'implied privileges'. Dr Maree exercised extensive clinical privileges in general medicine, general practice surgery,

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<sup>292</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p26)

<sup>293</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p26)

<sup>294</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p26)

anaesthetics and obstetrics. It seems that Dr Maree exercised those privileges by virtue of his position as Director of Medical Services. The Coroner found that with respect to the exercise of 'implied privileges' by Dr Maree:

That may have been acceptable had Dr Maree been a junior doctor working under the close supervision of a more experienced practitioner. It was obviously problematic when he was the 'boss' of the hospital and expected to give clinical leadership to the two other doctors employed there.<sup>295</sup>

5.200 Dr Johnson and Dr Farlow, in their report recommended that due to the fact the Medical Superintendent is the key position for ensuring quality clinical practice, especially in a rural facility:

The appointment process and granting of clinical privileges must be part of the one process to ensure that the appointed practitioner is capable of exercising the responsibilities incumbent in the role.<sup>296</sup>

5.201 Dr Farlow gave evidence about rural credentialing and privileging in the Northern Zone. Credentials represent the formal qualifications, training and clinical competence of a medical practitioner.<sup>297</sup> As a medical practitioner, the Northern Zone rural credentialing and privileging committee was to assess Dr Maree's credentials and award him clinical privileges.<sup>298</sup> However, Dr Maree did not apply for privileges until 2 December 2000, shortly before Ms Sabadina's death.

### **The Medical Board's attitude to an investigation**

5.202 The Medical Board chose not to continue its investigation as Dr Maree had not renewed his registration and had returned to his home country. The Coroner also addressed the Medical Board's subsequent approach to an investigation into allegations against Dr Maree:

[The Board] told the inquest the decision was based on Dr Maree having left the country and was influenced by the fact that it had a large number of investigations to deal with at the time. [The Board] was waiting for other inquiries such as this inquest to be completed before taking action, to avoid parallel inquiries occurring.

...

it was argued [in the Board's submissions to the Inquest] that no good purpose would have been served by the Board taking further action in this case as the most the Board could have done was de-register Dr Maree and this had already happened as a result of his resignation. Further, they suggest that no disciplinary prosecution in the Health Practitioners Tribunal would have been likely to succeed in the absence of criminal negligence.<sup>299</sup>

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<sup>295</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p27)

<sup>296</sup> Exhibit 56 page 65

<sup>297</sup> Exhibit 257 para 33

<sup>298</sup> Exhibit 257 para 32

<sup>299</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p28)

5.203 In response to those submissions the Coroner found that:

...the Board decided to take no further action in relation to [the complaints]. In my view that was an inappropriate response to the serious allegations contained in the report. The functions of a coronial inquiry are not coterminous with the Board's responsibility to uphold the standards of practice within the health professions and to maintain public confidence. For example, in this case there were 11 allegations of professional misconduct raised against Dr Maree and only one of those was the subject of this inquest. Nor is it appropriate for the Board to postpone taking action until other authorities that may consider some aspects of a practitioner's performance have done so. In my view, the Board should act as quickly as possible to determine matters within its special area of responsibility. It is primarily responsible for the maintenance of public confidence and standards within the profession in Queensland and it is inappropriate for it to forbear from doing its duty in this regard merely because some other body may take some action or the practitioner whose conduct is in question leaves the State.<sup>300</sup>

5.204 The conclusions of the Coroner are undoubtedly correct. It is inappropriate for the Medical Board to refrain from performing its statutory function simply because some other body may also be investigating the matter. Further the statement that the Board had a large number of other complaints to investigate at the time is also unsatisfactory for reasons discussed elsewhere in this report. Significant delay in investigating complaints such as those made against Dr Maree is unacceptable for both the patients and the practitioner concerned.

### **Response by the Northern Zone and the Townsville Hospital**

5.205 Since the death of Ms Sabadina, there have been significant changes in the employment, credentialing and privileging of overseas trained doctors in the Northern Zone. Those changes revolve around an increased role for the Townsville Hospital in the orientation and supervision of overseas trained doctors recruited to work in the Northern Zone. Those changes are detailed above as they largely relate to the role of the Townsville Hospital as the tertiary referral hospital in the Northern Zone.

### **The result**

5.206 The events that occurred in Charters Towers in 2000 are indicative of broad failings of the system of registration, supervision, and complaints management by the Medical Board of Queensland. The events occurred some years before the employment of Dr Patel at the Bundaberg Base Hospital. In a parallel of the events that occurred three years later in Bundaberg, an overseas trained doctor was placed in a position where he was the senior practitioner with no one capable of providing any meaningful supervision. The Medical Board

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<sup>300</sup> <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p31)



relied upon Queensland Health in its recruitment process to verify Dr Maree's qualifications and experience, performing no independent assessment. Dr Maree was not credentialed or awarded clinical privileges, yet was allowed to practise unsupervised. Although Queensland Health, at least in the Northern Zone, appears to have taken steps to address the issues, the events in Bundaberg demonstrate that the fundamental failings in the system remain.

## Part C - The Rockhampton Hospital

### The City of Rockhampton

5.207 Rockhampton, a city of 60,000, is approximately 640 kilometers north of Brisbane.<sup>301</sup> The total population of Rockhampton and its surrounding districts is approximately 120,000.<sup>302</sup> Approximately 29.5% of the population is aged over 50 years, slightly higher than the state average of 28.7%.<sup>303</sup> The indigenous population accounts for approximately 5.4% of the population, above the state average of 3.1%.<sup>304</sup> In general, those two factors often result in a higher demand being placed on medical services.

5.208 Settled on the Fitzroy River in 1855, as a convenient port and service centre for the grazing industry, Rockhampton grew significantly with the discovery of gold in Canoona to the north and later in nearby Mount Morgan.<sup>305</sup> Proclaimed as a city in 1902,<sup>306</sup> the main industries in Rockhampton and the surrounding region are farming, grazing, and meat processing. The city also acts as a service centre for the mining industry located in the Bowen Basin to the west.

5.209 Rockhampton has three hospitals:

- The Rockhampton Hospital, a Queensland Health facility;
- The Mater Private Hospital - Rockhampton, a 125 bed facility;
- The Hillcrest Private Hospital, a 60 bed facility.

There is also a 25 bed Mater Private Hospital located at nearby Yeppoon.<sup>307</sup>

### The Rockhampton Health Service District

5.210 The Rockhampton Health Service District falls within Queensland Health's Central Zone and covers the Shires of Fitzroy, Livingstone, Mount Morgan, the

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<sup>301</sup> [http://en.wikipedia.org/wiki/Rockhampton%2C\\_Queensland](http://en.wikipedia.org/wiki/Rockhampton%2C_Queensland)

<sup>302</sup> <http://www.rockhampton.qld.gov.au/article/detail.asp>

<sup>303</sup> <http://www.health.qld.gov.au/wwwprofiles/rocky.asp>

<sup>304</sup> <http://www.health.qld.gov.au/wwwprofiles/rocky.asp>

<sup>305</sup> [http://en.wikipedia.org/wiki/Rockhampton%2C\\_Queensland](http://en.wikipedia.org/wiki/Rockhampton%2C_Queensland)

<sup>306</sup> [http://en.wikipedia.org/wiki/Rockhampton%2C\\_Queensland](http://en.wikipedia.org/wiki/Rockhampton%2C_Queensland)

<sup>307</sup> <http://www.rockhampton.qld.gov.au/menuview.asp?item=8>

City of Rockhampton, and part of the Shire of Duinga.<sup>308</sup> The population of the district is approximately 102,251 living over a geographical area of 20,060 square kilometres.<sup>309</sup>

- 5.211 The Rockhampton Health Service District includes: the Rockhampton Hospital, three rural hospitals,<sup>310</sup> and a nursing home.<sup>311</sup> The executive staff of the District include: Ms Sandra Thompson, the District Manager; Mr David Yule, Executive Director of Corporate Services; Dr Adrian Groessler, Executive Director of Medical Services, and Mr Lex Oliver, District Director of Nursing.<sup>312</sup>

### The Rockhampton Hospital

- 5.212 Queensland Health classifies the Rockhampton Hospital as a large hospital, whose peers within the Central Zone of Queensland Health include the Bundaberg Hospital, the Caboolture Hospital, the Gladstone Hospital, the Hervey Bay Hospital, the Maryborough Hospital, and the Redcliffe Hospital.<sup>313</sup>
- 5.213 The Rockhampton Hospital, a 227 bed facility,<sup>314</sup> provides a wide range of services to the local community including: General Surgery; Orthopaedics; Obstetrics and Gynaecology; Ophthalmology; Ear Nose and Throat Surgery; General Medicine; Gastroenterology; Renal Services; Paediatrics; Paediatric Cardiology/Endocrinology; Coronary Care; Outpatients Department; Neurology; Anaesthetics; Emergency; and Intensive Care.<sup>315</sup>
- 5.214 Until recently Rockhampton also had the services of Dr John Baker a neurosurgeon who had lived and worked in Rockhampton for 16 years. Dr Baker was one of three neurosurgeons who practised in North Queensland.<sup>316</sup> However, for a number of reasons he moved his practice to Brisbane.<sup>317</sup>
- 5.215 Since the 2002/2003 financial year, the Rockhampton Hospital has experienced significant growth in the demand for its services. In 2002/2003 there was a 4.1% increase in admissions and a 6.1% increase in non-admission activity.<sup>318</sup>

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<sup>308</sup> [www.health.qld.gov.au/wwwprofiles](http://www.health.qld.gov.au/wwwprofiles), viewed 3 November 2005

<sup>309</sup> *Queensland Health Systems Review*, Final Report, September 2005, p78

<sup>310</sup> the Mount Morgan Hospital, the Yepoon Hospital, and the Wooralbina Hospital source:

<http://www.health.qld.gov.au/wwwprofiles/rocky.asp>

<sup>311</sup> [www.health.qld.gov.au/wwwprofiles](http://www.health.qld.gov.au/wwwprofiles), viewed 3 November 2005

<sup>312</sup> As above

<sup>313</sup> Exhibit 385 para 7

<sup>314</sup> [http://www.som.uq.edu.au/som/CQ\\_teachinglocations.shtml](http://www.som.uq.edu.au/som/CQ_teachinglocations.shtml)

<sup>315</sup> [http://www.health.qld.gov.au/wwwprofiles/rocky\\_rocky\\_hosp.asp](http://www.health.qld.gov.au/wwwprofiles/rocky_rocky_hosp.asp)

<sup>316</sup> T3439 including Dr Eric Guazzo and Reno Rossato in Townsville.

<sup>317</sup> T3439 line 30

<sup>318</sup> [www.health.qld.gov.au/www.profiles/rocky\\_rocky\\_hosp.asp](http://www.health.qld.gov.au/www.profiles/rocky_rocky_hosp.asp)

- 5.216 In 2003/2004 there was a further increase of 2.8% in admissions and a 4.8% increase in non-admissions patient activity.<sup>319</sup> 22,002 patients were admitted to the hospital that year.

### Emergency Medicine in Australia

- 5.217 In Australia, emergency medicine is a recognised specialty of which the Australian College of Emergency Medicine is the specialist body.<sup>320</sup> Emergency medicine as a discipline covers virtually all facets of medicine. The nature of emergency departments and the variety of illness and injuries that present to the emergency departments across Australia require a medical practitioner to have both breadth and depth of experience and knowledge.<sup>321</sup>
- 5.218 To become a specialist in emergency medicine a medical practitioner must undergo a minimum of 7 years training in order to attain Fellowship with the Australasian College of Emergency Medicine.<sup>322</sup> Fellows of the College of Emergency Medicine are entitled to use the letters 'FACEM' following their name.<sup>323</sup> When employed by Queensland Health, Fellows of the Australasian College of Emergency Medicine are entitled to be paid as Staff Specialists,<sup>324</sup> which attracts higher remuneration than a Senior Medical Officer.<sup>325</sup>

### The Rockhampton Hospital Emergency Department

- 5.219 The Rockhampton Hospital Emergency Department is regarded by Queensland Health as a major regional emergency department, whose peers include Cairns, Nambour, Redcliffe and Toowoomba.<sup>326</sup> The efficiency and effectiveness of the emergency department is critical to the smooth running of a hospital generally, as the emergency department is often the first point of call for many patients that are admitted to the hospital.<sup>327</sup> During the first 11 months of the 2003/04 financial year, a total 35,735 patients attended the Emergency Department.<sup>328</sup>
- 5.220 Upon arrival at the emergency department, usually by ambulance or self presentation, patients are assessed to determine how quickly each patient needs medical attention. This assessment is to ensure that those patients requiring urgent medical attention receive it promptly, whilst those whose

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<sup>319</sup> [www.health.qld.gov.au/www.profiles/rocky\\_rocky\\_hosp.asp](http://www.health.qld.gov.au/www.profiles/rocky_rocky_hosp.asp)

<sup>320</sup> <http://www.acem.org.au/open/documents/history.htm>

<sup>321</sup> <http://www.acem.org.au/open/documents/overview.htm>

<sup>322</sup> <http://www.acem.org.au/open/documents/elements.pdf>

<sup>323</sup> *Medical Practitioners Registration Regulation 2002* ss 6-8, Sch2

<sup>324</sup> see *District Health Services – Senior Medical Officers' and Resident Medical Officers' Award – State 2003*

<sup>325</sup> see s.5.2 *District Health Services – Senior Medical Officers' and Resident Medical Officers' Award – State 2003*

<sup>326</sup> Exhibit 129 para 4

<sup>327</sup> T2240 line 50

<sup>328</sup> T2240

condition is less serious are treated later. This process of allocated priority according to clinical need is known as 'triage'.<sup>329</sup>

- 5.221 Patients are classified on a triage scale of one to five. Triage category one are those patients whose need for medical attention is immediate, their injuries or illness being life threatening. Category one patients require treatment within two minutes. A Category five patient, by comparison, is the least urgent who ideally should receive treatment within two hours of arriving at the emergency department,<sup>330</sup> although waiting times for well in excess of this can be common for category five patients.<sup>331</sup>
- 5.222 Triage data is collected in hospitals in order to benchmark the performance of emergency departments across the State and between peer hospitals. The information regarding the time each patient waits for treatment is an important measure of emergency department performance. It reflects the efficiency of staff and also indicates whether there are sufficient staff to cope with demand.<sup>332</sup> However, in order to be a useful tool, the data recorded must be accurate. As discussed below, the data collected at the Rockhampton Hospital Emergency Department is inaccurate (at least the data collected in the first half of 2004).

### The Emergency Department Review Report

- 5.223 In 2004 the District Manager commissioned a review into the Rockhampton Hospital Emergency Department.<sup>333</sup> Dr Peter Miller, a Staff Specialist and Director of the Emergency Department at the Toowoomba Hospital, Ms Michelle McKay, Nursing Director at the Toowoomba Hospital, and Mr Tim Williams, an administrative officer at the Emergency Department of the Gold Coast Hospital were appointed to conduct the review. The Review Team visited the Rockhampton Hospital on 15 and 16 June 2004.<sup>334</sup> The final report of the Emergency Department Review ('the Miller Report') was delivered in June 2004.
- 5.224 The Miller Report did not come to the Commission's attention until it was referred to in an article published in *The Courier-Mail* newspaper on 5 July 2005. It was subsequently provided to the Commission, by those who appeared on behalf of Queensland Health, later that day.<sup>335</sup> Queensland Health had not previously provided the report to the Commission, or it seems its own solicitors, despite its obvious relevance.

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<sup>329</sup> T2240

<sup>330</sup> As above

<sup>331</sup> Exhibit 129 page 5 shows that 79.2% of patients in Rockhampton were seen within the required time.

<sup>332</sup> Exhibit 129 page 4

<sup>333</sup> Exhibit 129 attachment A

<sup>334</sup> Exhibit 129 page 1

<sup>335</sup> T1936

- 5.225 The Miller Report identified serious problems in the operations and staffing of the Emergency Department at the Rockhampton Hospital. Firstly, it identified inadequate information management processes, including poor utilisation of the department's existing information management system.<sup>336</sup> This affected the ability of the Emergency Department to manage and track its patients.<sup>337</sup> The Miller report also said that data collected by the department could be utilised to improve its services. However, that data was not being so utilised.<sup>338</sup> This failure devalued data collection in the eyes of the staff, to the point where a degree of apathy became evident as far as data collection was concerned.<sup>339</sup> The staff were either unwilling to use the information technology provided, or did so in an haphazard manner.
- 5.226 The Miller Report also identified that the failure to appropriately use the information management tools meant that the data collected by the hospital was inherently unreliable.<sup>340</sup> With respect to the hospital's published data on waiting time in the Emergency Department the data collection process:
- clearly produces waiting time data that is so fundamentally flawed that it is totally meaningless. No indication of real waiting time performance can be inferred due to the ... process<sup>341</sup>
- 5.227 The Miller Report identified that patients were remaining in the Emergency Department for too long before being admitted to the wards within the Hospital. This delay was not as a result of access block,<sup>342</sup> but rather a delay imposed by the need for the Registrars from the various wards to assess patients in the Emergency Department before admitting that patient into the ward. Ordinarily it is the staff of the Emergency Department who perform that assessment and arrange for the patient to be admitted to the ward. However in the Rockhampton Hospital, before admission to a ward, the Registrar from that ward travels to the Emergency Department to assess the patient resulting in excessive delay. There did not appear to be any sensible explanation for this.
- 5.228 Other problems identified in the Miller Report included:
- That the Emergency Department provided services that fell outside its core role thus draining its resources. For example the hospital's needle exchange service operated through the Emergency Department rather than through a more appropriate body.

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<sup>336</sup> Exhibit 129 pages 6-8

<sup>337</sup> Exhibit 129

<sup>338</sup> Exhibit 129 page 8

<sup>339</sup> As above

<sup>340</sup> Exhibit 129 page 6

<sup>341</sup> Exhibit 129 page 6

<sup>342</sup> the situation where a bed is not available for a patient who requires admission to the Hospital

- The Emergency Department itself was small, crowded, and unsuited to the volume of patients attending the Department.<sup>343</sup>
- The Emergency Department's triage practices were outside accepted practice as it utilised a practice describe as 'rapid triage' followed by a later, more detailed, assessments of the patients condition resulting in duplication and wasted time.<sup>344</sup>
- The Director of the Emergency Department was not a member of the clinical management committee as there were no clear lines of communication. The report stated:

It is difficult to imagine how issues concerning the ED [Emergency Department] are discussed, and how the ED is involved in the broader clinical and management issues with the Division and the Hospital.<sup>345</sup>

5.229 However, the key findings of the report concerned the staffing of the Emergency Department.

#### *Staffing of the Emergency Department*

- 5.230 The Miller Report identified a number of problems with the staffing of the Emergency Department, concerns which are particularly pertinent as an example of the difficulties in rural and regional hospitals.
- 5.231 The senior staff of the Emergency Department comprised five Senior Medical Officers comprising the Director of the Department, three permanent employees, and one temporary employee. The Miller Report considered that without the employment of the additional temporary Senior Medical Officer, the service would fall to an unacceptable and unsustainable level.<sup>346</sup> It was notable that the Department did not employ a specialist in emergency medicine, relying instead on Senior Medical Officers.
- 5.232 The junior medical staff of the Emergency Department comprised seven Principal House Officers, three Resident Medical Officers and three Interns. The supervision of the junior medical staff was inadequate for a number of possible reasons:<sup>347</sup>
- Inadequate staffing numbers;
  - The heavy personal case load of Senior Medical Officers;
  - The senior staff concentrating their supervision on the underperformers at the expense of the good performers;

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<sup>343</sup> Exhibit 129 pages 8,9,18

<sup>344</sup> Exhibit 129 pages 7 and 10

<sup>345</sup> Exhibit 129 page 17

<sup>346</sup> Exhibit 129 page 12

<sup>347</sup> Exhibit 129 page 13

- A cultural issue within the department that does not foster close clinical supervision of junior doctors as a high priority goal; or
  - Lack of confidence of the Senior Medical Officers in their own clinical abilities.
- 5.233 The staffing mix of the Emergency Department was highly variable. Many of the staff were not performing at a level commensurate with their employment classification. Indeed, according to the Review Team the situation often arose that staff on lower pay scales were required to 'supervise' staff on higher pay scales.<sup>348</sup>
- 5.234 There was a perception within the hospital staff that the Emergency Department was used as the Hospital's 'dumping ground' for underperforming doctors so that they could be 'managed' there.<sup>349</sup>
- 5.235 Many of the junior medical staff were overseas trained. According to the Miller Report a recurrent theme of the evidence gathered by the Review Team was that the medical knowledge and competencies of a large proportion of the overseas trained doctors within the Emergency Department was inappropriate for the level of practice required in the Emergency Department. In some, the level of English competency was poor to the point of affecting their ability to practise medicine.<sup>350</sup>
- 5.236 The absence of a specialist in emergency medicine adversely affected staff recruitment and retention as well as the standard of clinical care.<sup>351</sup> The absence of specialists in emergency medicine also meant that the Emergency Department was not accredited for training purposes by the Australasian College of Emergency Medicine. Non-accreditation directly impacts on staffing as without accreditation the Emergency Department cannot employ training registrars. That had the following adverse effects:<sup>352</sup>
- There was no specialist role model for junior staff;
  - There was no culture of ongoing professional development amongst the medical staff;
  - There was no incentive for registrars of other disciplines to spend time in the department because their time there would not count towards training in their relevant specialty;
  - There was no prospect of recruiting or retaining staff who may wish to pursue a career in emergency medicine.

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<sup>348</sup> Exhibit 129 page 13

<sup>349</sup> Exhibit 129 pages 13-14

<sup>350</sup> Exhibit 129 page 14

<sup>351</sup> Exhibit 129 page 14

<sup>352</sup> Exhibit 129 page 14

All of these factors lead to poor performance of staff generally.

5.237 Perhaps related to the problems with staffing issues identified above, the Review Team was particularly concerned about the Emergency Department's use of the hospital's Medical Emergency Team. A Medical Emergency Team exists to provide a rapid, skilled medical and nursing response to previously agreed and defined ward based emergency situations.<sup>353</sup> Ordinarily Medical Emergency Teams do not respond to calls in a hospital's emergency department.<sup>354</sup> That department should, ordinarily, have the skills and expertise to manage an emergency situation without calling on outside assistance. However, due to what was described as chronic underperformance of the Emergency Department in fulfilling its core duties, the Emergency Department seemed to be regularly in need of the services of the hospital's Medical Emergency Team to care for patients that the Emergency staff should have been able to care for. The report described this practice as 'worrying in the extreme'.<sup>355</sup> It said:

If the ED [the Emergency Department] cannot perform the service and has to call on emergency response from staff outside the department on a regular, systemised basis it reflects a deficit in ED capacity or skill mix that needs urgent attention.<sup>356</sup>

5.238 The Miller report made a number of recommendations concerning the procedures in the Emergency Department including:<sup>357</sup>

- improvements to data collection and management practices,
- refocusing of the department's services on its core functions,
- education and performance management for staff, and
- improvements to triage practices.<sup>358</sup>

5.239 In respect of staffing of the Emergency Department the Miller Report recommended:<sup>359</sup>

- That as a priority the Emergency Department and the Rockhampton Health Service District be accredited by the Australasian College of Emergency Medicine as an advanced training facility for Emergency Medicine;
- The Emergency Department employs a minimum of four full time Fellows of the Australasian College of Emergency Medicine (or deemed

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<sup>353</sup> T2241

<sup>354</sup> Exhibit 129 page 8

<sup>355</sup> Exhibit 129 page 8

<sup>356</sup> Exhibit 129

<sup>357</sup> Exhibit 129

<sup>358</sup> Exhibit 129 pages 1-2

<sup>359</sup> Exhibit 129 page 2



specialist equivalent). This is necessary to provide a stable sustainable quality service. By creating a 'critical mass' of specialist emergency staff there would be flow on effects of raising the standard of clinical care and supervision, improving the status of the emergency department in the hospital and community;

- As an interim measure until the department can attract and recruit registered emergency specialist staff, the review team recommended that the department seek to establish formal links with either individual emergency specialists on contract or another accredited emergency department.

5.240 Partly in a response to those recommendations, the Rockhampton Hospital employed Dr William Kelley, an American trained specialist in emergency medicine who had 25 years experience in emergency medicine in the United States.

### **Dr William Kelley**

5.241 Dr Kelley trained at The John Hopkins Medical Centre in Baltimore, a world leading training centre in emergency medicine.<sup>360</sup> Upon completion of his training, rather than taking up an offer of a teaching position, Dr Kelley chose to work at a large trauma centre in the Lehigh Valley, about 90 minutes from New York. He also worked as Director of Emergency Medicine in a rural hospital in Pennsylvania for 15 years where he supervised three doctors.<sup>361</sup>

5.242 In the United States, emergency medicine specialists must undertake examinations (every ten years) to demonstrate their continued competence.<sup>362</sup> Dr Kelley had completed those examinations on two previous occasions, the latest occasion being in 2004.<sup>363</sup>

5.243 In March 2005, Dr Kelley moved to Rockhampton with his wife and children to work at the Rockhampton Hospital.<sup>364</sup> Within weeks of commencing duties at the Rockhampton Hospital Dr Kelley had serious concerns about the operation of the Emergency Department.<sup>365</sup> He brought those concerns to the attention of the Rockhampton Hospital's Executive who advised him that they were aware of the problems and provided him with a copy of the Miller Report. Dr Kelley was informed that the Miller Report was confidential and had not been released to the public.<sup>366</sup>

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<sup>360</sup> T2236 line 34

<sup>361</sup> T2236 line 55

<sup>362</sup> T2236

<sup>363</sup> T2237 line 1

<sup>364</sup> Dr Kelley obtained his position by way of a medical recruiter, Global Medical Services see T2237

<sup>365</sup> T2238 line 16

<sup>366</sup> T2238 line 30

- 5.244 In Dr Kelley's opinion, and the evidence that he gave to the Commission, it seemed that by the time of his arrival in March 2004, little progress had been made in implementing the recommendations of the Miller Report. The staffing of the Emergency Department remained inadequate and he felt that patient safety was being compromised.
- 5.245 Dr Kelley considered that there continued to be poor utilisation of information technology resources within the Emergency Department.<sup>367</sup> Internet access at the Hospital was not standard issue to all clinicians.<sup>368</sup> This he found surprising because he considered internet access as an essential clinical tool, where, for example, he could compare medications used in the American system with the English system.<sup>369</sup>
- 5.246 More particularly, Dr Kelley said that the Department's existing information management system, referred to in the Miller report, was cumbersome and out of date. He noted that the Department was introducing a new system. Although the new system and the existing system did assist in the collection of important data, they did not serve a function which he considered much more clinically relevant and in much more urgent need of address, patient charting.<sup>370</sup>
- 5.247 Dr Kelley sought to introduce a computerised system of charting that allowed clinicians to chart patient histories, examinations, and other information, which he believed would improve teaching and the movement of patients through the Emergency Department.<sup>371</sup> Dr Kelley said that by improving the efficiency of the Emergency Department, often being the first point of contact between patients and the hospital, there could be flow on effects to the rest of the hospital. However, when he suggested that new system he was told that the Rockhampton Hospital did not have any money for it.<sup>372</sup>
- 5.248 Dr Kelley complained that there were no radiologists in the Rockhampton Hospital at all. Dr Kelley considered radiologist support as essential to the practice of emergency medicine.<sup>373</sup>
- 5.249 Most significant were Dr Kelley's observations as to the state of staffing in the Emergency Department almost one year after the Miller report was completed. He said that while he worked there the Department had a large number of junior doctors and many of the Hospital's overseas trained doctors were concentrated in the Emergency Department.<sup>374</sup> Indeed, while Dr Kelley was

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<sup>367</sup> T2239, line 20

<sup>368</sup> T2239

<sup>369</sup> T2240

<sup>370</sup> T2239, T2240

<sup>371</sup> T2239, T2240

<sup>372</sup> T2240

<sup>373</sup> T2244, T2245

<sup>374</sup> T2241, T2243

there, the core medical staff of the Department were all overseas trained.<sup>375</sup> Dr Kelley felt that because there was no one at his level of experience in the Department he constantly had to 'baby sit' staff because he felt they were not capable of performing their role independently and patient care was suffering.<sup>376</sup>

- 5.250 Dr Kelley confirmed that during his period at Rockhampton the practice of using the Medical Emergency Teams to support the Emergency Department was continuing, which he agreed was worrying in the extreme.<sup>377</sup> He commented:

The problem is that in a well run Emergency Department, the emergencies are handled by the doctors in the emergency room. In Rockhampton, the talents of the people who are present [in the Emergency Department] are so lacking that the emergency room has depended on having doctors come from other parts of the hospital when an emergency happened.

In Rockhampton, not only do they not have specialists in the emergency room, but they rely on doctors in other parts of the hospital to respond to critical care.<sup>378</sup>

- 5.251 When Dr Kelley arrived and realised the problems he faced, he approached the Executive and offered to contact senior doctors from around the world in places such as England, South Africa, New Zealand and the United States to join the Rockhampton Hospital's Emergency Department. However that offer was not accepted. Indeed a representative from Global Medical Services, the company that had placed him in Rockhampton, contacted him and indicated that the company had two candidates in the United States willing to come and work in Rockhampton.<sup>379</sup> However, when he informed the executive, it advised that the Hospital would not accept any applicants through Global Medical Services.<sup>380</sup>
- 5.252 Dr Kelley recommended to the Executive that, rather than employ a large number of junior doctors in the Emergency Department, the hospital should reallocate its funds so that it employed senior doctors instead. However, that suggestion was never acted upon.<sup>381</sup>

### General comments on Rockhampton

- 5.253 While some progress has been made with respect to implementing the recommendations of the Miller report, the evidence received about the lack of progress at the Rockhampton Hospital is symptomatic of a range of issues

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<sup>375</sup> T2243

<sup>376</sup> T2243

<sup>377</sup> T2241

<sup>378</sup> T2241 line 33

<sup>379</sup> T2242 line 25

<sup>380</sup> T2242

<sup>381</sup> T2243, T2244

facing public hospitals in Queensland, particularly those outside of the south-east corner such as:

- Either an inadequacy in funding or a reluctance by administration; or both
- Difficulty in attracting and retaining sufficient specialist staff to provide an adequate and safe service;
- A lack of sufficient specialist staff to create a 'critical mass' of practitioners within a hospital.
- A tendency to use Senior Medical Officers instead of recognised specialist staff;
- Inadequate supervision of junior staff, both Australian and overseas trained;
- An excessive number of inadequately qualified overseas trained doctors
- Consequently, a lesser standard of medical treatment in rural and regional public hospitals

## Part D – The Prince Charles Hospital

### Cardiac care at Prince Charles Hospital

- 5.254 The Prince Charles Hospital, located at Rode Road, Chermside, Brisbane is within the Prince Charles Hospital Health Service District (Central Zone). The District includes the City of Brisbane north of the Brisbane River and the Shire of Pine Rivers but excludes the Royal Brisbane Hospital complex, the Royal Womens Hospital complex, the Royal Childrens Hospital complex, the Queensland Radium Institute, and integrated adult mental health services associated with the Royal Brisbane Hospital.<sup>382</sup>
- 5.255 The hospital provides quaternary and supra-regional cardiac services, including Cardiac Surgery and Cardiology (including paediatric cardiac), quaternary and supra-regional thoracic services, orthopaedic surgery, rehabilitation and geriatric respiratory medicine, adult mental health and palliative care. The District provides health services to residents living in the northern suburbs of Brisbane and specialist services to the broader Queensland and Northern New South Wales population.

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<sup>382</sup> [www.health.qld.gov.au](http://www.health.qld.gov.au)

*An increasing demand for cardiac services*

- 5.256 Cardiovascular disease is the major cause of morbidity and mortality in Australia. The most common forms of heart disease in Australia are coronary heart disease, acquired valve disease, conduction defects, congenital heart failure and congenital heart defects.<sup>383</sup>
- 5.257 Dr Con Aroney commenced at the Prince Charles Hospital as a Staff Cardiologist on 11 February 1991. He was appointed a Senior Staff Cardiologist on 1 July 1994, and on 4 August 1994 he was appointed Clinical Director of the Coronary Care Unit.<sup>384</sup> Dr Aroney was the President of the Cardiac Society of Australia and New Zealand. He was on leave for 1 year prior to his resignation from the position as Senior Staff Cardiologist at the Prince Charles Hospital<sup>385</sup> effective from 22 May 2005.
- 5.258 Dr Michael Cleary held the position of Executive Director of Medical Services at the Prince Charles Hospital for approximately five years before taking up the position of Acting District Manager at the Prince Charles Hospital on 2 August 2005.<sup>386</sup> Dr John Scott was State Manager, Public Health Services from October 1996 until November 2003 when he was appointed to act as Senior Executive Director, Health Services and was appointed to the role in December 2004. Dr Scott was on long service leave from July to October 2004. His services were terminated by the Queensland Government on 27 July 2005.<sup>387</sup>
- 5.259 Until 1996 public cardiac surgical services were provided solely by the Prince Charles Hospital.<sup>388</sup> In 1996, as a result of an increased and changing demand for cardiology services, particularly in relation to management of the acute coronary syndrome, and acute myocardial infarction,<sup>389</sup> Queensland Health supported the development of two additional cardiac surgical units at Townsville and the Princess Alexandra Hospital Health Service District to establish and develop zonal services.<sup>390</sup>
- 5.260 In order to improve access to cardiac services in Queensland, Princess Alexandra Hospital established its service in 1998-1999.<sup>391</sup> The Prince Charles Hospital was also funded to address the extensive waiting list which existed for cardiac surgery.<sup>392</sup> The Prince Charles Hospital was allocated

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<sup>383</sup> Exhibit 301C para 3

<sup>384</sup> Exhibit 301C para 15

<sup>385</sup> Exhibit 403; Aroney T4801 line 55

<sup>386</sup> Exhibit 301C para 17

<sup>387</sup> Exhibit 317 para 1.6; T5230 line 15 (Dr Scott)

<sup>388</sup> Exhibit 301C para 6

<sup>389</sup> Exhibit 301C para 5

<sup>390</sup> Exhibit 301C para 6

<sup>391</sup> Exhibit 301C para 19

<sup>392</sup> Exhibit 301C para 19

elective surgery funding during the late 1990s.<sup>393</sup> The Prince Charles Hospital had been faced with significant cost pressures resulting from:

- (a) Increased demand for interventional cardiology;
- (b) Marginal cost funding of elective surgery;
- (c) Growth in transplant services;
- (d) Clinical supply cost increases which eventuated from the devaluation of the Australian dollar; and
- (e) Increased clinical consumable costs related to single use items.<sup>394</sup>

Those demands resulted in the Prince Charles Hospital incurring a budget deficit in the 1999-2000, 2000-2001, and 2001-2002 financial years.<sup>395</sup>

5.261 Some of this increase in demand related to changes in clinical practice following the release of the 'Australian Management of Unstable Angina Guidelines – 2000' by the National Heart Foundation and Cardiac Society of Australia and New Zealand.<sup>396</sup> The guidelines represent a much more aggressive strategy of doing angiograms on patients and revascularising them before they die or have further heart attacks.<sup>397</sup> Following the release of the guidelines the number of inter-hospital transfers to the Prince Charles Hospital has increased significantly.<sup>398</sup> Dr Aroney gave evidence that additional causes of the increase were population growth, an increasingly ageing population and a severe unmet need for coronary angiography due to under servicing of the community for the past 20 years.<sup>399</sup> The waiting list for coronary care was large and growing.

5.262 Dr Aroney gave evidence that between 2001 and 2003 cardiologists made repeated warnings to management in most cardiac tertiary hospitals about the lack of response by management to increasing demand particularly in respect of heart attack and unstable angina.<sup>400</sup> Over several years cardiologists met with administration at the Prince Charles Hospital to discuss problems with bed access block; restrictions in beds which were 'physically available' in the Coronary Care Unit, but closed for financial reasons and restrictions upon performing procedures.<sup>401</sup> These problems were not alleviated, apparently due to financial constraint.

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<sup>393</sup> Exhibit 301C para 19

<sup>394</sup> Exhibit 301C para 20

<sup>395</sup> Exhibit 301C para 20

<sup>396</sup> Exhibit 301C para 7 attachment-MIC1; Aroney T4807 line 50

<sup>397</sup> Aroney T4807 line 55

<sup>398</sup> Exhibit 301C para 9

<sup>399</sup> Aroney T 4807 line 55

<sup>400</sup> Exhibit 263 para 5

<sup>401</sup> Aroney T3926 line 12-22

*A change in management of cardiac budgets; some apparent consequences*

- 5.263 Dr Aroney said that, until 2003, a practising cardiologist or cardiac surgeon was the chair of a cardiac committee which made budgetary decisions in relation to the Prince Charles Hospital cardiac program.<sup>402</sup> In 2003 Ms Podbury, the Hospital Manager, altered the management structure of the program to a triumvirate of the cardiac surgeon, a senior administrative nurse and a business manager. Dr Aroney states that under the auspices of this triumvirate there were significant delays, major cutbacks to the rehabilitation clinic and the dissolution of the anti-smoking clinic.<sup>403</sup>
- 5.264 In May 2003 Dr Aroney met with the Minister for Health, Ms Edmond, the Director-General, Dr Stable, Central Regional Director, Mr Bergin and the Prince Charles Hospital District Manager, Ms Podbury and informed them of the increased demand for cardiac care and that an increase in funding was required and not cutbacks and transfer of funds.<sup>404</sup> Dr Aroney states that, as there was no positive outcome from that meeting, he along with other cardiologists attended a further meeting in June 2003 with the Director-General of Queensland Health, Dr Stable and the regional directors. At this meeting the cardiologists detailed Queensland's high coronary morbidity and mortality rate, Queensland Health's inadequate response to increased demand of acute coronary syndromes and the urgent need for funding more beds and activity.<sup>405</sup>
- 5.265 In his evidence Dr Aroney gave examples of two requests by Dr Pohlner, the most experienced paediatric cardiac surgeon in the State, for the availability of a ventricular assist device which were refused by hospital administration.<sup>406</sup> These refusals, he said, caused dislocation of the operating staff<sup>407</sup> and, in the second case, delayed surgery.<sup>408</sup> Dr Aroney gave evidence that he believed that the issue was the cost of the use of the device and the cost of the consumables.<sup>409</sup> The decisions were ultimately reversed. Dr Aroney gave evidence that Dr Pohlner was threatened with a code of conduct violation by Ms Podbury.<sup>410</sup>
- 5.266 Dr Cleary, the Director of Medical Services stated that he recalled the cases referred to by Dr Aroney. He said that, in the first case, after extensive consultation with the Director of Cardiac Surgery at the Prince Charles Hospital and the Director of the National Unit in Melbourne, it was suggested

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<sup>402</sup> Aroney T3933 line 30

<sup>403</sup> Exhibit 263 para 10; Aroney T3933 line 45

<sup>404</sup> Exhibit 263 para 13

<sup>405</sup> Exhibit 263 para 14; Aroney T3937 line 40

<sup>406</sup> Exhibit 263 para 9; Aroney T3931 - T3932

<sup>407</sup> Aroney T3932 line 10

<sup>408</sup> Aroney T3932 line 30

<sup>409</sup> Aroney T3933 line 1

<sup>410</sup> Aroney T3931 line 40

that, if the child required support, the child could be maintained on cardiac bypass overnight and reassessed the following morning.<sup>411</sup> He said that this approach was in line with previously accepted clinical practice.<sup>412</sup> But the fact is that the decision whether the device was necessary for safe practice was made, not by the experienced paediatric cardiac surgeon, but at an administrative level. The same criticism may be made of the second case.

- 5.267 Dr Cleary referred to a bundle of documents,<sup>413</sup> which included a memorandum dated 8 July 2003 from Ms Podbury to Dr Pohlner advising that, while she believed there had been a breach of the Code of Conduct, she did not propose to take any further action, but required acknowledgement that it was unacceptable for Dr Pohlner to willfully disregard a lawful instruction given by a staff member in authority.<sup>414</sup> This tends to support, rather than deny, Dr Aroney's evidence that Dr Pohlner was threatened with a code of conduct violation or, at least, reprimanded for requesting equipment which he thought was necessary for safe medical treatment. Ms Podbury did not give evidence.
- 5.268 Ms Podbury had earlier given a directive on 28 August 2002 that 'under no circumstances has approval been granted for the use of Sirolimus – Eluting Stent Devices'.<sup>415</sup> Dr Aroney said that, in late 2003, Ms Podbury had threatened to dismiss the Director of the Prince Charles Hospital Catheter Laboratory who considered it was clinically indicated to implant a stent in a private patient.<sup>416</sup> Dr Aroney said that the doctor's position was only saved by a large petition of staff members because they realised that his loss would have been catastrophic to the provision of cardiac services.<sup>417</sup> As mentioned earlier, Ms Podbury did not give evidence.

#### *A proposal to transfer cardiac procedures to Princess Alexandra Hospital*

- 5.269 In February 2002, Princess Alexandra Hospital prepared a submission to the Director-General of Queensland Health seeking funding to expand cardiac surgical services. This submission was presented again in February 2003.<sup>418</sup> Following discussions between the Director-General, General Manager Health Services, and Zonal Managers, Queensland Health made a decision in early 2003 to transfer services from the Prince Charles Hospital to Princess Alexandra Hospital.<sup>419</sup> This decision was made without reference to clinicians at the Prince Charles Hospital. For reasons mentioned below, this may have

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<sup>411</sup> Exhibit 301C para 88

<sup>412</sup> Exhibit 301C para 88

<sup>413</sup> Exhibit 301C para 97 attachment – MIC 18

<sup>414</sup> Memorandum dated 8 July 2003 attachment - MIC18

<sup>415</sup> Exhibit 301C attachment -MIC 17B

<sup>416</sup> Exhibit 263 para 8

<sup>417</sup> Exhibit 263 para 8

<sup>418</sup> Exhibit 301C par 21; Cleary T4839

<sup>419</sup> Exhibit 301C paras 22-23



effectively reduced the level of cardiac services overall. It certainly reduced the level of cardiac services provided by Prince Charles Hospital.

- 5.270 A Cardiac Surgery Services working party was commissioned to 'facilitate the allocation of resources to Princess Alexandra Hospital to enable a targeted increase of 300 cardiac surgery cases in the Southern Zone'.<sup>420</sup> One of its roles was to determine an appropriate volume and mix of resources to be transferred to Princess Alexandra Hospital from the Prince Charles Hospital, it was said, to support a sustainable efficient and equitable service delivery at both sites.<sup>421</sup> Of the 17 members of the working party only four were clinicians.<sup>422</sup>
- 5.271 In April and May 2003 both the Prince Charles Hospital and Princess Alexandra Hospital prepared Impact Analysis Reports based upon the transfer of 300 cardiac surgical procedures, 700 coronary angiograms and 233 coronary angioplasty procedures.<sup>423</sup> The Prince Charles report, produced by a committee consisting primarily of administrators,<sup>424</sup> expressed concern that the continuing growth of cardiac services at Princess Alexandra Hospital might be at the cost of existing services at the Prince Charles Hospital. That is, of course, what occurred. By reducing the amount paid to the Prince Charles Hospital for cardiac services, the transfer effectively reduced the existing service which could be provided at the Prince Charles Hospital. The report also noted that the terms of reference restricted it to the analysis of the impact following the transfer; and that no consideration was to be taken of population trends, existing service profiles, or planned future service delivery.<sup>425</sup> It made clear that assessment had to be made 'in light of the existing resource environment'.<sup>426</sup>
- 5.272 Dr Aroney said that the reduction of funding for cardiac services at the Prince Charles Hospital, which happened because of the transfer of procedures to Princess Alexandra Hospital, was done at a time when hospital administrators were aware of a huge increase in demand in inter hospital transfers to the Prince Charles Hospital.<sup>427</sup> This increase from 46 patients in the September 2002 quarter to 93 patients in the September 2003 quarter, had led to a major imbalance between demand and capacity for cardiac services.<sup>428</sup> Dr Aroney said that, in 2003, he attended a large Prince Charles Hospital staff meeting at which 12 presentations were handed to Mr Bergin, Zonal Manager on the

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<sup>420</sup> Exhibit 301C paras 24, 25 attachment MIC 3

<sup>421</sup> Exhibit 301C- MIC3

<sup>422</sup> See membership list in attachment MIC 3

<sup>423</sup> Exhibit 301C attachment MIC4; Cleary T4839

<sup>424</sup> Exhibit 301C attachment MIC 4/p2

<sup>425</sup> Exhibit 301C attachment MIC 4 /p77

<sup>426</sup> Exhibit 301C attachment MIC 4 /p77

<sup>427</sup> Aroney T3934 line 50

<sup>428</sup> Exhibit 263 par 12; Aroney T 3934 line 50

deleterious effect on the hospital and the community of the cutback in funding at the Prince Charles Hospital caused by the reduction in its allocation of clinical procedures.<sup>429</sup> Dr Aroney said that Mr Bergin stated that the cuts would proceed and that the funds were required for the Princess Alexandra Hospital.<sup>430</sup>

*The transfer of procedures, and consequently of funds, to Princess Alexandra Hospital*

- 5.273 On 30 July 2003, at a meeting between Dr Cleary, an independent consultant, Mr Jim Louth, Mr Graeme Herridge, Manager Central Zone Management Unit, and Dr Paul Garrahy, Director of Cardiology Princess Alexandra Hospital, it was agreed that the final transfer numbers from the Prince Charles Hospital to Princess Alexandra Hospital would be 300 cardiac surgical procedures, 500 coronary angiograms and 96 coronary angioplasty stent procedures.<sup>431</sup> This was to occur between April and July 2004.<sup>432</sup> Dr Cleary gave evidence that he personally found it difficult to support the transfer.<sup>433</sup> He said that the decision to make the transfer was made by Dr Buckland.<sup>434</sup>
- 5.274 The simple and fair solution to the perceived problem would have been to have transferred the above patient procedures to Princess Alexandra, but, given the large backlog at Prince Charles, to have provided extra funding for this to Princess Alexandra, leaving the total funding at Prince Charles intact. But that would have required an increase in total funding of cardiac care and that was never the intention of Queensland Health. To be fair to its officers, it may have been beyond its capacity to provide it.

*A further attempt to obtain more funding*

- 5.275 On 24 November 2003, an urgent submission was made by the Prince Charles Hospital Cardiology Department to Dr John Scott seeking additional funding within Central Zone to address the increasing ratio of emergency unplanned activity that was compromising capacity to undertake elective revascularisational procedures at the Prince Charles Hospital.<sup>435</sup> Dr Scott was not sure but imagined he would have responded to the submission.<sup>436</sup>
- 5.276 On 16 December 2003, Dr Aroney wrote to the Honourable the Premier advising him of the very serious and deteriorating state of public cardiac services in Queensland and the death of three cardiac patients on the waiting

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<sup>429</sup> Exhibit 263 para 12; Aroney T3936 line 10

<sup>430</sup> Exhibit 263 para 12; Aroney T3936 lines 10 - 30

<sup>431</sup> Exhibit 301C para 28 and 29

<sup>432</sup> Exhibit 301C para 30; Exhibit 263 para 4

<sup>433</sup> Cleary T4843 line 5

<sup>434</sup> Cleary T4845 line 10

<sup>435</sup> Exhibit 263 attachment CA 4

<sup>436</sup> Scott T5279 line 40

- list.<sup>437</sup> A copy of the letter to the Premier was provided to Dr Cleary. On 5 January 2004 he cleared a briefing note for the Minister for Health providing a response to Dr Aroney. The response did not propose any action other than the Minister note the contents.<sup>438</sup>
- 5.277 Dr Aroney said that, during December 2003, as a cost control measure, there was enforced closure of catheter laboratory activity at the Prince Charles Hospital for all except emergency cases, and of the cardiac outpatients. Staff were advised to take holidays at this time.<sup>439</sup>
- 5.278 Dr Scott denied that there was a cut in activity at that time.<sup>440</sup> However, in November 2003, the District of which the Prince Charles Hospital was a part, had provided figures indicating that they would be over budget for the financial year by approximately \$2.2m.<sup>441</sup> This was caused, in a large part, by the fact that cardiac interventions were being performed at a greater rate than was allowed for by the funding that had been provided to the Prince Charles Hospital.<sup>442</sup> Dr Scott said that Dr Aroney would have been aware of the level of activity that was funded and that he was exceeding this level of activity. Queensland Health reminded the Prince Charles Hospital that they were obliged to limit themselves to the new level of activity which had been funded.<sup>443</sup>
- 5.279 Dr Aroney gave evidence that the outpatients department at the Prince Charles Hospital was closed for a month over the Christmas period for several years for budgetary reasons.<sup>444</sup> He said that, during December 2003, there was also an enforced closure of catheter laboratory activity for all except emergency cases.
- 5.280 Dr Cleary responded that it was usual practice at the Prince Charles Hospital and other major hospitals to have a period over Christmas during which minimal activity was undertaken. Emergency and acute services were maintained but elective services were generally not scheduled during the period. This provided an opportunity for staff to take leave and was not a cost cutting exercise.<sup>445</sup> But this, to me, does not make sense. I would have thought leave should have been staggered so that services important as these are maintained continuously.

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<sup>437</sup> Exhibit 301C para 43

<sup>438</sup> Exhibit 301C attachment MIC 8

<sup>439</sup> Exhibit 263 para 16; Aroney T3929 line 30

<sup>440</sup> Exhibit 317 para 19.7

<sup>441</sup> Exhibit 317 para 19.7

<sup>442</sup> Exhibit 317 para 19.7

<sup>443</sup> Exhibit 317 para 19.7

<sup>444</sup> Aroney T3929 line 28

<sup>445</sup> Exhibit 301C paras 123 - 126

- 5.281 On 5 January 2004, Dr Aroney attended a meeting of all the cardiologists at the Prince Charles Hospital at which the affect of the cutbacks were discussed. The cardiologists were concerned that the cutbacks imposed restrictions on placing stents into patients unless it was an emergency.<sup>446</sup> Dr Aroney said that it was felt that this was totally untenable.<sup>447</sup> The cardiologists decided at the meeting in desperation to present this publicly.<sup>448</sup> On the following day Dr Aroney released details of these cutbacks and what he believed were unnecessary recent deaths to the media.
- 5.282 On 7 January 2004, in view of Dr Aroney's allegations regarding the recent deaths, Dr Cleary appointed Dr Stephen Ayre, Deputy Executive-Director of Medical Services of the Royal Brisbane and Womens Hospital and Health Service District, and Dr Peter Thomas, Principal Clinical Co-ordinator of the Princess Alexandra Hospital Health Service District to ascertain whether there was evidence to support or reject the allegations.<sup>449</sup> Neither Dr Ayre nor Dr Thomas was a cardiologist. Dr Cleary said that the report made 3 recommendations relating to the inter-hospital referral process, procedure bookings and waiting lists for implantable cardioverter defibrillators which were implemented.<sup>450</sup> Dr Aroney states that as far as he is aware the results of this internal inquiry were never released despite repeated requests.<sup>451</sup>

*Dr Aroney's public disclosure causes a threat of retribution*

- 5.283 On 8 January 2004, following a telephone request by Dr Scott, Dr Aroney, accompanied by Dr Andrew Galbraith, met Dr Scott and Mr Bergin to discuss the issues raised in his media release. Dr Aroney had assumed that the meeting would be about remedying the problem but it related to his going to the media about it. He said that Dr Scott stated to him 'you come after us with more shots and we'll come after you'. He said that he felt intimidated by that statement and thought it was a threat of retribution.<sup>452</sup>
- 5.284 At that meeting, Dr Aroney said that he also raised the question of the high risk of acute coronary syndrome and the topic of whether patients should be treated with stents and not surgery. He said Dr Scott informed him that he had advice from another cardiac specialist that they should be treated with surgery rather than stents. Dr Aroney said that he informed Dr Scott that his view was to the contrary and that Dr Scott had obviously not read the national guidelines for treating acute coronary syndromes of which he, Dr Aroney, was a national

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<sup>446</sup> Aroney T3937 line 5

<sup>447</sup> Aroney T3937 line 15

<sup>448</sup> Exhibit 263 para 20; Aroney T3937 line 15

<sup>449</sup> Exhibit 301C para 48

<sup>450</sup> Exhibit 301C para 50 – attachment MIC10

<sup>451</sup> Exhibit 263 para 32

<sup>452</sup> Exhibit 263 para 23; Aroney T3938 line 55

author.<sup>453</sup> Dr Aroney and Dr Galbraith made minutes of the meeting.<sup>454</sup> Although Dr Scott has a different recollection of what occurred, I accept what seems to be the better recollection of Dr Aroney in this respect which is corroborated by the minutes of the meeting.

5.285 Dr Scott denied any intention to intimidate. He admitted that he did state words to the effect attributed to him<sup>455</sup> but said that he did not intend to convey that Queensland Health would take steps to go after Dr Aroney personally, but that, if he continued to criticise Queensland Health in the media, Queensland Health would respond directly to any allegations he made.<sup>456</sup> Whatever Dr Scott's intention was, I am satisfied that Dr Aroney was justified in thinking, in the circumstances, that it was a threat of retribution if he continued to make public statements about what he perceived to be a very serious issue of patients' lives and safety.

#### *Further cuts*

5.286 On 8 January 2004 Dr Cleary wrote to Dr Andrew Braithwaite, Director of Cardiology, Jenny Walsh, Nursing Director, Cardiology, and Hayley Middleton, Business Manager, Cardiology which included an instruction effective immediately that 'patients referred from within Central Zone but from outside the Brisbane North area, are only to be accepted if they can be managed within our existing capacity.'<sup>457</sup> Dr Aroney asked why Central Zone patients were made a lower priority than Brisbane North patients when Central Zone patients were an accepted responsibility of the Prince Charles Hospital.<sup>458</sup>

5.287 Dr Cleary said that his memorandum of 8 January 2004 was sent in response to advice from Queensland Health and the Executive and Director of Cardiology at Princess Alexandra Hospital that:

- Princess Alexandra Hospital had the capacity to undertake additional activity (in the order of 10-20 cases a week) effective immediately.
- The waiting list at Princess Alexandra Hospital (category 1 patients = -0); (category 2 patients = 2) was dramatically lower than that at the Prince Charles Hospital; (category 1 patients = 229; category 2 patients = 79).<sup>459</sup>

5.288 It was these figures, it seems, which were said to justify the transfer of procedures from Prince Charles Hospital to Princess Alexandra Hospital in 2004. Dr Aroney had consistently maintained that these figures were

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<sup>453</sup> Aroney T3940 line 15

<sup>454</sup> Exhibit 263 attachment CA6

<sup>455</sup> Exhibit 317 para 19.12

<sup>456</sup> Scott T5281 lines 1-20

<sup>457</sup> Exhibit 263 attachment CA3

<sup>458</sup> Exhibit 263 para 6

<sup>459</sup> Exhibit 301C para 35

erroneous and that, in real terms, the waiting list at Princess Alexandra Hospital were much greater than this.<sup>460</sup> This was belatedly recognised. Dr Cleary said that, in or about January 2005, he became aware for the first time, that Princess Alexandra Hospital had been using a different categorisation process in cardiology from that used by the Prince Charles Hospital and acknowledged that this would have contributed to the significant difference in waiting list numbers between the two hospitals.<sup>461</sup> It seems that Princess Alexandra Hospital had a much narrower view of who should be included in categories 1 and 2 (urgent and semi-urgent cases) than other public hospitals.<sup>462</sup>

- 5.289 Dr Cleary said that the implementation of the arrangements in the memorandum of 8 January 2004 meant that approximately 10 patients a week were receiving care earlier, and that this, in particular, related to patients in the Central Zone who appeared to have delayed access to services at the Prince Charles Hospital.<sup>463</sup> It is difficult to see how Dr Cleary could have any confidence in saying that in the light of the information in the preceding paragraph.

*Further complaints and criticisms by clinicians*

- 5.290 On 25 January 2004, Dr Aroney again wrote to the Premier informing him of his continuing concern and that three further patients had died on cardiac waiting lists at the Prince Charles Hospital.<sup>464</sup>
- 5.291 On 15 February 2004, Queensland Health called an urgent meeting of the Cardiac Society of Australia and New Zealand which was attended by almost all the senior cardiologists who worked in the public hospitals in South East Queensland together with the acting Director-General, Dr Buckland and Dr Scott.<sup>465</sup> Dr Aroney said that during the presentation of the first speaker, who was giving details of the inadequacy of public services for managing acute coronary syndrome, Dr Buckland stood up, interjected very aggressively, mentioned a profanity and stated that what had been said by the speaker was Prince Charles-centric and that the information was irrelevant.<sup>466</sup> Dr Aroney said that, in his view, Dr Buckland's outburst intimidated subsequent speakers and discouraged an open discussion of the problems being presented.<sup>467</sup>

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<sup>460</sup> Aroney T6241 - 6242

<sup>461</sup> Exhibit 301C para 41; Cleary T4833, 4865

<sup>462</sup> Aroney T6241 - 6242

<sup>463</sup> Exhibit 301C para 38

<sup>464</sup> Exhibit 263 para 27 attachment CA7

<sup>465</sup> Exhibit 263 para 28

<sup>466</sup> Exhibit 263 para 30; Aroney T 3941 line 15

<sup>467</sup> Exhibit 263 para 30; Aroney T3941 line 20

- 5.292 Dr Aroney said that, nevertheless, later there was considerable discussion about the lack of publication of waiting lists for coronary angiograms and cardiac defibrillators which the doctors considered should be transparent as by far more cardiac deaths occurred on those lists than on the open cardiac surgical lists.<sup>468</sup> Dr Aroney said that Dr Buckland and Dr Scott would not accept that the lists should be public.<sup>469</sup> Whilst not denying that he said that, Dr Scott said that the decision to publish waiting lists was a decision for government and not Queensland Health. The data was available to the government if it wished to publicly use it.<sup>470</sup>
- 5.293 Dr Scott said that, from the first presentation at the meeting, he, Dr Buckland and Queensland Health were attacked. He said that Dr Buckland had said that they were happy to hear peoples' points of view, but that they were not there to be personally attacked.<sup>471</sup> Dr Scott rejected the allegation of any intention to intimidate speakers or to discourage open discussion of the problems being presented.<sup>472</sup> He pointed to the fact that the first speaker at the meeting was Dr Darren Walters who has since been promoted to the position of Director of Cardiology at the Prince Charles Hospital.<sup>473</sup>
- 5.294 It was unanimously agreed by all cardiac society members at the meeting that:
- Queensland had the worst coronary heart disease outcomes of all the major States;
  - There was severe tertiary public cardiac under servicing in Queensland;
  - All tertiary cardiac units in Queensland required major upgrades;
  - There was a major deficiency in the public cardiology workforce;
  - There was a lack of transparency in cardiology waiting lists and bed access block.<sup>474</sup>
- Drs Buckland and Scott asked the Cardiac Society of Australia and New Zealand provide a submission on cardiac services in Queensland.<sup>475</sup>
- 5.295 On 24 May 2004, Prince Charles Hospital made a submission to Dr Scott for additional funding to allow the Prince Charles Hospital to increase elective cardiac surgery throughput.<sup>476</sup> Additional funding in the sum of \$2.4 m was provided for the 2004-2005 financial year.<sup>477</sup>

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<sup>468</sup> Exhibit 263 para 31

<sup>469</sup> Exhibit 263 para 31; Aroney T3941 line 35

<sup>470</sup> Exhibit 317 para 19.18

<sup>471</sup> Exhibit 317 para 19.16

<sup>472</sup> Exhibit 317 para 19.16

<sup>473</sup> Exhibit 317 para 19.17

<sup>474</sup> Exhibit 263 para 31 attachment CA 8

<sup>475</sup> Exhibit 263 para 31

<sup>476</sup> Exhibit 301C para 32 – attachment MIC7

<sup>477</sup> Exhibit 301C para 33

5.296 On 29 July 2004, in response to the request by Drs Buckland and Scott on 15 February 2004, the Queensland Branch of the Cardiac Society of Australia and New Zealand provided a submission to Queensland Health.<sup>478</sup> The submission emphasised the crisis in adult and paediatric care in all areas, particularly in acute coronary syndrome management and cardiac defibrillators where most deaths had occurred, and asked for an increase in activity.<sup>479</sup>

5.297 By memorandum dated 4 August 2004 Janelle Taylor, Acting Nursing Director – Cardiology Program informed Cherly Burns, Executive Sponsor, Cardiology Program as follows:

As an acting member of the Cardiology program management team I believe that it is my role to apprise you of the situation resulting from the high numbers of patients waiting in regional hospitals as priority cases for cardiac investigation/intervention. Over the past month I have observed a particular situation many times but none more so than today and I believe it is worthy of your notice.

Dr Darren Walters was due to be on leave from today and henceforth had no bookings for cardiac procedures for the next ten days due to his heavy involvement in the organizing of the August meeting of the Cardiac Society of Australia and New Zealand. It became clear to us as today progressed that the increasing number of patients waiting in regional hospitals as priority cases for cardiac investigation/intervention was getting to levels that needed addressing. CCL activity is being reduced over the next 10 days and there was potential for some 9 patients to be held in regional health facilities for 10 days or more until full CCL activity recommenced.

The NUM of CCL, the D/NUM, the Medical Director of Cardiology and myself tried to sort out some way of dealing with this situation. The RBH was contacted and unable to assist us in any significant way. When Dr Walters was apprised of the situation he voluntarily gave up his leave to do 7 of the cases tomorrow afternoon.

I have seen Dr Walters repeatedly pick up a disproportionate workload many times over the past month in an effort to ensure patient safety and service is continued. As such I believe he is to be commended for his commitment to the Cardiology program and as such deserves our collective thanks.<sup>480</sup>

5.298 As a result of emails by Dr Russell Denman, and Dr Darren Walters dated 29 August, and 30 August 2004 regarding the death of a patient awaiting an automatic implantable cardiac defibrillator implantation and a patient awaiting cardiac surgery, it was decided by management that a further investigation was needed.<sup>481</sup> On 20 September 2004 Dr Andrew Johnson, Executive Director, Medical Services, Townsville General Hospital, and Dr Leo Mahar, Director, Cardiology, Royal Adelaide Hospital were appointed as investigating officers.<sup>482</sup> Also following the issue being raised by the Opposition Health Spokesman, Dr Cleary undertook a review of the procedural management of

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<sup>478</sup> Exhibit 263 para 35 attachment CA2

<sup>479</sup> Exhibit 263 para 35

<sup>480</sup> Exhibit 263 para 36 attachment CA10

<sup>481</sup> Exhibit 301C paras 57 - 59

<sup>482</sup> Exhibit 301 C para 61



the patients and prepared a memorandum to Dr Scott dated 22 October 2004.<sup>483</sup>

*A further cutback in activity*

- 5.299 Dr Aroney gave evidence that at a staff meeting on 24 September 2004 the Prince Charles Hospital Manager, Ms Gloria Wallace (Ms Podbury had moved to Princess Alexandra Hospital) announced that cardiac catheter laboratory activity would be reduced from the 70-90 (average 80) cases per week to 57 cases per week, including a 50 per cent reduction in paediatric cases (from 8 to 4).<sup>484</sup> Dr Aroney said that the cardiologists at the Prince Charles Hospital were shocked as in December 2003 they had asked for an increase of 19 cases per week because of the increase in demand and in waiting lists.<sup>485</sup> Dr Aroney stated at this meeting that the reduction was totally unacceptable, and unconscionable, and that more patients were condemned to death while waiting for coronary angiography.<sup>486</sup>
- 5.300 Dr Aroney, in his evidence, expressed the view that the cutback was imposed as a deliberate target against the Prince Charles Hospital because of persistence in raising the alarm about deaths of patients on waiting lists.<sup>487</sup> Dr Aroney also said that Ms Wallace stated that she had a list of foreign doctors who were prepared to take our positions.<sup>488</sup> He also said that, as a response to a statement that the Prince Charles Hospital was being bullied, Ms Wallace stated that Queensland Health bureaucracy had a poor perception of the cardiology program at the Prince Charles Hospital and it had to become more politically savvy.<sup>489</sup> Minutes to the meeting taken by Dr Radford make reference to possible locums from an agency in South Africa.<sup>490</sup>
- 5.301 Dr Aroney said that he construed the statement by Ms Wallace about foreign doctors as a threat to replace the existing troublesome cardiologists with overseas trained doctors. I think that this was a reasonable construction of what was said.
- 5.302 By memorandum dated 28 September 2004, Dr Darren Walters, Director Cardiac Catherterisation Laboratory, provided responses to the District Manager in relation to the reduction requirements and identified risks which may result from the requirements.<sup>491</sup> Results of a statistical evaluation of the effect of cutbacks on cardiac catheter laboratory waiting lists which had been

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<sup>483</sup> Exhibit 301C para 69 attachment MIC 17A

<sup>484</sup> Exhibit 263 para 39; Aroney T3944 line 40

<sup>485</sup> Exhibit 263 para 39; T3944 line 45

<sup>486</sup> Exhibit 263 para 39; Aroney T3944 line 50

<sup>487</sup> Aroney T3947 line 40

<sup>488</sup> Exhibit 263 para 39; Aroney T3945 line 1

<sup>489</sup> Exhibit 263 para 39; Aroney T3947 line 50

<sup>490</sup> Exhibit 301C para 106, 107 attachment MIC19

<sup>491</sup> Exhibit 263 para 41 attachment CA11

commissioned by the Catheter Laboratory Director from Dr H Bartlett of the School of Mathematics at Queensland University of Technology, were also provided.<sup>492</sup> These results indicated that the required reduction would have the effect of increasing the waiting list.

- 5.303 Dr Scott said that this was not a cutback in activity, but a return to baseline activity after the one-off extra funding of \$20 million to reduce elective surgery waiting lists, provided after the election of early 2004.<sup>493</sup> But even if that was correct, the base line level was far too low to permit Prince Charles Hospital to provide an adequate, safe system of cardiology.
- 5.304 In any event, it seems that the reduction of cardiac catheter laboratory activity to 57 cases per week lasted only about three months.<sup>494</sup> But Dr Aroney said that, during that time, there was a huge escalation in problems attending to patients and that he had identified 11 patients who he believed had died as a result of the cutbacks.<sup>495</sup> It is by no means clear that the latter was the case but that does not detract from the seriousness of the cutbacks, whether or not they reflected a return to an earlier lower baseline. Dr Aroney also said that, during this time, the Catheter Laboratory lost a substantial number of highly trained scrub nurses because they were not required, and it would take many months to train up nurses to become experienced and safe.<sup>496</sup>
- 5.305 Ironically, it appears from Dr Aroney's evidence that these restrictions were removed in January 2005 purely for funding reasons. The Prince Charles Hospital realised that funding was contingent on maintaining elective surgery activity and if activity of the elective cardiac program remained low, then funding would be greatly reduced for the following year.<sup>497</sup> Dr Scott said that this extra funding was provided.<sup>498</sup>

#### *Further complaints and responses*

- 5.306 In September/October 2004 Dr Aroney publicly disclosed in radio interviews that many more deaths had occurred on cardiac waiting lists in the period since the first enquiry into deaths in February.<sup>499</sup> Dr Aroney raised the issue of the deaths of patients on waiting lists at the Prince Charles Hospital due to regional hospital access block to a tertiary hospital and identified Patient nine from Kilcoy as an example.<sup>500</sup>

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<sup>492</sup> Exhibit 263 para 42 attachment CA12

<sup>493</sup> Exhibit 317 para 19.8; Scott T5274 line 20 – 5275 line 10, T5392 line 50

<sup>494</sup> Aroney T3948 line 10

<sup>495</sup> Aroney T3948 lines 10, 25

<sup>496</sup> Exhibit 263 para 44; Aroney T 3950 line 10

<sup>497</sup> Aroney T3948 lines 15 - 25

<sup>498</sup> Exhibit 317 para 19.10

<sup>499</sup> Exhibit 263 para 45

<sup>500</sup> Exhibit 263 para 37

- 5.307 Dr Aroney said that following his press release he was labeled as dishonest on television by Dr Scott.<sup>501</sup> He said that on 15 October 2004 he stated on ABC Stateline that cardiac catheter laboratory activity was planned to be reduced to 57 per week but when Dr Scott was asked on the same program he stated that this was not true.<sup>502</sup> He further states that he was repeatedly attacked in the media and elsewhere by the Health Minister, Gordon Nuttall.<sup>503</sup> Dr Scott said that while he disagreed with the view put forward by Dr Aroney to the media, he did not recall labeling Dr Aroney as dishonest.<sup>504</sup> I accept that Dr Scott did not intend that, but his statements could have been construed that way.
- 5.308 On 24 February 2005, Ms Wallace and Dr Cleary proposed a briefing to Dr Terry Mehan, Acting Senior Director Health Services informing him of issues in the development of the Mahar-Johnson Report.<sup>505</sup> On 4 March 2005 the Mahar-Johnson Report which contained 10 recommendations was circulated.<sup>506</sup> Its general conclusions were expressed in vague terms rather than directly. It said in relation to inadequate funding:
- Queensland Health was unable to routinely achieve best practice in this regard as tertiary hospitals were unable to accept their patients for care in a timely fashion due to either bed unavailability or capped activity in cardiac catheter laboratories.
- Nowhere does the report say, as was clearly the case, and as this statement appears to imply, that cardiac services were grossly underfunded
- 5.309 In response to the Mahar-Johnson Investigation Report recommendations, Dr Cleary prepared a document entitled 'Queensland Health Response to Recommendation Contained in the Mahar-Johnson Report'.<sup>507</sup>

*Dr Aroney resigns and the hospital rejects his offer*

- 5.310 By letter dated 9 March 2005 Dr Aroney tendered his resignation from Senior Staff Cardiologist at the Prince Charles Hospital effective from 22 May 2005.<sup>508</sup> Dr Aroney said that he felt overwhelmed by the intransigence of Queensland Health in relation to the crisis and its cavalier attitude to unnecessary deaths and patient care requirements.<sup>509</sup> Dr Aroney also said that he could not work with the bullying, intimidation and threat of reprisals, and that he felt personally unsafe in his employment with Queensland Health after being previously threatened by Dr Scott.<sup>510</sup> Dr Aroney offered to continue

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<sup>501</sup> Exhibit 263 para 46

<sup>502</sup> Exhibit 263 para 46 Aroney T3945 line 45

<sup>503</sup> Exhibit 263 para 47; Aroney T 3947 lines 10 - 30

<sup>504</sup> Exhibit 317 paras 19, 23

<sup>505</sup> Exhibit 301C para 64 – MIC15

<sup>506</sup> Exhibit 301C para 65 – MIC 16

<sup>507</sup> Exhibit 301C para 66 attachment MIC 17

<sup>508</sup> Exhibit 403

<sup>509</sup> Exhibit 263 para 55

<sup>510</sup> Exhibit 263 para 56

as an honorary visiting cardiologist with catheter laboratory credentialing to assist where required in difficult cardiac interventional cases.<sup>511</sup> His offer was in effect refused.<sup>512</sup> By letter dated 21 March 2005 Dr Cleary advised Dr Aroney that, if the need arose, the process for considering and awarding privileges would be through Medical Administration.<sup>513</sup> There was no sensible reason for refusing Dr Aroney's offer. I infer that it was because he had been publicly critical of Queensland Health.

### **Conclusion with respect to cardiac services at Prince Charles**

5.311 The following conclusions, in my opinion, follow from the above brief summary of the evidence:

- (a) Throughout the relevant period the demand for cardiac services at Prince Charles Hospital greatly exceeded its capacity to supply these services; and that incapacity was caused by a gross under-funding of those services.
- (b) There was too much administrative involvement and too little clinical involvement in decision making about the need for these services and the way in which they should be supplied.
- (c) Those who complained about the gross under-funding of those services, especially those like Dr Aroney who did so publicly, reasonably perceived that they were threatened for doing so. In particular what Dr Scott said to Dr Aroney, what Ms Podbury said to Dr Polhner and what Ms Wallace said at a staff meeting were all reasonably perceived as such threats.

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<sup>511</sup> Exhibit 403, 263 para 58

<sup>512</sup> Exhibit 263 para 58; T3925 line 40

<sup>513</sup> Exhibit 301C para 113 attachment MIC 22