



Queensland Public Hospitals Commission of Inquiry

Report

Hon Geoffrey Davies AO

INTRODUCTION

This Commission of Inquiry was appointed by the *Commissions of Inquiry Order (No 2) 2005*, dated 6 September 2005. Its Terms of Reference were amended by *Commissions of Inquiry Amendment Order (No 1) 2005*, dated 23 September 2005. A copy of the amended order follows this introduction.

The Commission commenced its first public hearing on 8 September 2005. On that day, I ordered, among other things, that the whole of the evidence admitted in the Commission of Inquiry constituted by *Commissions of Inquiry Order (No 1) of 2005*, other than the evidence of Mr Leck and Dr Keating and any documents tendered as exhibits during the evidence of either of them be admitted as evidence in this Inquiry. At the same time I gave leave to any party, within a stated time, to object to any of that evidence. In the event none did. The evidence so admitted consisted of the transcript evidence of 84 witnesses and documentary evidence consisting of 311 exhibits.

The earlier Commission of Inquiry had been effectively terminated by Order of the Supreme Court, made on 2 September 2005, restraining the Commissioner and Deputy Commissioners appointed in that Inquiry from further proceeding with it. The ground of that order was reasonable apprehension of bias by the Commissioner.

This Commission then sat for a total of 30 days hearing evidence from a further 37 witnesses and receiving a little over 200 further exhibits. In the end, the evidence amounted to over 7000 pages of transcript and over 500 exhibits occupying many thousands of pages.

The task of presenting this evidence in the Inquiry, collating it, making findings of fact on the basis of it and drawing inferences, expressing opinions, and making recommendations in consequence, was a massive task. In performing that task, I have received enormous support and help from a dedicated and able legal team. In the first place, this consisted of four counsels from the independent bar, David Andrews SC, Richard Douglas SC, Errol Morzone and Damien Atkinson. I am extremely grateful to all of them for their industry and dedication. Supporting them and me were four officers from the Attorney-General's department, lawyers Tony Stella, Jarrod Cowley-Grimmond and Clare Murphy, and Angus Scott, a law clerk who has just finished his degree. All of them proved, as a number of witnesses in this Inquiry proved, that there are extremely able, dedicated and industrious people working in the public system. I am also very grateful to them.

I need hardly add that none of the persons whom I have named is responsible for any of the findings, opinions or recommendations made in this report. The responsibility for these is entirely mine.

I was very fortunate in having, as Secretary to this Inquiry, Mr David Groth. I had come in contact with Mr Groth when he had been the Chief Executive of the Supreme and District Courts, but I was not fully aware, until we had been together for some time in this Inquiry, of the full extent of his ability, dedication and capacity for sustained hard work and long hours. I am most grateful to him for his help, and his independence in performing a difficult task.

Although I have not mentioned them by name, I should also express my gratitude to all of the Commission's administrative support staff. I enjoyed working with them all.

I transmit the attached report to the Honourable, the Premier and Treasurer and to the Crime and Misconduct Commission.

Hon Geoffrey Davies AO

Commissioner

30 November 2005

Commissions of Inquiry Act 1950

COMMISSIONS OF INQUIRY ORDER (NO. 2) 2005
[as amended by *Commissions of Inquiry Amendment Order (No.1)*
2005]

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Short Title

1. This Order in Council may be cited as *Commissions of Inquiry Order (No. 2) 2005*.

Appointment of Commission

2. UNDER the provisions of the *Commissions of Inquiry Act 1950*, Her Excellency the Governor, acting by and with the advice of the Executive Council, hereby appoints Honourable Geoffrey Davies AO to make full and careful inquiry in an open and independent manner with respect to the following matters:-
- (a) The role and conduct of the Queensland Medical Board in relation to the assessment, registration and monitoring of overseas-trained medical practitioners, with particular reference to Dr Jayant Patel and persons claiming to be overseas-trained medical practitioners.
- (b) (i) Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by Dr Patel at the Bundaberg Base Hospital;
- (ii) the employment of Dr Patel by Queensland Health;
- (iii) the appointment of Dr Patel to the Bundaberg Base Hospital;
- ~~(iii)~~ (iv) the adequacy of the response by Queensland Health to any complaints received by it concerning Dr Patel; and
- ~~(iv)~~ (v) whether or not there were any reprisals or threatened reprisals made by any official of Queensland Health against any person who made the complaints referred to in ~~(iii)~~ (iv) above.
- (c) Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by other medical practitioners, or

persons claiming to be medical practitioners, at the Bundaberg Base Hospital or other Queensland Public Hospitals raised at the Commission of Inquiry established by *Commissions of Inquiry Order (No. 1) of 2005*.

- (d) The appropriateness, adequacy and timeliness of action taken to deal with any of the allegations, complaints or concerns referred to in (a), (b) and (c) above, both:
 - (i) within the Bundaberg Base Hospital; and
 - (ii) outside the Bundaberg Base Hospital.
- (e) In relation to (a) to (d) above, whether there is sufficient evidence to justify:
 - (i) referral of any matter to the Commissioner of the Police Service for investigation or prosecution; ~~or~~
 - (ii) action by the Crime and Misconduct Commission in respect of official misconduct or disciplinary matters;
 - (iii) the bringing of disciplinary or other proceedings or the taking of other action against or in respect of any person; or
 - (iv) amendments to the Coroners Act 2003 in relation to appropriate reporting of deaths caused by or as a result of a health procedure.
- (f) For the purpose of clarification and the removal of doubt, the phrase 'substantive allegations, complaints or concerns relating to the clinical practice and procedures' in (b) and (c) hereof includes allegations, complaints or concerns relating to acts or omissions by current and former employees of the Queensland Department of Health which relate to clinical practices or procedures conducted by medical practitioners or persons claiming to be medical practitioners including acts or omissions relating to waiting lists both for patients referred to specialist outpatient's appointments and for surgical procedures.'

Commission to report

- (3) AND directs that the Commissioner make full and faithful report and recommendations concerning the aforesaid subject matter of inquiry and transmit the same to the Honourable the Premier and Treasurer and to the Crime and Misconduct Commission before 30 November 2005.

Report to be made public

- (4) AND further directs that the Report transmitted to the Honourable the Premier and Treasurer be made public upon its transmission to the Honourable the Premier and Treasurer.

Application of Act

- (5) The provisions of the 'Commissions of Inquiry Act 1950' shall be applicable for the purposes of this inquiry except for section 19C – Authority to use listening devices.

Conduct of Inquiry

- (6) The Commissioner may hold public and private hearings in such manner and in such locations as may be necessary and convenient.

ENDNOTES

1. Made by the Governor in Council on 6 September 2005.
2. Published in an Extraordinary Gazette 6 September 2005.
3. Not required to be laid before the Legislative Assembly.
4. The administering agency is the Department of the Premier and Cabinet.

Queensland Public Hospitals Commission of Inquiry

Report

Hon Geoffrey Davies AO

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Chapter One – Report summary

The origin of this Inquiry

- 1.1 This Commission of Inquiry arose out of complaints relating to Dr Jayant Patel at Bundaberg Base Hospital in 2004 and early 2005. These complaints, and other concerns expressed about Dr Patel's judgment, competence and care, and the failure of Bundaberg Base Hospital's administrators, and later officers of Queensland Health, to address those complaints and concerns, have been one of the main focuses of this Inquiry.
- 1.2 Those complaints and concerns might never have been made public or been properly addressed if it had not been for the efforts of three people. The first and most important of these was Ms Toni Hoffman. It was her courage and persistence which, in the face of inaction and even resistance, brought the scandalous conduct of Dr Patel to light. I say more about Ms Hoffman's contribution in Chapter Three at paragraphs 3.324 to 3.331 and 3.432.
- 1.3 The second was Mr Rob Messenger MP. Had he not raised Ms Hoffman's complaints in Parliament it may be that there would never have been a public inquiry into them. I mention his contribution further in Chapter Three at paragraphs 3.370 to 3.373 and 3.432.
- 1.4 And the third was Mr Hedley Thomas of *The Courier-Mail*. His investigative skill, persistence and undoubted authority as a respected journalist ensured that public notice and government action was taken notwithstanding the apparent reluctance of hospital administrators and officers of Queensland Health to take appropriate action or to permit the matter to be exposed. It was he who first publicly revealed Dr Patel's discreditable past in the United States. I say more about his contribution also at paragraphs 3.402 and 3.433.

Bundaberg Base Hospital: Chapter Three

Area of Need Registration and Bundaberg Base Hospital before 2003

- 1.5 A short history of Bundaberg Base Hospital up to the appointment of Dr Patel in April 2003 and an analysis of the evidence with respect to Dr Patel's appalling conduct and its consequences, is discussed in Chapter Three. That is preceded in Chapter Two by a discussion of base hospitals and the recruitment of doctors, in particular that of overseas trained doctors, about which I make some critical findings and recommendations in Chapter Six.
- 1.6 The history of Bundaberg Base Hospital up to April 2003, which I discuss at paragraphs 3.1 to 3.65 is revealing. It shows a gradual deterioration of what was

once an efficient, safe hospital providing reasonable care to one which was inefficient, unsafe and incapable of providing reasonable care. In retrospect, it is perhaps unsurprising that into that environment Dr Patel should come.

Dr Patel's registration and appointment at Bundaberg Base Hospital 2003:

Paragraphs 3.66 to 3.138

- 1.7 Dr Patel was registered by the Medical Board of Queensland under the area of need scheme¹ as a senior medical officer in surgery at Bundaberg Base Hospital on 11 February 2003. As the Act required, his registration was for a period of one year. He was appointed as Director of Surgery by Dr Nydam, the Acting Director of Medical Services at Bundaberg Base Hospital.
- 1.8 This registration and appointment occurred through a chapter of negligent mistakes by the Medical Board and by administrators at Bundaberg Base Hospital. The Medical Board negligently failed to properly check Dr Patel's paper credentials and to make any assessment of whether he had the qualifications and experience for practising surgery in Bundaberg. And Dr Nydam, and later, Dr Keating negligently failed to have any assessment made of his skill or competence by a committee of peers called a Credentialing and Privileging Committee.

Registration

- 1.9 He came to be registered because of a negligent omission by the Medical Board to advert to a notation on Dr Patel's Certificate of Licensure from Oregon, United States of America which, if pursued, would have revealed a restriction imposed on him, as a disciplinary measure, from performing certain types of surgery in Oregon; a negligent failure by the Board to make independent inquiries about Dr Patel's past practice in the United States which would probably also have revealed that he had surrendered his licence to practise in New York in consequence of disciplinary proceedings against him there and that he had been unemployed for over a year; and a negligent failure by the Medical Board to assess, or to have assessed, his qualification and experience suitable for practising as a Senior Medical Officer performing general surgery at the hospital as required of s135(2) of the *Medical Practitioners Registration Act 2001*. I make findings against and recommendations with respect to the Medical Board at paragraphs 6.116 to 6.134.

Appointment

- 1.10 He came to be employed at Bundaberg Base Hospital without any assessment being made of his clinical skill and competence. This should have been done by that hospital, as a condition of his appointment, by a process of credentialing and privileging, pursuant to a policy and guidelines of Queensland Health which had been in force since 2002. This failure was due to the negligence of Dr Nydam,

¹ *Medical Practitioners Registration Act 2001*, s 135

then Acting Director of Medical Services of Bundaberg Base Hospital. Dr Nydam also caused Dr Patel, who had been registered and appointed as a Senior Medical Officer, a position which would ordinarily be supervised, to be appointed as Director of Surgery, a position ordinarily occupied by a registered specialist surgeon, where he was subject neither to supervision nor even peer assessment. By doing it in this way, Dr Nydam avoided the need, he thought, to convene an appointment committee. I make findings against Dr Nydam at paragraph 3.426.

- 1.11 About a fortnight after Dr Patel commenced work at the Base, Dr Keating replaced Dr Nydam as Director of Medical Services there. In breach of his duty to do so, and knowing that Dr Patel's skill and competence had not been assessed before he commenced employment at the Hospital, Dr Keating failed at any time between April 2003, when he was appointed, and when he left in 2005 to have that skill and competence assessed by an appropriate credentialing and privileging committee. This was notwithstanding that the Policy and Guidelines required that his employment was conditional on that being done, and that, in the meantime, Dr Patel's registration was renewed and his employment extended. I make findings and recommendations against Dr Keating in respect of this and other matters at paragraphs 3.427 and 3.428.

Dr Patel's conduct at Bundaberg Base Hospital 2003-2005: Paragraphs 3.415 to 3.420

- 1.12 In the period during which he performed surgery at Bundaberg Base Hospital, from April 2003 until early 2005, Dr Patel performed a large number of operations. The results of an examination of a comprehensive sample of his operations and aftercare was the subject of evidence by three respected general surgeons, Drs de Lacy and O'Loughlin, both of whom examined and performed corrective surgery on a number of Dr Patel's former patients, and Dr Woodruff who conducted a comprehensive survey of Dr Patel's work by examining hospital records.
- 1.13 Dr De Lacy said that Dr Patel's conduct as a surgeon was deficient in four main respects, namely:
- (a) His assessment of a presenting patient was inadequate;
 - (b) His surgery techniques were defective;
 - (c) His post operative management was poor, and
 - (d) His follow up was inadequate.

He concluded by saying that Dr Patel's results were not ten times worse than one would expect; they were one hundred times worse.

- 1.14 Dr O'Loughlin observed shortcomings in Dr Patel's judgment, knowledge and technical ability. When asked whether he would permit Dr Patel to operate on him, he said 'No'.

- 1.15 Dr Woodruff found that there were 13 deaths in which an unacceptable level of care on the part of Dr Patel contributed to the adverse outcome; and there were a further 4 deaths in which an unacceptable level of care by Dr Patel may have contributed to the outcome. He found, in addition, 31 surviving patients where Dr Patel's poor level of care contributed to or may have contributed to an adverse outcome. He said that he had no hesitation in saying that Dr Patel's performance was incompetent, and that this performance was far worse than average, or what one might expect by chance.

Complaints about Dr Patel and his avoidance of scrutiny: Paragraphs 3.181 to 3.282

- 1.16 In his 24 months at Bundaberg Base Hospital, staff or patients made over 20 complaints about Dr Patel. Those complaints commenced with a procedure he performed six weeks after he commenced at the Hospital and continued until he ceased working there. All of the patients' complaints were verified by the examinations of the above specialist surgeons. Whilst the complaints varied in their seriousness and the formality with which they were made, some of them were extremely grave. Dr Keating and Mr Leck persistently ignored or downplayed the seriousness of these complaints. Dr Keating, for instance, was keen to describe them as 'personality conflicts'. In some cases their conduct was obstructive or antagonistic to complainants. On the whole their actions and inaction were unresponsive and discouraged complaint. Nevertheless, despite the fact that Dr Patel also, in a number of ways, avoided scrutiny of his conduct, complaints continued.
- 1.17 Dr Patel's avoidance of scrutiny of his conduct was contributed to by the position to which he was appointed, Director of Surgery, and the manner in which that occurred, referred to above. By this means, Dr Nydam managed to circumvent the more difficult route of seeking deemed specialist registration under s.135, having the consequence stated in s143A, which would have required assessment by the Royal Australasian College of Surgeons. The result was that Dr Patel was not supervised and, given the size of the Hospital, he had no peers at the Hospital who could assess his clinical skill and competence in the course of their work.

The failure of Mr Leck and Dr Keating to properly investigate these complaints:

Paragraphs 3.306 to 3.359

- 1.18 Notwithstanding the isolation from scrutiny that Dr Patel was able to achieve, it may now seem astonishing that the number and seriousness of the complaints against him did not cause either Dr Keating or Mr Leck to institute some thorough independent investigation of his conduct, at the latest by the end of October 2004. But their failure in this respect becomes less surprising, although no less reprehensible, when it is seen how they saw their role of running the Hospital, and where their priorities lay.
- 1.19 In the first place, both saw themselves as running a business of providing hospital services. They were not solely at fault in this for that is how Queensland

Health officers also saw their role. Indeed, the terminology used was that Queensland Health was 'purchasing medical services' from the hospitals and that patients were 'consumers' of these services. The hospital budget was fixed on an historical basis, that is based on that of the previous year, with an additional incentive payment based on elective surgery throughput. Up until quite recent times it also provided for a small percentage reduction from the historically fixed budget on the assumption that improved efficiencies would enable that to be achieved. In other words the budget was fixed as if the hospital was running a business of selling goods or services. Patient care and safety was not a relevant factor.

- 1.20 There was a strong incentive to Mr Leck, and consequently to Dr Keating, to maintain that budget. Mr Leck said that District Managers had been sacked for exceeding budget. And because achievement of the elective surgery target was necessary to obtain maximum funding for the following year, there was considerable pressure on both of them to achieve that target.
- 1.21 In this respect Dr Patel was a considerable asset. He was very industrious and, no doubt also partly because of his careless surgery, and lack of proper after care, maintained a high throughput of general surgery. Without him, the hospital would not have been able to achieve its elective surgery target. Mr Leck's and Dr Keating's greater concern with maintaining their elective surgery target than with patient care or safety is reflected in a great deal of the evidence.
- 1.22 Secondly, Dr Keating and Mr Leck were also both more concerned with procedures than with substance; what the purpose of those procedures were. Nowhere is this better reflected than in Dr Keating's attempts, together with Dr Hanelt at Hervey Bay Hospital, over more than a year, to obtain specialist college representation on credentialing and privileging committees, whilst ignoring the urgent need to have Dr Patel and others properly credentialed and privileged. Whilst seeking to achieve what he thought was the ideal system of credentialing and privileging committees in what he mistakenly thought was the required system, Dr Keating failed to realise the essential purpose of credentialing and privileging; to assess the clinical skill and competence of a doctor to perform the task for which he or she is to be employed, before commencing work.
- 1.23 And thirdly, the complaints system at the Hospital was grossly inadequate; and neither Dr Keating nor Mr Leck seemed to appreciate, or they chose to ignore, the significance of the accumulation of complaints, some of them quite serious about Dr Patel, which built up over the period of his working at Bundaberg Base Hospital..
- 1.24 It was a gross dereliction of duty by each of Mr Leck and Dr Keating not to have investigated the complaints against Dr Patel, at the latest, by October 2004, when they met with Ms Toni Hoffman about her written complaint.

- 1.25 I make serious findings and recommendations in respect of conduct, including conduct which, on the evidence before me appears to constitute criminal offences, against Dr Patel. These are at paragraphs 3.424 and 3.425.

Conclusions with respect to Bundaberg Base Hospital

- 1.26 Four factors, in my opinion, contributed to Dr Patel's sustained path of injury and death at Bundaberg Base Hospital. They were:

(i) *The Hospital Budget.*

The Hospital budget contributed in two ways. The first was that, although a Director of Surgery is ordinarily, and should be, a registered specialist surgeon, a surgeon who had Australian specialist qualifications would have probably required an offer of salary and conditions more generous than Queensland Health would have permitted the Hospital to offer; and so also would an overseas trained specialist surgeon who would have been able to satisfy the Royal Australasian College of Surgeons that his qualifications and experience were sufficient for them to recommend that he be granted deemed specialist registration. It is unlikely that the Hospital would ever have obtained the money to pay this. The second aspect was the focus, dictated by the budget, upon elective surgery throughput. Dr Patel made himself so valuable in that respect that the administrators were plainly reluctant to offend him, let alone investigate him.

(ii) *The failure to check his background*

Both the Medical Board and Queensland Health failed to check the credentials which he submitted. Had that been done, his discreditable past would probably have been revealed.

(iii) *The failure to have him credentialed and privileged*

At no stage did Mr Leck or Dr Keating have Dr Patel's skill and competence assessed by a committee of his peers under Queensland Health Policy and Guidelines. That should have been done before he commenced to see or operate upon patients at the Hospital, and again before he was reemployed a year later.

(iv) *The failure of any adequate complaint system to operate*

As explained earlier, this failure was caused, in part, by the budget system and the focus of both Dr Keating and Mr Leck upon the maintenance of the elective surgery target, but it is hard to believe that, if Dr Keating had been constantly confronted with the accumulating number and seriousness of complaints, as he should have been under any proper system, he would not have felt obliged to act.

- 1.27 In retrospect it is, perhaps, unsurprising that these causes of Dr Patel's appointment and continued course of conduct causing death and serious injury,

emerged as a cause of problems in other hospitals, which were, in whole or in part, the subject of evidence before this Commission.

Hervey Bay Hospital: Chapter Four

- 1.28 The examination of Hervey Bay Hospital was primarily concerned with the absence of adequate supervision of two Fijian trained doctors, registered under the area of need provision of the *Medical Practitioners Registration Act 2001*, in the orthopaedic department at the Hospital. This meant that they were unsupervised whilst performing operations in orthopaedic surgery which were beyond their respective levels of competence, with consequent serious risk to patient safety, and in some cases, with unfortunate results.

The need for and failure to provide supervision of the Senior Medical Officers

- 1.29 Both Drs Krishna and Sharma had had experience performing orthopaedic surgery in Fiji. Dr Krishna had also had some experience of performing orthopaedic surgery, under close supervision, at Toowoomba Hospital. Both were, at all relevant times, registered as Senior Medical Officers under the area of need provision. Their registration in each case, lasted for a year but was, in each case, renewed.
- 1.30 The application to the Medical Board from Dr Hanelt, the Director of Medical Services at Hervey Bay Hospital for the registration of each, indicated, in each case, that they would be supervised. However, no condition with respect to supervision was imposed by the Medical Board upon their registration, as it could have been.
- 1.31 The uniform view of all specialist orthopaedic surgeons who gave evidence was that Dr Krishna and Dr Sharma required supervision when performing orthopaedic surgery. The extent of which that supervision was required gave rise to some differences of opinion but it was unnecessary to resolve those. None was provided.
- 1.32 There was never any real prospect that Dr Krishna or Dr Sharma would be properly supervised at Hervey Bay Hospital because there was only ever one specialist orthopaedic surgeon, Dr Naidoo, at that Hospital. In addition, as it turned out, he was absent from that Hospital frequently, and some times for long periods of time. The Commission was unable to investigate fully the legitimacy of all of the absences of Dr Naidoo and has made a recommendation for further investigation of those. That recommendation is at paragraph 4.238.

Complaints about lack of supervision and their rejection

- 1.33 Dr Mullen, a registered orthopaedic surgeon in private practice at Hervey Bay, and a Visiting Medical Officer at the Hospital, complained frequently to Dr Hanelt, the Director of Medical Services, about the failure of Dr Krishna and Dr Sharma to receive supervision. His complaints were either rejected or ignored. He eventually took his complaints to the Australian Orthopaedic Association, whose efforts resulted in the appointment of Dr North and Dr Giblin to investigate,

referred to below. Dr Mullen also gave evidence of unfortunate consequences of one of these doctors operating without supervision.

- 1.34 Complaints were also made by nurses about Dr Naidoo's absences and the lack of adequate supervision of operations conducted by these Senior Medical Officers. Their complaints were similarly dismissed or ignored by Dr Hanelt and Mr Allsopp.

The failure to credential and privilege either Senior Medical Officer

- 1.35 In addition, Dr Krishna and Dr Sharma were employed and commenced service at Hervey Bay Hospital without having their skills and competence assessed by a committee of peers, a credentialing and privileging committee. Indeed, no such committee ever existed at any relevant time at Hervey Bay Hospital. Dr Hanelt, like Dr Keating, was preoccupied over this period with drawing up a local policy and obtaining representation from specialist colleges on all credentialing and privileging committees, both unnecessary requirements. Like Dr Keating, Dr Hanelt, whilst drawing up a local policy for that purpose and then seeking to implement that policy in the way I have indicated, lost sight of the purpose of credentialing and privileging; to ensure a safe, adequate provision of hospital care. Consequently, Dr Hanelt failed to provide any means of assessment of the skill or competence of either doctor before he commenced work at the Hospital or, for that matter, at any later time.

There was never a safe, adequate orthopaedic service at Hervey Bay Hospital

- 1.36 Qualified and experienced orthopaedic surgeons were unanimous in saying that the provision of a safe, adequate orthopaedic service at Hervey Bay would have required the employment of four specialist orthopaedic surgeons. From the time of inception of an orthopaedic service at Hervey Bay, in 1997, until it was terminated in 2005, that was never the case. Consequently, Hervey Bay Hospital was never able to provide and consequently never provided a safe, adequate orthopaedic service. Its orthopaedic service was, for that reason, closed down in consequence of the North Giblin Report. Dr North and Dr Giblin were nominees of the Australian Orthopaedic Association.
- 1.37 No doubt it was because of budget constraints that the orthopaedic unit at Hervey Bay Hospital was, from the start, so inadequately staffed by orthopaedic surgeons, that it was an inadequate and unsafe service. Dr Krishna and Dr Sharma, who both required supervision in performing a substantial number of orthopaedic operations, were nevertheless expected by Mr Allsopp and Dr Hanelt to perform orthopaedic surgery unsupervised with only very few restrictions. Thus the main cause of the inadequacy and lack of safety of the orthopaedic service at Hervey Bay Hospital, which, after its investigation by Dr North and Dr Giblin, was closed down, was the failure to adequately resource it. There was never any attempt, at any time, to provide Hervey Bay Hospital with a full complement of four orthopaedic surgeons necessary to provide an adequate and safe service.

Conclusion with respect to Hervey Bay Hospital

1.38 The reasons for the risks which were taken and the injury caused to patients at Hervey Bay bear a remarkable similarity to the causes of the much more damaging consequences at Bundaberg Base Hospital. They were:

- (i) Insufficient funding to provide a safe, adequate service;
- (ii) A failure of the Medical Board to impose, as a condition of the registration of each of Dr Krishna and Dr Sharma that he be supervised;
- (iii) The failure to assess the clinical skill and competence of either Dr Krishna or Dr Sharma as should have been done by a credentialing and privileging committee;
- (iv) A failure to provide supervision to Dr Krishna and Dr Sharma; and
- (v) A failure to investigate and act on complaints by Dr Mullen an independent orthopaedic surgeon and nurses at the Hospital about the inadequacy of supervision of Dr Krishna and Dr Sharma.

Findings and recommendations against Dr Hanelt and Mr Allsopp

1.39 I have made findings and recommendations against Dr Hanelt and Mr Allsopp. These recommendations are at paragraphs 4.240 to 4.247.

Townsville Hospital, Charters Towers Hospital, Rockhampton Hospital and the Prince Charles Hospital

1.40 Because of limitations on my terms of reference the Commission was able to examine only limited aspects of the services provided by each of those hospitals. Nevertheless, these limited examinations were revealing of common problems, and, in the case of Townsville Hospital, an indication of some solutions.

Townsville Hospital: Chapter Five - Part A

1.41 The Townsville Hospital is a tertiary referral hospital. It has 425 beds and is the largest provincial hospital in Australia. It provides a comprehensive range of services comparable to the major Brisbane hospitals such as Royal Brisbane and the Princess Alexandra. Two of its systems are worth noting.

1.42 The first of these is that its management structure and manner of budget distribution is different from other public hospitals, or at least, other provincial public hospitals. In both respects there is greater involvement and control by clinicians. In the Institute of Surgery, for example, which is what the Department of Surgery is called, the Clinical Director, a practising surgeon, and the Operations Director, a nurse, between them control the surgery budget. And they have power to spend a substantial amount of money without reference to the District Executive. Consequently, the kind of problem which arose in Bundaberg, of surgeons having to seek District Manager's permission to replace rusty surgical instruments, does not happen. Moreover the budget of each Institute is negotiated each year between the Townsville Executive and the Clinical and Operations Directors of each Institute. Unlike in other hospitals, or at

least other provincial hospitals, in Townsville the role of the Executive is one of supporting clinicians, and advocating their case for budget to Corporate Office, rather than, as it appears to be elsewhere, a 'them and us' approach to the clinicians. Unsurprisingly, this refreshing approach to budget by the Executive seems to be neither understood nor welcomed by Corporate Office. But it has managed to achieve what I think is essential, an appropriate balance between clinicians and administrators in fixing and advocating for budgets. I discuss this approach in more detail at 5.14 to 5.25.

- 1.43 The second is its approach to the assessment and integration of overseas trained doctors. All overseas trained doctors employed in hospitals in the Northern Zone are first required to spend time working in the Townsville Hospital. Although it is not called this, this is, in effect, a probationary period during which the doctor is closely supervised by experienced doctors who can monitor and assess whether he or she has the qualifications and experience to work in the position to which that doctor is to be appointed. It also gives that doctor an opportunity to see how the Queensland health system works during a period of close supervision, and to meet the specialists from whom he or she may later need to seek advice. I have expressed the view in Chapter Six that although s135(3) requires the Medical Board to make an assessment of such a doctor's suitability to practise in a designated area of need before registering that doctor, there is no process by which that is done. But at least something is done about this in the Northern Zone before that doctor is permitted to operate unsupervised or with minimal supervision, albeit after registration rather than before it. I express the opinion in Chapter Six that a similar process should be adopted before registration pursuant to s135 whereby all overseas trained doctors who would otherwise be qualified for registration pursuant to s135 must first be conditionally registered and serve a probationary period of registration in a tertiary hospital.

Vincent Berg

- 1.44 The other main focus of the Commission's inquiry at Townsville Hospital was with respect to Vincent Victor Berg who was employed as a Resident Medical Officer at Townsville Mental Health Unit between January 2000 and January 2001. He claimed to have post-graduate qualification in psychiatry from the Voronezh State University in the former USSR, now the Russian Federation. It seems probable now that that claim is false, and that the documents which he produced to the Medical Board to obtain registration were forged.
- 1.45 Two aspects of Mr Berg's registration and practice at Townsville Hospital were the principal areas of inquiry by this Commission. They were how he came to be registered by the Medical Board, and why no investigation of his fraudulent conduct was carried out.
- 1.46 It was not until some six months after he had left the Townsville Hospital that these forgeries were first discovered. Curiously, Berg contributed to the

discovery by applying for specialist registration in Australia. As part of the process of assessment for that purpose the College of Psychiatrists took steps to verify the authenticity of Berg's qualifications. They did what might have been thought necessary for the Medical Board to have done before Mr Berg was first registered; they wrote to Voronezh State University who told them that that University did not produce the degree in psychiatry which Mr Berg claimed to have and, when they saw the documents which Mr Berg had produced, described them as very rough forgeries.

- 1.47 It is unlikely, when it registered Mr Berg, that the Medical Board had any knowledge of Voronezh State University or the quality of the degree which it produced, if any. Yet it made no inquiry from that University, or from anywhere else, other than Mr Berg, about the authenticity or quality of his credentials. It accepted the documents produced by Mr Berg, at their face value, and registered him.
- 1.48 This registration bears a striking similarity to the registration of Dr Patel in the omission to make the necessary inquiries by the Medical Board. In both cases, as I have shown, inquiries from a source independent of the applicant would have revealed, in the case of Patel, that he had been suspended for malpractice and, in the case of Berg, that his qualifications were fraudulent. I discuss those negligent omissions and a solution to them in Chapter Six.
- 1.49 The probable falsity of Berg's qualification was discovered by the College of Psychiatrists in or about September 2001. The College informed the Medical Board of this on 16 October 2001. Notwithstanding that, the Board, astonishingly, provided Berg with a certificate of good standing on 10 January 2002 with an added notation that 'the Board has not been able to verify the qualification on which Dr Berg's registration was granted.' Apparently on the basis of this, Berg applied for and was granted provisional registration by the Medical Board of Western Australia. However, that Board soon discovered, from the College of Psychiatrists, the doubts about the veracity of Berg's claimed qualifications and cancelled his registration on 28 February 2002.
- 1.50 The Medical Board did not notify either Queensland Health or the Townsville Hospital of what it had been told by the College of Psychiatrists. The Hospital found out about this, by accident, when one of its employees went to a meeting of the College of Psychiatrists. This was in or about December 2002. The Hospital then expressed immediate concern to Corporate Office about the need to contact Berg's former patients and to take other action against Berg, who had indicated to the Medical Board of Western Australia that he intended to return to Queensland. Both disclosure to former patients of Mr Berg, that his credentials appeared to be false, and referral to the Crime and Misconduct Commission or the Police by the hospital, were prohibited by Dr Buckland.
- 1.51 The first decision may have been justified. The second was plainly without justification. The matter should have been immediately referred to Police

because it was plain that there appeared to be a prima facie case of the commission by Berg of a number of criminal offences.

- 1.52 Dr Buckland's reasons, on 23 January 2003, for his failure to involve the Police, that the Medical Board refused to acknowledge that Berg was not registrable, did not make sense. Dr Buckland knew that there was prima facie evidence that Berg's so called qualifications were forgeries.
- 1.53 The circumstances relating to this matter, together with Dr Buckland's earlier decision not to permit former patients of Berg to be informed that Berg's qualifications might be forgeries, and Dr Buckland's decisions not to investigate Dr Patel's conduct in Bundaberg and, apparently, the complaints about the orthopaedic service at Hervey Bay, together lead me to think that Dr Buckland's concern about the possibility of adverse publicity to Queensland Health and the Government was a major factor in his decision not to permit any further investigation, by the Crime and Misconduct Commission or by Police, of Mr Berg.
- 1.54 I refer to the Commissioner of the Police Service for further investigation the question whether Vincent Victor Berg committed a number of offences. This is at 5.158.

Charters Towers Hospital: Chapter Five - Part B

- 1.55 Dr Maree was appointed as Medical Superintendent of Charters Towers Hospital in the middle of 2000. He was a South African trained doctor who claimed considerable experience in obstetrics and that he also had experience in anaesthetics.
- 1.56 He was granted conditional registration by the Medical Board under s17C(1)(d) of the *Medical Act* 1939, the predecessor of and in similar terms to s135. As in the cases of Dr Patel in Bundaberg and Dr Krishna and Dr Sharma in Hervey Bay the Medical Board made no independent assessment in order to satisfy itself that Dr Maree had suitable qualifications and experience to practise as a Medical Superintendent in Charters Towers.
- 1.57 Also, as the Coroner found in this case, as with Dr Patel's appointment in Bundaberg, Dr Maree's appointment was made in breach of appropriate policies concerning appointment on merit. And as with the cases of Drs Patel, Krishna, Sharma and Berg, Dr Maree was not subjected to any process of assessment of his clinical skill and competence by a peer committee.
- 1.58 Dr Maree was negligent in applying an anaesthetic to a patient on 17 December 2000 as a result of which she died.
- 1.59 This gave rise to a coronial inquiry which made a number of findings against Dr Maree. But the concern of the Commission here was these defects in the process of his appointment, and a failure by the Medical Board to investigate Dr Maree's conduct which resulted in death.

- 1.60 There seems little doubt that Dr Maree was unsuitable to perform the work ordinarily required of a Medical Superintendent at Charters Towers Hospital including, as it turned out, anaesthetics in which he claimed some expertise. And, like the other cases I have examined, it seems at least likely that, if the proper processes of registration, employment and credentialing and privileging had been applied, this would have been discovered before the tragedy occurred.
- 1.61 Dr Maree did not renew his registration and returned to South Africa. Nevertheless, there were complaints made against him which the Board could have investigated for the purpose of making recommendations. It was partly because Dr Maree had not renewed registration and returned to South Africa, and partly because it had a large number of other investigations to deal with, that the Board took no further action against Dr Maree. The Coroner found that it was wrong not to continue to investigate and prosecute him. I agree with that.

Rockhampton Hospital: Chapter Five - Part C

- 1.62 A review team produced a report, the Miller Report, on the Emergency Department at the Rockhampton Hospital in June 2004. It identified serious problems in the operations and staffing of that department. One serious problem in that department, a common one in other hospitals, was that Senior Medical Officers were employed to do the work which specialists in emergency medicine should have been performing. Secondly, it was substantially understaffed. And finally, and most importantly, it seems as if the Hospital, instead of employing its most competent doctors in the Emergency Department, was using it as the Hospital's 'dumping ground' for underperforming doctors.
- 1.63 The Miller Report made a number of recommendations, none of which, it seems, were ever adopted. However, partly in response to the recommendations, the Hospital employed Dr William Kelley, an American trained specialist in emergency medicine. He arrived at Rockhampton Hospital in March 2005 about nine months after the Miller Report. He noted that 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. There continued to be poor utilisation of information technology, which he considered essential to the safe and efficient operation of an emergency department. He was also concerned that there were no radiologists at the Hospital, as radiological support was essential to the practice of emergency medicine.
- 1.64 Dr Kelley offered to contact senior doctors in other places in the world to join Rockhampton Hospital Emergency Department. However, his offer was rejected as was a further approach when it was made known that there were two such doctors in the United States willing to come and work in Rockhampton.
- 1.65 Dr Kelley recommended that, rather than employ a large number of junior doctors in the Emergency Department, as was the case, the Hospital should reallocate its funds so as to employ senior doctors. Again, this suggestion was not taken up.

The Hospital remained with an inadequate number of doctors in the Emergency Department of inadequate seniority and training, mostly appointed on an area of need basis.

Cardiac care at Prince Charles Hospital: Chapter Five - Part D

A substantial shortage of funds

- 1.66 The main and continuing problem for the provision of cardiac services at Prince Charles Hospital was a substantial shortage in funding. That had been the position for some time but more so since 2000 because of an Australia wide acceptance of the need for earlier intervention in heart disease. The waiting list for such services was large and growing.
- 1.67 Despite warnings by cardiologists of this and requests for additional funding, Queensland Health failed to respond. Dr Aroney, then a Senior Staff Cardiologist, met with management on a number of occasions, including with the Director-General, Dr Stable between 2001 and 2003 to no avail.

A transfer of funding to Princess Alexandra Hospital

- 1.68 In 2003 the decision was made by Dr Buckland, the General Manager of Health Services, to transfer cardiac procedures, 300 surgical procedures, 500 angiograms, and 96 angioplasty stent procedures, and consequently the funds to be allocated for those procedures, from Prince Charles Hospital to Princess Alexandra Hospital. This decision was made contrary to the advice given by cardiologists at the Prince Charles Hospital, and it appears mainly on the basis of advice given to him by administrators. This was despite evidence of a substantial increase in demand for inter-hospital transfers to the cardiology unit at Prince Charles Hospital, causing a major imbalance between demand and capacity in that hospital.
- 1.69 There were, it seems, at least three disadvantages, for patient care, in that transfer. The first was that, notwithstanding the substantial increase in demand for services at Prince Charles Hospital, the transfer resulted in a substantial transfer of funds from Prince Charles Hospital to Princess Alexandra Hospital. The second was that it was not at all clear that the patients who were transferred in fact ended up going to Princess Alexandra Hospital. And the third was that, although it was thought by administrators that Princess Alexandra Hospital had a very small urgent waiting list, it appears, as Dr Aroney said, that this was not the reality, but rather the result of the adoption by that Hospital of a method of calculation of urgency of need for care which was different from that adopted by other hospitals. I am satisfied that, in reality, there was a cutback in funding to cardiac services at Prince Charles Hospital, notwithstanding the urgent need for an increase in funding, even if most of the above patients were, in fact transferred to Princess Alexandra Hospital.

- 1.70 The sensible and fair solution to the problem, one which would have, to some extent, relieved the chronic backlog in provision of cardiac care at Prince Charles, would have been to transfer the above patient procedures to Princess Alexandra Hospital, but to have provided additional funding to that Hospital for that purpose, rather than, as occurred, to transfer it from Prince Charles. But that would have required an increase in total funding of cardiac care and that was plainly not the intention of Queensland Health and, in fairness to its officers, perhaps beyond its capacity to provide it.

Retribution against those who complained

- 1.71 Whilst the administrators at Prince Charles Hospital and those at Queensland Health plainly resented the complaints about under funding by Dr Aroney and others, but did little about it, it does seem to be the case that there were at least implied threats of retribution. An example of this was Ms Wallace's implication that the cardiologists could all be replaced by foreign doctors.
- 1.72 In early 2005 Dr Aroney resigned. He offered to continue as an honorary Visiting Cardiologist with catheter laboratory credentialing to assist where required in difficult cardiac interventional cases, but his offer was refused. There was no sensible reason for refusing it. It seems likely that this refusal was, at least partly, motivated by the resentment to which I have referred.

Common problems, common causes: Chapter Six

- 1.73 As I think already appears from what I have said so far, this examination of the above hospitals revealed a number of common problems, which together resulted in inadequate, even unsafe health care, in some cases with disastrous results. It is, perhaps, unsurprising, that these problems, common to a number of hospitals, also had common causes. It therefore became clear that, unless all of those causes are removed, or their effects substantially diminished, a serious risk of inadequate and unsafe health care in public hospitals will remain. Those problems, their causes, and some remedies are discussed in Chapter Six.
- 1.74 The first of these was an inadequate budget defectively administered. In a number of cases, for example, in Bundaberg, Hervey Bay, Townsville, Charters Towers and Rockhampton inadequate budgets resulted either in doctors being appointed to hospitals who should never have been appointed, or in doctors being put in positions beyond their level of competence. In both kinds of cases, the decisions to appoint were made because the hospital budget did not permit the hospital to make an offer generous enough to attract an appropriate applicant; and where the applicant appointed was plainly in need of supervision, the hospital budget did not permit that supervision to be provided. In some cases, Bundaberg and Charters Towers being examples, this led to disastrous consequences; in all others there was a serious risk of harm and, in some, actual harm. At Prince Charles Hospital it resulted in unacceptable delays in urgent cardiac care. There were also serious defects in the way in which budgets were

allocated and administered. The allocation of elective surgery budgets placed too much emphasis on attaining target numbers, and too little on patient care; and the excessive control exercised by administrators, because of budget constraints, and a culture of economic rationalism, led to poor decisions about patient care. This problem, its causes and some possible solutions are discussed in Part B of Chapter Six.

- 1.75 The second was a defective system of special purpose registration for areas of need. The idea of special purpose registration for areas of need was a reasonable one. But it has been abused, rather than used. In many cases, registration was granted under s.135 when neither of its pre-requisites had been satisfied. The Minister's delegate and the Medical Board were both negligent in the performance of their respective duties under that section. Their failures also contributed to harmful consequences. These defects, their consequences, and the remedy, are discussed in Part C of Chapter Six.
- 1.76 The third was an absence of credentialing and privileging. In none of the relevant cases at Bundaberg, Hervey Bay, Townsville, Charters Towers or Rockhampton were the relevant doctors credentialed or privileged. This was astonishing for two reasons. The first was that the obligation to do so, and the manner of doing so, was clear and simple. Even though Mr Berg in Townsville, and Dr Maree in Charters Towers were appointed before the Queensland Health Guidelines came into effect in 2002, there were requirements in much the same terms before then. And the second and more important reason why this failure was astonishing was that it was so obviously vital for patient safety to have a doctor's skill and competence adequately assessed before he commenced work. There was no excuse for not doing it. This is discussed in Part D of Chapter Six.
- 1.77 The fourth problem was a failure to monitor the performance of doctors, including to record and properly investigate complaints. There were no regular meetings to monitor clinical performances and no adequate recording of complaints in Bundaberg. Moreover, complaints were discouraged by management. The same was true of Hervey Bay. Nor was there any adequate investigation of complaints at either place. To take Bundaberg as an example, there were more than 20 complaints against Dr Patel, in a little under 2 years, yet that fact was not recorded anywhere. Consequently, there was no way in which an accumulation of complaints, some very serious, could be seen to require investigation. Had there been any such system, Dr Patel's conduct would have been investigated properly long before it was. Much of this also applies to Hervey Bay. When one comes to making a complaint outside the Hospital, the array of bodies to which a complaint can be made, and the appropriate body in any case, is confusing, and the overlap in their powers leads to delay and frustration. And finally, those who do complain need greater protection against retribution than they now have. These problems and their consequences, and some general suggestions about what should be done, are discussed in Part E of Chapter Six.

- 1.78 And the fifth problem was a tendency of administrators to ignore or suppress criticism. Bringing to light these and other problems in the public hospital system was made very much more difficult by a culture of concealment of practices or conduct which, if brought to light, might be embarrassing to Queensland Health or the Government. This culture started at the top with successive governments misusing the *Freedom of Information Act* to enable potentially embarrassing information to be concealed from the public. Unsurprisingly, Queensland Health adopted a similar approach, and because inadequate budgets meant that there would be inadequate health care, there was quite a lot to conceal. I make findings and recommendations in this respect against Cabinets in successive Governments, against former Minister Edmond and Minister Nuttall, against Dr Buckland and against Dr FitzGerald. Again unsurprisingly, the same approach was adopted by administrators in public hospitals, and this, in turn, led to threats of retribution to those who saw it as their duty to complain about inadequate health care. I make findings and recommendations against Mr Leck and Dr Keating in Bundaberg and against Mr Allsopp and Dr Hanelt in Hervey Bay. These problems and their solution are discussed in Part F of Chapter Six.

Amendment to the Coroner's Act: Chapter Seven

- 1.79 As I mention in Chapter Three, thirteen people died in Bundaberg after an unacceptable level of care by Dr Patel. Extraordinarily, only two of these deaths were reported to the Coroner under the *Coroner's Act* 2003, which required reporting in any case in which death was not a reasonably expected outcome of a health procedure. It seems likely that none of these deaths were reasonably expected outcomes of the relevant procedure.
- 1.80 Defects in the provision of the *Coroner's Act* permitted Dr Patel to circumvent its provisions by imposing on junior doctors to certify cause of death, in each case falsely, but on Dr Patel's expressed opinion and instructions. Such defects would also have permitted circumvention of these provisions by Dr Patel if he himself had falsely certified the cause of death in each of those cases.
- 1.81 It therefore became necessary to recommend amendments to the *Coroner's Act*, and to its administration which would prevent this from occurring. I do that in Chapter Seven.

Conclusion: Chapter Eight

- 1.82 I then make some concluding remarks which are unnecessary to repeat here.

Chapter Two – Base hospitals, recruiting doctors, and Area of Need Registration

'It's...easy to connect a few points together to understand that if over the last 20 years...in Queensland the supply of graduates has remained ...the same, during which period of time [the] population has grown each year equivalent to the size of a city of Rockhampton, we were inevitably heading for a railroad crash.'

Dr Lennox, Rural Medical Advisor

Administrative structure of base hospitals

- 2.1 The legislative framework for public health in Queensland is provided by the *Health Services Act* 1991. It provides that the Governor in Council may, by gazette notice, declare an area of the State to be a Health Service District, and may assign a name to the District.² Pursuant to that power, the State of Queensland has been divided into 38 different districts, each named according to its location.³
- 2.2 The Act provides that there be a District Health Council for each district. It provides that the Governor in Council is to appoint council members,⁴ and it charges the District Council with a role that is, essentially, advisory.⁵ For instance, the Council is to 'identify and assess the health service needs of people living in the district'; 'monitor the quality of public sector health services delivered in the district', and 'advise the manager for the district about the development of health service agreements for the district'. Curiously, the Act does not confer upon the Council any powers for the performance of its functions.
- 2.3 The legislation also provides that there be a manager for each district.⁶ That manager is to be a public service officer or a health service employee and, subject to the control of the Director-General of Queensland Health, is to manage the delivery of public sector health services in the district.⁷ There is a requirement that the District Manager 'consult and liaise' with the district council but, as will be gleaned from the discussion, the Council has very little power to give directions.⁸

² *Health Services Act* 1991 s6

³ <http://www.health.qld.gov.au/wwwprofiles/default.asp>

⁴ *Health Services Act* 1991 s10. The section provides that the Council may have as many as 10 members

⁵ *Health Services Act* 1991 s8. The council is to identify the health needs of the district, to monitor compliance with budgets, and to provide advice and recommendations for the delivery of services, amongst other things⁵

⁶ *Health Services Act* 1991 s22

⁷ *Health Services Act* 1991 ss2,22 and 24; and see *Acts Interpretation Act* 1954 s33(11)

⁸ T1832 line 30 - 50, T4380-3, T581 line 50; T1833

- 2.4 Unlike some Australian jurisdictions,⁹ Queensland has a public health system which is effectively run by one organisation, namely Queensland Health through layers of administration¹⁰ with its head office in Brisbane. For administrative purposes, Queensland Health divides the State into three zones (southern, central and northern), and those zones are divided further into districts. The various districts, however, are not autonomous. The staff at the various health facilities¹¹ within each district are accountable to the District Manager who, in turn, is accountable to the Director-General (pursuant to the provisions set out above). The staff at the hospitals, and indeed all public health facilities, effectively contract with, or are employed by, the Director-General,¹² and the assets and liabilities utilised in the running of the hospitals vest in the State.¹³ In short, the Director-General, based in Brisbane, has very real control over the various public hospitals in the districts and they are operated in accordance with the policies and procedures of Queensland Health.
- 2.5 It was not always so in Queensland. The *Hospitals Act* 1936¹⁴ provided for a very different system of administration. The Governor in Council was to establish districts throughout the State. The districts were matched with a local 'hospitals board' and the board effectively ran the hospitals in its district.¹⁵ The board would comprise 5 to 9 members, namely a representative from the local government authority, together with such members as the Governor in Council might appoint. Each board was a body corporate with the attendant capacity at law. It had the power to enter into contracts and to accept gifts and bequests.¹⁶ It was charged with the 'treatment of the sick' and with 'the good rule and government of the district in relation to such function'. It had the power to receive property and, in practice, it is understood, all real and personal property associated with its enterprises, was vested in the board.¹⁷ The power to frame the budget for the hospitals in the district (through various prescribed funds) was conferred on the board.¹⁸ Further, the board employed the staff of

⁹ There has been a strong centralising tendency in recent re-structuring so that all states and territories, except South Australia and Victoria, have a central governing agency. See the comparative tables in 'Australian health system restructuring – what problem is being solved?', Judith Dwyer, *Australia and New Zealand Health Policy* 2004 1:6 available at: <http://www.anzhealthpolicy.com/content/1/1/6>

¹⁰ T577 line 8

¹¹ These facilities may include centres for immunisation, dental clinics etc

¹² *Health Services Act* 1991 ss24 - 28

¹³ *Health Services Act* 1991 s72

¹⁴ There was a similar decentralised regime pursuant to the *Hospitals Act* 1923. The Hospital Boards received funding from the Government, the local authority and the patients: Exhibit 159

¹⁵ *Hospitals Act* 1936 s12 In practice, there were 11, and later 12, districts: *Triumph in the Tropics, An Historical Sketch of Queensland*, Sir Raphael Cilento and Clem Lack Snr, Smith & Patterson Pty Ltd, 1959 p445

¹⁶ *Hospitals Act* 1936 s13

¹⁷ At least the *Hospitals Act* 1936 s12 gave the Boards power to receive such property and it is understood that, in practice, the property was so vested

¹⁸ *Hospitals Act* 1936 s21

each hospital in its district subject, in certain cases, to the approval of the Director-General.¹⁹

- 2.6 The Act also gave the Governor in Council power to designate certain facilities within a district as 'base hospitals', and those hospitals were to act as the primary referral centre for the other facilities.²⁰ In practice, there were 11, and later 12, districts, 'each with a base hospital strategically located, and with as adequate a staff of medical officers and specialists as could be found locally, striving towards complete provision'.²¹
- 2.7 When the *Health Services Act* 1991 was initially enacted, a large measure of decentralisation was retained. Although the old hospitals boards were dissolved,²² they were replaced by Regional Health Authorities responsible for designated regions, with members again largely appointed by Governor in Council.²³ The regional authorities were subject to the control and direction of the Minister²⁴ but their primary functions were substantive ones. They were charged, amongst other things, with ensuring that health services were of a high quality; ensuring that there was adequate access to health services; making available to the public reports, information and advice concerning the services in the region; and providing training and education to the service-providers.²⁵ The authorities were given power to do all things reasonable and necessary in the performance of their functions.²⁶ They were given specific power to hold property,²⁷ to enter into contracts²⁸ and to receive gifts.²⁹ The property, previously vested in the hospitals boards, was vested in the regional authorities.³⁰
- 2.8 There was some testimony³¹ before the Commission that appointments to the Regional Health Authorities was politicised (and it seems entirely probable that this was the case), and that this interfered with their performance. It seems clear, however, that the regional health authorities and the hospitals boards before them, were attentive to local issues and that planning was firmly focussed on the clinical needs of the immediate population.³²

¹⁹ *Hospitals Act* 1936 s18. It should be noted, however, that the appointment of a medical superintendent, a medical officer or a matron required the approval of the Director-General: of the *Hospitals Act* 1936 s5

²⁰ *Hospitals Act* 1936 ss12A, 12B

²¹ *Triumph in the Tropics*, p445

²² *Health Services Act* 1991 (Reprint No. 1) s1.4

²³ *Health Services Act* 1991 (Reprint No. 1) ss3.1 - 3.5

²⁴ Interestingly, there was an exception namely in relation to the contents of a recommendation or report made by the Authority to the Minister: s3.8

²⁵ *Health Services Act* 1991 (Reprint No. 1) s3.18

²⁶ *Health Services Act* 1991 (Reprint No. 1) s3.19

²⁷ *Health Services Act* 1991 (Reprint No. 1) s3.24

²⁸ *Health Services Act* 1991 (Reprint No. 1) s3.27

²⁹ *Health Services Act* 1991 (Reprint No. 1) s3.25

³⁰ *Health Services Act* 1991 (Reprint No. 1) s8.2(1)

³¹ T1834 line 40, T1835 line 20 (Dr Thiele)

³² T1834-5 line 20 (Dr Thiele)

- 2.9 In 1996, the *Health Services Act* 1991 was amended so that the regionalisation provisions were removed and the current, corporate model (with the structure described above) was introduced.³³ Queensland Health grew into one of the largest employers in Australia with a staff of 64,000 people, engaged across a range of departments. Patients became known as 'clients', Medical Superintendents became known as Directors of Medical Services, and hospitals tended to be run by managers who were career public servants rather than local officials or health professionals.³⁴ The drive for centralisation had the admirable goals of ensuring that health resources could be effectively distributed through the State, that services and competency levels could be standardised (to the extent that is possible in a State as diverse as this one), and that certain economies of scale could be achieved. It also worked to diminish inefficient competition between centres and to facilitate co-ordinated planning of State-wide issues.³⁵ Queensland was able, for instance, to develop a well-resourced, centralised renal unit and a burns unit, rather than presiding over a proliferation of lesser units in various regions.³⁶
- 2.10 In this endeavour, of course, there is a real need to ensure a proper balance between the logistical benefits of a centralised approach and the encouragement to initiative and ownership which comes with local autonomy. The evidence given before the Commission, and canvassed later, suggests that such a balance is yet to be achieved in Queensland.

The role of the base hospital

- 2.11 Queensland Health operates just over 100 hospitals in Queensland, the smallest being ten bed/one doctor facilities in places such as Augathella and Julia Creek, and the largest being tertiary hospitals in Brisbane, such as the Princess Alexandra, with more than 700 beds and 4000 staff. In all of Queensland's large regional centres including Toowoomba, Dalby, Mackay, Rockhampton, Townsville and Cairns, there is a 'base hospital' or, if the old language is not used, a central public hospital which serves as the primary referral facility for smaller centres in the area.³⁷ The base hospitals provide certain core functions to their catchment areas and, in particular, they treat most, or all, of the emergency cases in the district, either as a primary admission or a referral.³⁸ Each of the bases has a Director of Medical Services who is the 'line manager' to the doctors. Each also has a Director of Nursing who is 'line manager' to the nurses³⁹ and who, like the Director of Medical

³³ *Health Legislation Amendment Act* (No2) 1996; T1847 (Dr Thiele)

³⁴ T2942 line 5 (Dr Nankivell); T3257 line 10, T3296 line 50, T3270 line 10 (Dr Strahan); T4163 line 30, T4146 line 20 (Dr Nydam)

³⁵ T2871, T2879 (Dr Young)

³⁶ T2879 (Dr Young)

³⁷ For ease of reference, I will use the title 'base' to denote all such primary referral hospitals in regional areas

³⁸ This occurs simply because most private hospitals do not offer Accident and Emergency facilities. See, for instance, the situation at Bundaberg, explained by Dr Brian Thiele: T1830 line 10

³⁹ Exhibit 180 paras 17-19, 31-33, T2540, 2555-6 (Ms Mulligan)

Services, reports directly to the District Manager. That triumvirate of District Manager, Director of Medical Services and Director of Nursing together with the Director of Corporate Services, essentially constitute each base's senior leadership.

- 2.12 Each base incorporates a number of different medical departments (eg, Surgery, Medicine, Emergency, Anaesthetics and Obstetrics) and, for each department, there is a director. The directors are clinicians who take on certain administrative duties in addition to their clinical work. They sit below the District Manager and the Director of Medical Services in the hospital hierarchy.⁴⁰
- 2.13 Each of the bases employs doctors, nurses, and other medical staff across its departments. The doctors are known as Interns (who have not yet been fully registered with the Medical Board of Queensland as medical practitioners), Junior House Officers (being medical practitioners in their first year of service after full registration), Senior House Officers (being doctors in their second or subsequent year of practise who have not been appointed as a Principal House Officer, and who are not Registrars), Principal House Officers (being medical practitioners who are not undertaking an accredited course of study for a higher medical qualification, and have been appointed to this position), Registrars (being doctors who have been accredited by a specialist college as part of a recognised specialist training programme) and Staff Specialists (being doctors recognised as having qualifications in a given specialised area).⁴¹
- 2.14 It should be said that the term 'Senior Medical Officer' has different meanings in different contexts.⁴² In its strict sense, it refers to any senior medical practitioner within the hospital, and would include Medical Superintendents, specialists⁴³ and Principal House Officers. In its more colloquial use, it refers to a senior doctor who is not a specialist or a trainee for an accredited course.⁴⁴ In this report, the term will be used in the latter sense, unless otherwise indicated.
- 2.15 The base hospitals often employ, in addition to the staff set out above, a number of Visiting Medical Officers. These officers are doctors – usually specialists – who maintain practices away from the base but choose to work for a certain number of hours, or sessions, at the base per week. Traditionally, in Queensland, they have worked for remuneration which barely covers the cost of running their rooms for the time spent.⁴⁵ That arrangement has been acceptable, it seems, because of the goodwill enjoyed between the doctors and the public hospitals, and the doctors' inclination towards public service,

⁴⁰ Exhibit 448 para 13, DWK2 p9 Division of Medical Services

⁴¹ T5969; Also the *Regional Health Authorities – Senior Medical Officer's Interim Award* (No. R7-3/1992)

⁴² T4118, line 50

⁴³ T5969, line 15; T4118, line 48

⁴⁴ See, for instance, the way the term is used by Dr Molloy at T573, Dr Baker at T6357, Mr Demy Geroe at T439 line 10 and T448 line 35, Dr Mullen at T5774 line 50, Dr North at T3456.

⁴⁵ T612 line 40 (Dr Molloy)

teaching and the collegiate atmosphere which has existed in those facilities.⁴⁶ It has been particularly attractive to specialists who are junior or newly arrived to an area, because it serves as a vehicle for gaining experience and forging relationships in the medical community.⁴⁷

- 2.16 Visiting Medical Officers often provide important stability in that, whilst regional centres may have difficulty in retaining full time staff specialists, a Visiting Medical Officer is often somebody who has made a long-term commitment to the town.⁴⁸ Moreover, where a town relies on a number of Visiting Medical Officers, it is less likely to suffer the disruption which comes from complete reliance on a lesser number of staff specialists.⁴⁹
- 2.17 Traditionally, the engagement of Visiting Medical Officers has been very beneficial to the base hospitals.⁵⁰ Whilst staff specialists provide much needed continuity of service,⁵¹ the demands of a regional population may mean that the need fluctuates, that only a part of a specialist's time is required,⁵² or that the employed specialist needs to be relieved on a regular basis.⁵³ In all or any of these ways, the Visiting Medical Officers supplement the employed base staff, and, in particular, the Staff Specialists. Further, the Visiting Medical Officer may bring a certain amount of vigour and independent thought as an outsider,⁵⁴ and may perform a supervisory, or mentoring, role. In some cases, the Visiting Medical Officer has assumed a position as director of a department.⁵⁵

Recruitment of doctors

Past recruitment of doctors

- 2.18 There has been, until recently, only one medical school in Queensland⁵⁶ so that regional hospitals have drawn doctors from that school, from the existing State workforce, from interstate, and from certain overseas countries, particularly the United Kingdom, Ireland and South Africa.⁵⁷ The hospitals tend to advertise positions locally or nationally and, if that does not yield a suitable

⁴⁶ T1824-6 (Dr Thiele)

⁴⁷ T186, T2751-2, T2782-3

⁴⁸ Exhibit 118 para 30, Dr Mullen, Dr Anderson, Dr Strahan, Dr Theile and Dr Jelliffe (discussed later) were all examples of this

⁴⁹ T1826 line 40 (Dr Thiele)

⁵⁰ T1824 (Dr Thiele), Exhibit 118 paras 28 - 32, T2856 (Dr Young), T2936 line 10 (Dr Nankivell)

⁵¹ T2934 (Dr Nankivell)

⁵² The hospital may not be able to sustain a full time neurosurgeon, or it may need 1.5 full time Emergency Medicine specialists

⁵³ T1825 (Dr Thiele), T558 (Dr Molloy)

⁵⁴ T556

⁵⁵ eg, Dr Martin Strahan, T3257 line 40; Exhibit 232

⁵⁶ This is the University of Queensland at St Lucia, Brisbane, but as appears later in this report, there are courses in medicine now offered at James Cook University at Townsville, Griffith University in Brisbane and Bond University on the Gold Coast. The first graduates will emerge in 2006 and the total number of Queensland graduates will double by 2010/11: T825, T943 and see T776

⁵⁷ T880

applicant, they approach private, or in-house, recruiting agencies to find candidates overseas.⁵⁸ In recent years, Queensland hospitals have tended to recruit more and more doctors from the international market. Moreover, those doctors tend to be drawn now from developing countries rather than those identified above. This trend is more pronounced in the regional healthcare facilities than it is in urban, tertiary hospitals and the circumstances surrounding that trend are described below.

- 2.19 In passing, it should be noted that public hospitals also recruit doctors through a 'rural scholarship' system of longstanding.⁵⁹ Queensland Health pays an allowance to medical undergraduates for a period of time during their studies, and the scholar is then bonded to work for Queensland Health for an equivalent period.⁶⁰ Those doctors are required to work out the majority of that bonded period in a rural location, but they are usually assigned, first, to a larger hospital so that they can gain and develop relevant skills and knowledge.⁶¹

Staffing shortages

- 2.20 There has been much evidence that there is an international medical workforce shortage,⁶² that such a crisis affects the Australian states and that the staff shortages are more acute in Queensland than other parts of Australia.⁶³ These shortages are more evident in the public sector than the private sector. In Queensland, at least, it seems that this situation has been brought about by some or all of the following factors:

- (a) Over the last 30 years, the population of Queensland has almost doubled⁶⁴ but the number of places at the University of Queensland medical school has remained static at approximately 225;⁶⁵
- (b) The mean age of the Queensland population is steadily rising⁶⁶ and, with that rise, there is a greater need for healthcare;
- (c) The public has higher expectations of the public health sector;⁶⁷
- (d) On a *per capita* basis, Queensland spends considerably less than the Australian average on general health funding and on public hospitals,⁶⁸

⁵⁸ Exhibit 41 (Dr Bethell) para 29; Exhibit 51 S(Dr Nydam) paras 8-14

⁵⁹ T3012 line 50 (Dr Cook); T2804 (Dr Risson)

⁶⁰ T2829 line 20 (Dr Risson), T2049 line 15 (Dr Athanasiov), T900 (Dr Lennox)

⁶¹ A Dr David Risson, who had received such a scholarship, gave evidence that there were 30 recipients of the scholarships in his year: T2829-30

⁶² T824 line 10; Dr Jeanette Young, Chair of the Australian Medical Workforce Advisory Committee – Exhibit 209, T2861, T2863; Dr Molloy T515; Dr Lennox T876; Exhibit 28, paras 55 – 64 (Mr O'Dempsey)

⁶³ T700-702 (Dr Bethell); T899 (Dr Lennox); T2864 line 18, T2871-2 (Dr Young)

⁶⁴ The Queensland population increased from 2 million to 3.9 million between 1975 and 2005 and it continues to grow at 1.9% per annum (Australian Bureau of Statistics)

⁶⁵ T824 line 40 (Dr Molloy); T876-8, T899 line 50 (Dr Lennox); T2857 (Dr Young)

⁶⁶ See the *Queensland Government's Submission to the Productivity Commission Study of the Health Workforce*. July 2005

⁶⁷ T878 (Dr Lennox)

⁶⁸ Exhibit 34 page 11; Exhibit 35; T565, T589 line 10; T596 (Dr Molloy)

and much of that money is spent on administrators rather than service providers;⁶⁹

- (e) Australian rates of pay for doctors are low by first world standards, and Queensland Health specialist rates are low by Queensland and Australian standards;⁷⁰
- (f) Doctors are graduating later,⁷¹ their HECS debt⁷² and family circumstances make them less inclined to work in the public sector⁷³ and they are committed to working shorter hours for lifestyle reasons;⁷⁴
- (g) There are many more women graduating from medical schools than before,⁷⁵ but in the course of their careers, and as a group, they tend to work significantly fewer hours;⁷⁶
- (h) The shortage of doctors places an extra burden on those working within the public system, making the private sector even more attractive;⁷⁷
- (i) Queensland and Australian medical graduates are well-regarded and can readily obtain work overseas;⁷⁸
- (j) Even when adequate numbers of medical graduates are produced, the professional colleges restrict entry unnecessarily;⁷⁹
- (k) Doctors leave the public system because they see major compromises in the quality of care, and do not wish to be part of that, or because they are aware of intrusions into clinical autonomy⁸⁰ and a culture of bullying.⁸¹

2.21 Whatever the causes, there are, in fact, fewer doctors per head in Queensland than in any other state or territory,⁸² and the statistics for nurses are similar.⁸³ It is also clear that the state's needs are not nearly satisfied by the local graduates,⁸⁴ or even from interstate sources because other States or territories suffer from similar – but mostly, less critical – shortages and because doctors are inclined to make their career where they trained.⁸⁵ Concurrently, it has become much more difficult to recruit from countries with comparable medical

⁶⁹ T590, 515,577 (Dr Molloy)

⁷⁰ Exhibit 34 paras 6, 9; Exhibit 35; T575-6; T846 line 20 (Dr Molloy)

⁷¹ T2939 (Dr Nankivell)

⁷² T2957 (Dr Nankivell)

⁷³ T1826 line 45 (Dr Thiele); T2864 line 42 (Dr Young)

⁷⁴ T2859 line 30 (Dr Young); T850 (Dr Molloy); T4105 (Dr Nydam)

⁷⁵ Dr Young gave evidence that the proportion in the UK is approaching 70% and that Australia tends to follow the UK workforce trends: T2859

⁷⁶ T2861, T2859 (Dr Young); T2939 (Dr Nankivell); T850 line 20 (Dr Molloy)

⁷⁷ T2864 (Dr Young)

⁷⁸ T880 (Dr Lennox)

⁷⁹ This theory is highly contentious (and, in any case, does not seem to be a current problem): T888 - 891, T924-5 (Dr Lennox); T776-80 (Dr Molloy); T2938 line 40; Exhibit 57 (Dr Nankivell)

⁸⁰ T592-5 (Dr Molloy) and see the evidence of Baker, Thiele, Jelliffe

⁸¹ T562, T577; T584-8; T818-20, T859-60 (Dr Molloy)

⁸² T2864 line 18, T2871-2, T2887 (Dr Young); See *Queensland Health Systems Review*, Final Report, p13

⁸³ T2887 (Dr Young); See *Queensland Health Systems Review*, Final Report, p14

⁸⁴ T879 line 15 (Dr Lennox)

⁸⁵ T2857 line 25 (Dr Young)

systems⁸⁶ because those countries are experiencing shortages, because some countries have introduced measures to ensure that they retain their graduates,⁸⁷ and because such doctors can command better remuneration elsewhere.⁸⁸

- 2.22 In consequence, Queensland has become highly dependent for a number of years on doctors from developing countries.⁸⁹ This state employs well more overseas trained doctors than any other Australian state⁹⁰ and, at least by 2003, the proportion of Resident Medical Officers who were overseas trained doctors across the State was approaching 50 per cent.⁹¹ Whereas in 1997-08, the United Kingdom and Ireland accounted for 70 per cent of the temporary working visas issued to overseas trained doctors (known as the subclass 422), by 2002-03 that share had fallen to 43 per cent.⁹² Over the same period, the proportion of doctors originating from India, Pakistan, Sri Lanka, Malaysia, the Philippines, Bangladesh and 'other'⁹³ increased from 9.6 per cent to 37.3 per cent. Queensland authorities often know little about the training standards at particular medical schools in those countries⁹⁴ and, in any case, the training may address quite different conditions from those operating in this State.⁹⁵ The practice is also problematic from a moral point of view: it deprives developing countries of doctors in circumstances where those countries may have paid for their education and are likely to have at least an equal need for their services.⁹⁶
- 2.23 The *Medical Practitioners Registration Act* 2001 prohibits people from taking or using certain restricted titles, including 'medical practitioner', unless they are registered by the Queensland Medical Board.⁹⁷ It might be thought, against that background, that any concerns about varying standards of training between overseas trained doctors, are allayed in the course of the registration process. In practice, that has not always been the case.
- 2.24 Doctors can obtain general registration from the Medical Board if they have completed an appropriate course accredited by the Australian Medical Council or passed an examination set for that purpose by the Australian Medical Council.⁹⁸ They are eligible for specialist registration if they are members of a

⁸⁶ T2863 line 50 (Dr Young)

⁸⁷ T424 (Mr Demy Geroe); T2863 line 20 (Dr Young)

⁸⁸ T424 (Mr Demy Geroe); T679 (Dr Bethell)

⁸⁹ T2863 (Dr Young); T880-1 (Dr Lennox). Exhibit 28 para 55, Exhibit 34 para 3, T701 (Dr Bethell)

⁹⁰ T459 (Mr Demy Geroe); In the article cited below, figures gathered by Professor Birrell show that for 2002/03, of the subclass 422 nominations, 37 per cent emanated from Queensland

⁹¹ Exhibit 55, DR12 p5; It is assumed that Dr Lennox uses the term 'resident medical officers' as it is used in the award R7-3/1992 so that it includes junior house officers, senior house officers, Principal House Officer, and registrars. Also Queensland Health Systems Review (Final Report) p13

⁹² Professor Birrell of Monash University has published a number of articles on this issue including 'Australian policy on overseas-trained doctors', *Medical Journal of Australia* November/December 2004, p635

⁹³ According to Professor Birrell's table, 'other' excludes Canada, South Africa, the USA, and, of course, the UK and Ireland. In all cases, the country identified is the practitioner's country of birth

⁹⁴ T2863-4 9 (Dr Young), and especially T880 (Dr Lennox)

⁹⁵ T881 (Dr Lennox); T2863 line 50 – T2864 (Dr Young); Exhibit 24 para 17

⁹⁶ T567 (Dr Molloy)

⁹⁷ s161

⁹⁸ s44; Exhibit 28 para 33

College prescribed by the regulations or the Board considers they have sufficient qualifications and experience, having regard to the advice of the relevant College and the Australian Medical Council.⁹⁹ To the extent that doctors gain general or specialist registration, the community can be assured that they have met stipulated Australian standards.

Special purpose registration for an area of need

2.25 There is, however, another path to practice in Queensland, namely 'special purpose' registration. Sections 131 to 144 of the Medical Practitioners Registration Act provide various circumstances in which the Board might allow registration of a doctor notwithstanding non-compliance with the regime set out above. They include post-graduate study,¹⁰⁰ medical research or teaching¹⁰¹ and practice in the public interest.¹⁰² The most commonly invoked circumstance, however, relates to 'area of need'. It is contained in s135 which provides that:

- (1) The purpose of registration under this section is to enable a person to practise the profession in an area the Minister has decided, under subsection (3), is an area of need for a medical service.
- (2) A person is qualified for special purpose registration to practise the profession in an area of need if the person has a medical qualification and experience the board considers suitable for practising the profession in the area.
- (3) The Minister may decide there is an area of need for a medical service if the Minister considers there are insufficient medical practitioners practising in the state or a part of the state, to provide the service at a level that meets the needs of people living in the state or the part of the state.
- (4) If the Minister decides there is an area of need for a medical service, the Minister must give the board written notice of the decision.

2.26 Special purpose registration must be for no more than one year¹⁰³ and the Act goes on to provide in s141 that::

- (1) The board may decide to register the applicant as a special purpose registrant on conditions the board considers necessary or desirable for the applicant to competently and safely undertake the activity the subject of the application.
- (2) If the board decides to register the applicant as a special purpose registrant on conditions, it must as soon as practicable give the applicant an information notice about the decision.

2.27 In addition, s143A provides that:

⁹⁹ s111. The second path, in practise, has required that the candidate pass specialist exams set by the AMC

¹⁰⁰ s133

¹⁰¹ s134

¹⁰² s137

¹⁰³ s140

- (1) This section applies to a registrant who is registered, under s135, to practise the profession in a specialty in an area of need.
- (2) While the registrant is registered to practise the profession in a specialty in an area of need, the registrant is taken to also be a specialist registrant in the specialty.
- (3) The registrant's deemed specialist registration under subsection (2) is taken to be subject to any conditions of the registrant's special purpose registration under section 135.
- (4) Part 3, division 9¹⁰⁴ does not apply to the registrant while the registrant is taken, under subsection (2) to be a specialist registrant.
- (5) Also, Part 3, division 11¹⁰⁵ does not apply to the registrant's deemed specialist registration under subsection (2).

2.28 The Commission received evidence that, at least as at May 2005, the Minister for Health had delegated the power given by s135(3) to three Queensland Health officers.¹⁰⁶ Where District Managers or directors of medical services considered that there was a shortage of some service in their district, they made application to the Minister's delegate for a decision to that effect in relation to a particular position.¹⁰⁷

2.29 If the approach was successful, an overseas trained doctor could then make application to the Medical Board of Queensland, seeking that he or she be given special purpose registration in relation to the identified position.¹⁰⁸ The Commission received evidence that the following would be submitted to the Board on a prescribed form on behalf of the overseas trained doctor,¹⁰⁹ another form on behalf of the nominating employer, together with a fee of approximately \$416.00,¹¹⁰ and certain supporting documents (including the area of need determination, a certificate of good standing – issued by the medical authority in the applicant's jurisdiction - and a certified photograph) as prescribed by the Board's Policy for Special Purpose Registration.¹¹¹

2.30 When the application came to the Board, it would be 'case-managed' by a registration officer, the officer would use a checklist to confirm that the application contained all documents prescribed by the Board's policy,¹¹² and liaise, if it was considered necessary, with the doctor concerned about any outstanding matters.¹¹³ Unless the registration officer considered that the application was clearly non-compliant,¹¹⁴ he or she would provide it to a

¹⁰⁴ This Part deals with specialist registration generally

¹⁰⁵ This part deals with general provisions about registration

¹⁰⁶ T957 (Dr Huxley)

¹⁰⁷ Exhibit 24, MDG14; T476 line 18 (Mr Demy Geroe); T954-5 (Dr Huxley)

¹⁰⁸ Exhibit 24, para 27; T414 (Mr Demy Geroe)

¹⁰⁹ I have used the past tense to describe this process, not because all elements have ceased but because I understand that changes are being made, currently, by an incremental approach

¹¹⁰ T443 (Mr Demy Geroe)

¹¹¹ Exhibit 24, MDG14

¹¹² Exhibit 24 para 26

¹¹³ T471 lines 20 - 30 (Mr Demy Geroe)

¹¹⁴ T418 (Mr Demy Geroe)

standing subcommittee, the Registration Advisory Committee,¹¹⁵ which made recommendations for confirmation by the Board.¹¹⁶ In this process, the Committee did not 're-process the application or check individual documents'. Instead, it tended to focus its attention on the forms completed by the doctor and the hospital, and the doctor's *curriculum vitae* together with the area of need certifications, with a view to considering whether the skills matched the position.¹¹⁷ Where the applicant was a non-resident, a temporary working visa with the Department of Immigration also needed also to be arranged. In effect, then, there were three obstacles that needed to be navigated for an overseas trained doctor to fill an area of need: the area of need decision to be made by Queensland Health, the registration to be secured from the Medical Board, and the subclass 422 visa to be issued by the Department of Immigration. In practice, the Commission heard it was common for recruitment agencies to co-ordinate the paperwork for all three applications.¹¹⁸

- 2.31 The process, in short, allowed overseas trained doctors to be registered for practise in Queensland in circumstances where they had not met the standards set by the Australian Medical Council and were not members of any relevant College. The intent of the legislation was that the process could be invoked only where there was an inadequate supply of Australian-trained doctors to provide the relevant service in the stipulated area.
- 2.32 Almost any medical position available in Queensland might be the subject of an area of need decision and be secured by an area of need applicant who adheres to the process. It follows that overseas trained doctors, through this route, might fill positions as general practitioners, Junior House Officers, Principal House Officers, Registrars and Directors of specialist departments in base hospitals,¹¹⁹ and possibly even directors of medical services in such hospitals.
- 2.33 The extent to which the process allows area of need applicants to practise as specialists is more problematic. Section 143A was introduced by s85 of the *Health Legislation Amendment Act 2001*. The explanatory notes for that Act usefully set out the background to the provision:

Area of Need

The Commonwealth Government, in consultation with the medical profession, has recently developed a national scheme for the assessment of overseas-trained specialists seeking registration to practise in an area of need (ie. an area where there are insufficient medical practitioners to meet the needs of people living in the area). The scheme is a response to national concerns about the need to improve the current assessment processes.

¹¹⁵ T415 (Mr Demy Geroe) s33 of the *Medical Practitioners Registration Act 2001* provides for the establishment of committees and the Registration Advisory Committee is one

¹¹⁶ T545-546 (Dr Cohn)

¹¹⁷ Exhibit 24 paras 34, 35; MDG 3

¹¹⁸ T468-9 (Mr Demy Geroe)

¹¹⁹ T431 line 48 (Mr Demy Geroe), T6659 (Dr Jelliffe)

The Medical Practitioners Registration Act 2001, which has yet to be proclaimed into force, enables the Medical Board of Queensland (the board) to register overseas trained practitioners to practise in the area of need if the board considers the applicant's qualifications and experience are suitable to practise in the area.

Under the proposed national scheme, the board will consider, applications for Area of Need Registration having regard to the recommendations of the relevant Specialist College and, once registered, registrants will be subject to periodic assessment by the relevant Specialist College...

[An obstacle] to the implementation of the scheme exists in that the Act allows area of need specialists to be granted special purpose registration but not specialist registration. Without specialist registration, these practitioners would be disadvantaged. For example, specialist registration is required for appointment to public sector specialists positions and for specialist recognition under the Health Insurance Act 1973, to enable payment of Medicare benefits at the higher specialist rates.

The Bill overcomes this problem by providing that area of need specialists who have special purpose registration are deemed to also have specialist registration. Such deemed registration will be subject to the same conditions as the registrant's special purpose registration.

- 2.34 When the legislation itself is considered,¹²⁰ it will be seen that there were two features to the path introduced by s143A. First, an important safeguard was introduced: where the Board was considering registering an overseas trained doctor 'to practise ... in a specialty in an area of need' under s135, it would, first, have regard to the recommendations of the relevant college pursuant to the national policy. That policy was published by the Australian Medical Council, in concert with the state medical boards and other parties. It is in evidence before the Commission and is entitled: *Assessment Process for Area of Need Specialists*.¹²¹ Secondly, and presumably on the basis that the safeguard would ensure quality, if such registration was granted under s135 then, by operation of s143A(2), the overseas trained doctor was deemed a specialist in the specialty. That deeming provision would provide certain benefits to the practitioner including, of course, the right to be held out as a specialist.
- 2.35 In effect the amendment permitted the Medical Board to register area of need applicants as specialists without complying with the process that would be required of an Australian-trained doctor.
- 2.36 In my view, the implementation of the area of need scheme – both in relation to general applications, and those that might attract the operation of s143A - has not been faithful to its purpose. I describe the shortcomings below.

¹²⁰ In a strict legal sense, the Explanatory Note is probably irrelevant because it is only a legitimate tool for construction in the event of ambiguity, and the legislation seems plain: *Acts Interpretation Act* 1954 s14B

¹²¹ Exhibit 36

Defects disclosed by implementation of Area of Need Registration

- 2.37 There are, of course, many overseas trained doctors who have come to Queensland under the auspices of s135 and who are gifted and committed practitioners. The Commission certainly became aware of or heard evidence from many such doctors. Some of them had, soon after arrival, proceeded to obtain a fellowship in the relevant college or taken the relevant Australian Medical Council examination, so that their qualifications were indisputably the equivalent of their Australian colleagues. The way in which the special purpose registration has been implemented, however, leads me to doubt the benefits of the legislative scheme, at least in its present form. It seems that no genuine attempt has been made either to give effect to the evident purpose of s135(3) in identifying areas of need nor in ensuring that, by qualifications and experience, overseas trained doctors are suited to particular area of need positions. For this reason, and perhaps others, the scheme has resulted in large numbers of overseas trained doctors practising in this State without meeting the standards required of Australian-trained doctors. That consequence is particularly worrying. It allows those doctors to work in senior positions in, say, an orthopaedic department or an internal medicine department (and usually in a regional area), without informing the public that they have not satisfied the same criteria as those required of their Australian-trained counterparts.

Defects in deciding that there is an area of need

- 2.38 There are a number of troubling features to the Minister's approach, to date, in exercising the discretion granted by s135. First, one of the Minister's delegates, Dr Suzanne Huxley, gave evidence that she had worked full-time in the area of need classification since October 2003, that she had received some 1700 applications,¹²² and that she had never refused any applications for public hospitals. This, obviously, makes one question the extent to which the delegate has considered the statutory task.¹²³ Secondly, and more specifically, Dr Huxley gave evidence that, in making the area of need decisions, she had never made any enquiries to ascertain whether, in fact, the precondition for s135(3) was made out.¹²⁴ Rather, she had proceeded on the assumption that hospital administrators would prefer an Australian-trained doctor so that, it seems, if they were making application for an area of need application, that was itself proof of a need.¹²⁵ Dr Huxley disclosed in her testimony that there were no protocols for making determinations because 'our data is not good

¹²² T945 line 50

¹²³ T938-9

¹²⁴ T958-960

¹²⁵ T958-9; Dr Bethell of Wavelength Consulting did give evidence that employers 'always prefer' an Australian candidate for a number of reasons: T703

enough'.¹²⁶ Thirdly, Dr Huxley disclosed that, in making decisions, the Minister's delegates would have regard to a ministerial policy on area of need which was some four years old (when the *Medical Act* 1939 was in force) and which preceded the proclamation of the *Medical Practitioner's Registration Act* 2001. Fourthly, it was the practice for the Minister's delegate to renew the area of need classification automatically every year until the incumbent chose to leave, despite the terms of the legislation. No checks were made to ascertain whether the pre-conditions in s135(3) prevailed at the time of renewal and, in consequence, there was no impetus for the overseas trained doctor to satisfy the Australian standards required for registration.¹²⁷ Although the (outdated) ministerial policy stipulated that area of need doctors should proceed to general or specialist registration after four years, that was not enforced until recently.¹²⁸ As a result, there have been overseas trained doctors who have practised for many years in Queensland pursuant to the area of need concession.¹²⁹

- 2.39 It emerges, perhaps as a natural consequence of these matters, that the number of overseas trained doctors working on temporary visas in Queensland is in the order of 1,760 and, as mentioned earlier, well more than any other state.¹³⁰ It seems clear that neither the Minister's delegate nor Queensland Health has attended to their role as statutory gatekeepers with any degree of vigilance.

Defects in Area of Need Registration by the Medical Board

- 2.40 There are, in addition, related shortcomings in the manner of registration of applicants under the provisions and its consequences. First, neither the Medical Board nor Queensland Health has carried out any examinations – theoretical or practical – to test the competence of the overseas trained doctors.¹³¹ Indeed, until May 2004, the Board did not even satisfy itself that the candidate could speak English proficiently.¹³² This is in contrast to other jurisdictions including Canada, the United States, the United Kingdom and, to some extent, New South Wales, where the overseas trained doctor must establish competence in English, medical knowledge and clinical skills.¹³³

¹²⁶ T957 line 55

¹²⁷ T942 (Dr Huxley)

¹²⁸ T942 (Dr Huxley)

¹²⁹ T887 line 25 (Dr Lennox)

¹³⁰ Exhibit 28 para 62; T899 line 50 (Dr Lennox); T459 line 15 (Mr Demy Geroe); T3182 line 45 (Dr FitzGerald); 'Australian Policy on Overseas Trained Doctors', Robert Birrell, [2004] *Medical Journal of Australia* 635

¹³¹ T491 (Mr Demy Geroe)

¹³² T419 line 45 (Mr Demy Geroe)

¹³³ T491 (Mr Demy Geroe); *Australian Policy on Overseas Trained Doctors*, Robert Birrell, *Medical Journal of Australia*. Professor Birrell notes that in New South Wales the Medical Board 'assesses candidates by means of a face to face interview covering clinical skills and conducted by clinicians familiar with the relevant area of practice'

- 2.41 Secondly, perhaps for a number of reasons, the Medical Board's scrutiny of the qualifications of overseas trained doctors has been inadequate.¹³⁴ As was conceded by the Deputy-Registrar of the Board, the Board simply did not have the resources to carry out comprehensive background checks.¹³⁵ It met fortnightly¹³⁶ and considered an average of 50 to 100, and sometimes 200, applications at a sitting so that it relied almost entirely on the registration officers to peruse documents.¹³⁷ In January 2003, (a relevant date for purposes below), there were four registration officers dedicated to *all* special purpose registration processing, and 1.4 full time employees dedicated to area of need applications.¹³⁸ In January 2003, the registration officers considered 233 applications for Area of Need Registration alone.¹³⁹ At the same time, it seems, they would deal with the distraction of agencies, applicants and employers seeking to expedite applications.¹⁴⁰ Moreover, the registration officers were not professionals but rather clerical staff. They were employed at the level of 'Administrative Officer 3'¹⁴¹ (which is the level expected of a filing and serving clerk). They should not have been expected to shoulder such a large part of the quality monitoring for overseas trained doctors.
- 2.42 Neither the registration officers nor anyone else within the Board would, as a matter of practice, contact the referees nominated by the applicant or even satisfy themselves that this task had been carried out by others,¹⁴² nor would they make contact with the issuing authority for the Certificate of Good Standing. Whilst the resources may have been inadequate for such inquiries, it is difficult to see why – given that the registration fee paid on behalf of the overseas trained doctor was only \$416.00, and that it was intended that the fee fully cover the costs of registration¹⁴³ - the fee was not increased to allow for more comprehensive checks. It was incumbent on the Board to ensure that it had adequate resources to fulfil its statutory duty of considering whether candidate's qualifications and experience rendered them 'suitable for practising the profession in the area'. In the circumstances, there was great potential for discrepancies in applications to be overlooked and, as will be seen later, such an oversight had a very real impact in the events which led to this Commission.

¹³⁴ T467 line 40 (Mr Demy Geroe); Consideration is given later in this report to specific cases including Keith Muir, Jayant Patel, Vincent Berg, and the Hervey Bay situation

¹³⁵ T467 line 45 (Mr Demy Geroe)

¹³⁶ T417 (Mr Demy Geroe)

¹³⁷ T417 (Mr Demy Geroe).Exhibit 24, MDG3, para 5.3; Exhibit 28, especially para 29; Exhibit 24, paras 31 - 36; Exhibit 421, paras 5 - 8. The Board meetings considered three broad issues in equal measure, of which registration was only one: T546 (Dr Cohn)

¹³⁸ Exhibit 24, MDG3, para 5.6: this is despite the fact that July/August and December/January were the peak times: T417 (Mr Demy Geroe)

¹³⁹ Exhibit 24, para 47; Note also T415 (Mr Demy Geroe) to the effect that only one and a half staff members were dedicated to area of need applications

¹⁴⁰ Exhibit 24, MDG3, para 5.6

¹⁴¹ T418 (Mr Demy Geroe)

¹⁴² T467 (Mr Demy Geroe)

¹⁴³ T443 (Mr Demy Geroe); The fee is prescribed by Schedule 2 to the *Medical Practitioners Registration Regulations* 2002

- 2.43 Thirdly, neither Queensland Health's area of need staff¹⁴⁴ nor the Medical Board¹⁴⁵ had any system for monitoring the performance of area of need doctors in the course of their registration.
- 2.44 Fourthly, of the persons registered pursuant to s135, those who are most in need of supervision tend to be in areas where supervision is least likely to be capable of being provided.¹⁴⁶ In the competition to fill positions, the large tertiary hospitals, such as the Princess Alexandra in Brisbane, almost invariably obtain better qualified registrants than the regional hospitals or the small one-doctor centres.¹⁴⁷ The Director of Medical Services at that hospital testified:
- We have got a lot of advantages at PA. We're a large hospital, we're well-known internationally, we have had a lot of doctors come to us over the years and they go back and talk about us. So we sort of get a lot of recruitment through word of mouth, and also we don't employ a lot of overseas-trained doctors as a percentage of our total staff.
- 2.45 There are a range of 'enticements' the tertiary hospitals can offer including research facilities, proximity to an urban centre and fixed hours of employment. Further, practitioners are not paid any additional sum for working in a more remote setting, and (if they are seeking higher, or Australian, qualifications) they will find it difficult to carry out further study from rural posts where the workload is high and the access to colleagues and courses is low.¹⁴⁸
- 2.46 Fifthly, the Medical Board assumed – notwithstanding the features of the area of need policy set out above and of which the Board should have been apprised - that, if doctors were employed in a hospital as a Senior Medical Officer or in a more junior position, they would be carefully supervised.¹⁴⁹ They were not required to identify any supervisor,¹⁵⁰ and there appears to have been no process in place for the Board to confirm, during the period of registration, that overseas trained doctors – particularly those working in regional locations – were receiving supervision commensurate with their backgrounds.¹⁵¹ That omission occurs in a legislative context where, as discussed above, the Board might have imposed a condition that the registrant be supervised. It also occurs in a context where overseas trained doctors may be acting as Directors of specialty units in some hospitals.¹⁵² Indeed, when it was put to one witness that the Medical Board was entitled to expect that area of need practitioners in

¹⁴⁴ T941 line 30 (Dr Huxley)

¹⁴⁵ Exhibit 33 para 32

¹⁴⁶ The evidence of Dr Thiele and others suggests that, in most regional hospitals, it is normal to have well more than 50% of the doctors employed on an area of need basis; also T884-5 (Dr Lennox) especially T2854-5 (Dr Young)

¹⁴⁷ T939 line 40 (Dr Huxley); The tertiary hospitals are able to offer more alluring positions because they have better resources, more fixed hours of employment and of course proximity to an urban centre. The rates of pay are no higher in the regional facilities and it is almost impossible for an overseas trained doctor to carry out the necessary study whilst holding a position in a regional hospital, T6651 (Dr Jelliffe)

¹⁴⁸ T6650 (Dr Jelliffe)

¹⁴⁹ T435, T492 lines 30 – 50 (Mr Demy Geroe); T627-8 (Mr O'Dempsey); T940 line 45 (Dr Huxley)

¹⁵⁰ T492 line 32 (Mr Demy Geroe)

¹⁵¹ T470 line 32, T471 line 20 (Mr Demy Geroe)

¹⁵² There was, for example a Director of Anaesthetics at the Bundaberg Base in 2001, namely Dr Martin Wakefield, who was not a fellow of the College: T6659 (Dr Jelliffe). Also T4120 line 30 (Dr FitzGerald)

hospitals would be supervised by the directors of their specialty unit, he responded:

...with due respect to the Medical Board, they ought to get in the car and drive around the country and see what's going on...there's an ideal, isn't there? There is an ideal that every director should be an Australian-trained, Australian-recognised specialist. That unfortunately has not been the case in Queensland for years at every hospital.

- 2.47 Sixthly, many doctors who are approved under s135 tend to come from countries with different cultures and languages from ours and sometimes with a medical and hospital system which is less developed or complex than ours. The language difficulties¹⁵³ will be particularly frustrating when taking a history from a patient or when explaining the patient's history by telephone to, say, a patient retrieval expert.¹⁵⁴ Some face cultural challenges and difficulty in understanding systemic matters, such as the impact of Federal/State cost arrangements, and the interaction of regional and tertiary hospitals. There has not been any attempt to date in Queensland to co-ordinate the induction or integration of overseas trained doctors into the system¹⁵⁵ in any of these respects.
- 2.48 Seventhly, evidence was given about a further serious concern about the scheme and its administration.¹⁵⁶ The terms of Area of Need Registration usually require that they work at a specific hospital or at the direction of a particular person. Moreover, the temporary working visas¹⁵⁷ usually include a condition that the holder is not permitted to change employer;¹⁵⁸ they cannot join the private sector and, if their employment is terminated, it is likely they may be compelled to return to their country of origin.¹⁵⁹ There was a widely-held perception amongst doctors that, in the circumstances set out above, overseas trained doctors working within the public health sector are more compliant, and more accepting of conditions and directions, than their Australian-trained counterparts.¹⁶⁰ It was considered that the differential was increased when overseas trained doctors are compared with Visiting Medical Officers.¹⁶¹ There was a view expressed by some doctors that Queensland Health, as both a major employer and the 'gatekeeper' for s135(3) applications, was unduly ready to invoke the area of need policy on the basis that it made for more

¹⁵³ In 2003, the Board did not have an English language policy and, although interviews would be conducted, this was after registration was approved and the interviewer were not in the position to assess language proficiency:

T419 – 421 (Mr Demy Geroe)

¹⁵⁴ T2907-8 (Dr Rashford)

¹⁵⁵ T554-5 (Dr Molloy); Miller Report Exhibit 129 p14

¹⁵⁶ Exhibit 34, p8; T959 (Dr Huxley)

¹⁵⁷ Commonly, the Medical Practitioner Visa Subclass 422.

¹⁵⁸ Exhibit 448 para 31, Exhibits 450, 451

¹⁵⁹ T2753 line 30 (Dr Anderson); T885-888 (Dr Lennox)

¹⁶⁰ T886 (Dr Lennox); T2753 (Dr Anderson), T6660 (Dr Jelliffe); Exhibit 34, p9

¹⁶¹ Many doctors have suggested that Queensland Health is actively chasing away Visiting Medical Officers – eg Dr Molloy at T557, Dr Nankivell at T2970. The evidence of the Queensland Health Systems Review Final Review is that, whilst medical numbers have increased by 49 to 59 per cent since 1989, Visiting Medical Officers numbers have decreased by 41 per cent. Also Exhibit 34, p10; T1826 line 1 (Dr Thiele); T2936 line 30 (Dr Nankivell); Exhibit 34 Statement Molloy p10

accepting and malleable employees.¹⁶² That view was given some support by evidence that the policy would be invoked in circumstances where – despite the alleged dearth of available doctors – private hospitals in the same area had filled their equivalent positions with Australian-born practitioners.¹⁶³ It was also given support from the Chief Health Officer, Dr FitzGerald, when he testified before the Commission. When he was asked whether it was the case that news of things ‘going wrong’ would spread quickly through a hospital, he replied, ‘...that’s an expectation, from our experience in hospitals such as [Bundaberg] where today things, particularly in hospitals such as this with the number of overseas-trained doctors and their degree of anxiety about their employment, et cetera, that things are different.’¹⁶⁴ It has the disturbing consequence that the area of need policy has been used to buttress poor working conditions in public hospitals rather than to supplement a dearth of medical practitioners in a particular location.

- 2.49 Finally, it is noted that there are grounds for concern about the way that the Medical Board interpreted and administered s143A. The purpose of the legislation seems to have been significantly thwarted in two respects. First, it seems that, whether by design or through poor advice, the Board may have inadvertently registered people as specialists. It will be seen later that Dr Patel was registered as a ‘Senior Medical Officer – Surgery’. A perusal of the Medical Board register shows that it was not unusual for the special purpose registration to record that the applicant was to fill an area of need ‘as a Principal House Officer in Obstetrics & Gynaecology’ or as ‘a Principal House Officer in Paediatrics’. At least in the last two examples, the doctor fulfils the criteria in s143A(2): he or she is ‘registered to practise the profession in a specialty in an area of need’ because obstetrics and gynaecology, on the one hand, and paediatrics, on the other, are each defined, when the Act and the regulations are read together, as specialties.
- 2.50 I understand that the Board took the view that s143A only had its deeming effect where the doctor was registered to practise the profession as a *specialist* in an area of need. The legislation, however, does not speak in those terms. On the contrary, the draftsman makes clear that a distinction is drawn between a specialty and a specialist when it is said later in s143A(2) that the registrant is taken to be a ‘specialist registrant in the specialty’.
- 2.51 In my view, the Board has registered many area of need applicants on terms that would deem them to be specialists, but without invoking the safeguards set out in the national guidelines, namely consultation with the relevant College. I say more about this in Chapter Six.

¹⁶² Exhibit 34 Statement Molloy p8; T3059 (Dr Nankivell)

¹⁶³ This skepticism was articulated by a number of witnesses including Dr Nankivell at T2935 line 30 – 2936, T2973 line 15

¹⁶⁴ T3227

- 2.52 The second matter in which the purpose of the legislation was thwarted was that the process of obtaining deemed specialist registration was largely circumvented. The Commission has been informed that, where Area of Need Registration was sought for a specialist position, it was the practice of the Board to apply the Australian Medical Council national guidelines and require the involvement of the relevant specialist college and the Australian Medical Council¹⁶⁵ before granting registration. The colleges, for their part, normally examined the applicant's history, required that the applicant work under supervision, and stipulated that the person undergo training towards obtaining a fellowship¹⁶⁶ so that there was significant quality protection in the process. In effect, the overseas trained doctor would satisfy the Australian college that his or her qualifications were substantially equivalent to the Australian fellowship but would also agree to work for a time under supervision, and would take steps towards a full fellowship.¹⁶⁷
- 2.53 Unfortunately, the reality is that this path has not always been taken. Instead, even if Queensland Health anticipates that an overseas trained doctor will perform the role of a specialist in a department, it might seek an area of need declaration only for a Senior Medical Officer position or as a senior medical in a designated specialty. The then President of the Australian Medical Association in Queensland, Dr David Molloy, gave evidence, which was not contradicted, that Queensland Health 'mostly avoided' the two pathways for ensuring quality, namely fellowship or deemed specialisation.¹⁶⁸ Mr O'Dempsey of the Medical Board lent some support for this view when he gave evidence that, in April 2005, of the 1760 overseas trained doctors who had received special purpose registration, only 94 had obtained 'deemed specialist' positions.¹⁶⁹
- 2.54 Dr Molloy gave evidence that there were a number of reasons for the avoidance of the quality control measures contained in the Australian Medical Council Specialist Guidelines. They included that Queensland Health could pay Senior Medical Officers considerably less than deemed specialists,¹⁷⁰ that it was not always easy to obtain a college's approval for a particular candidate, that the college would almost always impose a condition that supervision be provided and this could be awkward for Queensland Health, and that colleges would also require continuing medical education, which might be inconvenient for Queensland Health.¹⁷¹ Rather than accept those quality control measures that go with the deemed specialist position, it was simply easier to obtain an area of need declaration, and registration, for a Senior Medical Officer and then

¹⁶⁵ Exhibit 36, T572 (Dr Molloy); T430, T480-481 (Mr Demy Geroe); Exhibit 34 para 5; T543 line 10 (Dr Cohn)

¹⁶⁶ Exhibit 34 para 5-6

¹⁶⁷ Exhibit 36; T572 (Dr Molloy); T480-1 ((Mr Demy Geroe)

¹⁶⁸ Exhibit 34 para 5;

¹⁶⁹ Exhibit 28 paras 62-3; The case of Dr Patel, set out below, provides one example, and the Hervey Bay situation, explored below, another, where overseas trained doctors were, at the very least, held out as senior doctors in specialised areas, without any application being made for 'deemed specialist' status. Exhibit 448, para 46-47

¹⁷⁰ Exhibit 34 para 5; T573 (Dr Molloy); T5969 line 25 (Dr Jayasekera); T6660 (Dr Jelliffe)

¹⁷¹ T573-4 (Dr Molloy)

assign the doctor activities in a specialty area.¹⁷² The circumstances of the appointment of Dr Patel and of Dr Chris Jelliffe would appear to be illustrative of this practice.

What these problems reveal about the scheme

2.55 These problems show that the legislative scheme for special purpose registration in areas of need has been implemented in a way which assumes, or at least accepts, that those who live in some areas of the State must suffer a substantially lower standard of medical care than that enjoyed by those in other areas; in particular, that those who live outside the metropolitan area of Brisbane must suffer a substantially lower standard of such care than those who do not. This is a morally untenable approach.¹⁷³ It is a self-perpetuating process in that, if regional health is expected to operate as an inferior system, it becomes harder and harder to attract good quality doctors and the system declines further. It is all the more disturbing because the evidence disclosed that the major stakeholders – Queensland Health, the Medical Board and the Australian Medical Association – have been aware, at least since late 2002, that the registration system for overseas trained doctors was in crisis.¹⁷⁴ I shall discuss later the possible solutions to these problems.¹⁷⁵

¹⁷² T571 line 35, T837-40 (Dr Molloy); T618 line 30 (Mr O'Dempsey); T837-40

¹⁷³ Unfortunately that approach is revealed in some other aspects of the administration of public hospitals.

¹⁷⁴ T893-4 (Dr Lennox); T3198-9 (Dr FitzGerald)

¹⁷⁵ Chapter 6

Chapter Three – The Bundaberg Base Hospital

‘...any healthy organisation has to welcome criticism because that is the means by which the organism changes and... grows. If you stifle criticism, you are asking for trouble.’

Dr Brian Thiele, Bundaberg

The history of the Hospital

- 3.1 Bundaberg is a town of approximately 46,000 people,¹⁷⁶ lying 385 kilometres north of Brisbane. The town has been involved, traditionally, with industries which support the surrounding cane and small crop farms but, in recent times, it has become home to a growing but increasingly ageing population.¹⁷⁷
- 3.2 There are three hospitals in Bundaberg, namely the Friendly Society Private Hospital (‘the Friendlies’), the Mater Misericordiae (‘the Mater’), and the Bundaberg Base (‘the Base’). The Friendlies and the Mater are both private hospitals whilst the Base is, of course, a public facility run by Queensland Health.¹⁷⁸ There are other public hospitals located in the area, being at Gin Gin and Childers, but whereas those hospitals have 18 beds each, the Base has 136 beds¹⁷⁹ and is the primary referral centre. It has a staff of approximately 850 (including 65 medical practitioners) and an annual budget in the order of \$56 million.¹⁸⁰
- 3.3 The Base was established in 1900.¹⁸¹ It services the northern part of the Wide Bay region as well as the Central and North Burnett Regions. The catchment area includes the coastal towns from Burnett Heads to Woodgate, as well as Gin Gin, Childers and Mount Perry. In all, the Base services a population of about

¹⁷⁶ See the Bundaberg City Council website at www.bundaberg.qld.gov.au

¹⁷⁷ See the Resident Orientation Handbook for Bundaberg Base Hospital at <http://www.matereducation.com.au/ssl/1/bundaberg.pdf>

¹⁷⁸ The Base falls within Queensland Health’s ‘Central Zone’ which stretches from inner city Brisbane (on the northside of the River) in a northerly direction beyond Bundaberg, and west to the State’s border.

¹⁷⁹ Exhibit 230, page 2: Clinical Audit of General Surgical Services, Bundaberg Base

¹⁸⁰ Exhibit 448, para 15

¹⁸¹ The Bundaberg General Hospital, as it was previously known, is discussed in a 1928 Inquiry: see Exhibit 158: [Report - Royal Commission into the Medical Emergency at Bundaberg - dated 11/06/1928 by Commissioners Charles Kellaway, Pete MacCallum and A H Tebbutt](#)

85,000.¹⁸² Some measure of the community's heavy reliance on the facility will be gleaned from the fact that, in the financial year ended 30 June 2005, the Base has received 18,000 admissions, 24,500 people attending the outpatients' clinic, and 28,500 people attending at the Department of Emergency.

1994 – 1999: Poor budget and politicisation erode the quality of service

- 3.4 From 1994 to 1999, the Director of Medical Services at the Base was a vascular surgeon called Brian Thiele.¹⁸³ Dr Thiele and his wife grew up in Bundaberg but he trained in Victoria and then worked as a surgeon in the USA for 18 years (where he distinguished himself within his profession.)¹⁸⁴ In 1994, as he approached retirement, he determined to leave his position as head surgeon at Pennsylvania State University Hospital and return to Bundaberg. By a happy coincidence, the position of Director of Medical Services at the Base was being advertised, and he secured it, starting at Bundaberg in June 1994.
- 3.5 The evidence made clear that Dr Thiele was a very 'hands on' leader. He would make a round of some part of the Base every Friday in the company of the Director of Nursing; he ran a clinic in the Base's outpatient's department,¹⁸⁵ and he conducted surgery from time to time,¹⁸⁶ spending about 20-30% of his time on clinical issues, and the balance in administration.¹⁸⁷ Dr Thiele explained that, in his view, one could not be sure that a hospital was running well unless 'you go around and have a look and you participate'.¹⁸⁸ He maintained an 'open door' policy but he emphasised the importance of moving amongst the staff and engaging them directly.¹⁸⁹ He testified that this was a relatively easy task at the Base because the hospital was small enough that 'you can wrap your arms around it'.¹⁹⁰
- 3.6 Dr Thiele testified that, when he first arrived, he found the hospital staff had a low morale (so that there was 'a reluctance of staff to make eye contact ... and bid you the time of day',¹⁹¹) but he was convinced this was an environmental issue. He and his wife worked hard to overcome that problem. They introduced monthly

¹⁸² see the Queensland Health information at www.health.qld.gov.au/medical/facilities/BUNDABERG; Exhibit 230, page 2: Clinical Audit of General Surgical Services, Bundaberg Base

¹⁸³ See the evidence from T1818 and Exhibit 118

¹⁸⁴ See the Statement and CV for Dr Thiele, being Exhibit 118

¹⁸⁵ T1823, line 30

¹⁸⁶ T1821, line 10

¹⁸⁷ T1821, line 15

¹⁸⁸ T1821, line 40; T1862, line 50

¹⁸⁹ Exhibit 118, para 15; T1862, line 52

¹⁹⁰ Exhibit 118, para 19, T1862, line 50, T1847, line 30

¹⁹¹ T1820, line 20

staff barbecues, an annual fete, resident dinners, a Christmas pageant and an annual staff concert, and they revived an auxiliary organisation.¹⁹² Dr Thiele told, moreover, how he developed close ties to the local community¹⁹³ and liaised with Bundaberg business leaders about providing funding for the Base.¹⁹⁴

- 3.7 During most of Dr Thiele's term,¹⁹⁵ the District Manager was a man called Bruce Marshall,¹⁹⁶ the Director of Medicine was a physician called Martin Strahan, and the Director of Surgery was a surgeon called Pitre Anderson.¹⁹⁷ The evidence suggests that the four men worked well together¹⁹⁸ and that the leadership at the Base maintained a constant physical presence in the wards.¹⁹⁹ It seems that, although there were problems with lack of resources from time to time, the hospital staff worked to overcome them and the District Manager and the Director of Medical Services enjoyed the support of the staff.²⁰⁰
- 3.8 Dr Thiele and, I infer, other leaders within the Base, had strong views about the importance of teaching to clinical standards. During the 1994 -1999 period of his administration, Dr Thiele said, the Base introduced regular weekly clinical meetings for staff, visits from Brisbane specialists, teaching ward rounds, and regular educational presentations.²⁰¹ He said he also introduced an ethics committee to which staff could bring concerns with an ethical dimension.²⁰² Dr Thiele explained that he was keen to create an environment which attracted quality residents on the basis that they could be assured that their educational experience would be broadened at the hospital.²⁰³ He considered there was some affirmation of his strategy in the fact that half of the residents at the hospital were Australian-trained, and that overseas trained doctors were reporting favourably to their compatriots about the benefits of the Base.²⁰⁴
- 3.9 Dr Thiele gave evidence that the surgical department, in particular, became highly effective during his administration. He noted that the College of Surgeons awarded the Base training institution accreditation in this department and that, in consequence, the Base was able to attract registrars from Brisbane tertiary hospitals.

¹⁹² T1820

¹⁹³ See Dr Strahan's evidence at T3257, which I accept

¹⁹⁴ T1833-4

¹⁹⁵ Although Dr Thiele's term as Director of Medical Services finished in March 1999, he worked as a VMO at the Base until January 2004; T1853-4

¹⁹⁶ T3259

¹⁹⁷ Exhibit 118, para 9

¹⁹⁸ See T3252-3, and the evidence of Drs Strahan, Thiele, Nankivell and Anderson generally

¹⁹⁹ T3259; Exhibit 118, para 15

²⁰⁰ T3260; T2937, line 35; T2938, line 5

²⁰¹ T1823, Exhibit 118, para 8

²⁰² T1836, line 10

²⁰³ T1823

²⁰⁴ T1823-4

- 3.10 I should interpolate here that many specialists²⁰⁵ who appeared before the Commission, including Dr Thiele,²⁰⁶ emphasised the importance of registrars being available to a hospital. Apart from the obvious long term benefit in producing specialists, there is an immediate advantage in that these trainees can be expected to function at a higher level of competence than residents. In their chosen areas, they are able to give relatively sophisticated clinical care, to provide a triaging role (so that the specialist's time is not engaged unnecessarily) and to provide something of an auditing role in relation to the competence of the teacher.²⁰⁷ It seems that, where this middle layer of medical talent is absent, there is an increasing burden placed on the residents, the specialists, or both.²⁰⁸
- 3.11 Dr Thiele testified that he gradually became frustrated with a culture and a system within Queensland Health where 'an inordinate amount of energy' was required to make things happen.²⁰⁹ He said he could see that 'the goodwill, which was the oil in the cogs of the Queensland Health system, was drying up, and ...was concerned that, as that happened, it would become increasingly difficult to be able to get people to work in the public system, and difficult to do things'.²¹⁰ His frustration led, in March 1999, to his resigning as the Director of Medical Services at the Base and taking up a role there as a Visiting Medical Officer two days per week until 2003. In that year, he terminated his involvement with the Base almost completely²¹¹ because, he testified, there was needless inefficiency in the surgical scheduling and because, with the loss of registrars²¹² and the decline in standards, he could not be comfortable that his patients would receive good care.²¹³
- 3.12 There were a number of systemic problems to which Dr Thiele alluded. One of his primary concerns involved the issue of budgets. When he had first arrived, the regionalisation structure was still in place. At that time, a very detailed study had been carried out in relation to the current clinical services offered to the population and the likely need in the future. Dr Thiele considered the plan to be 'very enlightened' and viewed it as an impressive attempt to improve services.²¹⁴ Contemporaneously, there was a 'fairly rapid' expansion of services at the Base. The problem which emerged was that Queensland Health did not appear to allocate budgets on a needs basis but, instead, on an historical basis. There was no attempt to match budgets to clinical matters or emerging demographic trends but, instead, the central officer would fix the budget, perhaps with, say, a

²⁰⁵ See also Dr Anderson at T2744-5

²⁰⁶ T1822, 1824, T1828, T1839-40

²⁰⁷ T1836 and T2853

²⁰⁸ T2940

²⁰⁹ T1838

²¹⁰ T1838

²¹¹ He still conducted an amputation clinic: see T1854, line 18

²¹² The reasons for this are set out later.

²¹³ T1839; 1849, line 10

²¹⁴ T1834

four per cent increase, and the hospital was expected to work within it.²¹⁵ Regional hospitals were encouraged towards common resources and management, rather than responding to important needs and opportunities in their own geographic area.²¹⁶

- 3.13 That position created immediate problems. Dr Thiele gave an example of a CT scan machine. He said that, when he first arrived at the Base, he found that there was no CT scanner at the Base, and he was told that this was because it was too expensive.²¹⁷ He considered that this was thoroughly unacceptable. The Base carried out all the trauma work in Bundaberg, and early CT scanning was crucial if the extent of patients' injuries were to be identified. Instead, major trauma patients were being taken by ambulance to the CT scanner at the Mater Hospital in Bundaberg and then brought back to the Base. Dr Thiele said that, even though the equipment was of fundamental importance to the delivery of services, it was only purchased in the course of a rebuilding project at the Base.²¹⁸ He said that such decisions were often affected by an attitude within Queensland Health that, if 'Rockhampton doesn't have it, neither should Bundaberg'.²¹⁹
- 3.14 Dr Thiele also spoke about compromises being made in clinical care and good doctors with a public service ethos being worn down by this environment. He spoke, in particular, about waiting lists for endoscopies, a procedure used to diagnose and arrest the early development of cancer.²²⁰ Large numbers of patients were being referred to the Base for such investigations but there was not sufficient staff to review the patients, nor any way of knowing which patients had the most dire need. In the event, the treating surgeons (Dr Pitre Anderson and Dr Charles Nankivell) worked their way through the list progressively but they would come across patients inevitably who had a potentially lethal problem and had been waiting an unacceptable period of time. Dr Thiele testified that this caused considerable distress to the doctors.²²¹ He said that doctors and nurses have complained about quality issues in the system and championed patients' causes, but 'for whatever reason' they were ignored, and they became disheartened.²²²

²¹⁵ This evidence was corroborated before the Commission by the District Manager, Mr Leck. He said that there might be an increase in the budget on account of wage increases or a decrease on the basis that the Base should have been working towards more efficient practices. T7180. He said that occasionally the Base would receive 'enhancement funding for a new service: T7189

²¹⁶ T1831, line 35

²¹⁷ According to Dr Thiele, the machines cost a sum in the region of \$600,000.00 to \$700,000.00; T1830, line 29

²¹⁸ T1830

²¹⁹ T1831, line 38

²²⁰ The term 'endoscopy' incorporates gastroscopies – where access is obtained orally – and colonoscopies – where access is made via the colon.

²²¹ T1829

²²² T1851, line 35

3.15 He testified that:

I think this [the events surrounding Dr Patel] happened because there has been a gradual shift within the health care system from the primary goal of providing quality medical services to primarily be fiscally responsible....the system gradually became structured more to as a fiscal organisation, corporation and not a healthcare system... The service delivery issue became linked to unrealistic budget allocations and service delivery was made to fit fiscal boundaries, not the need that existed. Budgets became heavily linked to activity and activity indicators, without fundamentally ensuring there was no erosion of quality.²²³

3.16 A further problem to which Dr Thiele alluded was that, as fiscal matters assumed primary importance, Queensland Health manifested a keen, if not obsessive, interest in exerting control from head office at the expense of local initiative and autonomy.²²⁴ He gave an example of a plan he formulated to establish a foundation, governed by a board of local people, so that local people might make bequests and donations to assist the Base. It took Queensland Health almost two years to approve the plan (during which time, Dr Thiele had worked to garner support from local businesses). When approval was granted, however, it was accompanied by a list of people that Queensland Health would approve for the board, and Dr Thiele was particularly dismayed to find that they had 'political overtones'.²²⁵

3.17 Indeed, Dr Thiele linked the matter of centralised control with the lack of independent thinking²²⁶:

There's a desire to control, which to me is almost pathological, and it discourages critical commentary, it discourages thereby, progressive improvement from the bottom up, as I mentioned before, and it leads to a system which walks around with its head down, has not a great deal of self-respect because all the problems are identified from above and they're fixed from above and so people ask themselves, 'Well, what's my role here?'...And if you keep complaining about something that you fundamentally feel is wrong, and those for whom you work ignore you and ignore you and ignore you, the natural consequence is you ask yourself, 'What is my relevance here?'

3.18 Another example he gave of a failure to respect a level of autonomy or a failure to act 'opportunisticly'²²⁷ concerned the engagement of Visiting Medical Officers. He considered the use of such doctors vital to the proper functioning of regional hospitals (largely for the reasons identified above) but he said he had great difficulty in convincing Queensland Health to take on specialists when it seemed clearly beneficial to the hospital.²²⁸ He said that the reasons for engaging Visiting Medical Officers – particularly in a regional setting - were 'just

²²³ T1850

²²⁴ T1851

²²⁵ T1833-4

²²⁶ T1851

²²⁷ T1831, line 40

²²⁸ T1840, T1844-1845

commonsense things that I think are really no-brainers',²²⁹ but there was a persistence in the view of employing full time staff, perhaps, he thought, because they were more amenable to control.²³⁰ Dr Thiele maintained that Queensland Health did not adequately appreciate that there was a need to manage urban and rural environments differently and, in particular, that regional hospitals needed to be especially adaptable in the integration of proximate staff and facilities.

3.19 Dr Thiele spoke about the politicisation of the health system, as he perceived it. He testified that he had observed a very strong culture within Queensland Health of 'pleasing the boss'. He said that, particularly amongst administrators, as opposed to clinicians, he found that staff were reluctant to 'discuss real problems' and, instead, tended to downplay them.²³¹ He said that the politicisation had become intense, and it had a negative effect on the provision of services. He gave, as an example, an initiative during his term as Director of Medical Services at Bundaberg, to establish a renal dialysis service in the area. He said that the hardware for such a service was all present in Bundaberg,²³² as was a physician with renal dialysis experience and a surgeon (namely himself) with experience in access techniques.²³³ Notwithstanding what seemed like a straightforward decision, Queensland Health took the view that the unit should be located in Hervey Bay, and it took a year of concerted lobbying to change the decision. Dr Thiele speculated that the only reason for considering Hervey Bay at all was that it was a marginal seat and that some people in Queensland Health were 'trying to please the political masters'.²³⁴

3.20 On the same theme, Dr Thiele spoke passionately about the powerlessness of district health councils. Whereas, he said, they should involve locally active people and should ensure that patients are represented at the highest level, he considered that, in Bundaberg, the council only received 'filtered information',²³⁵ and that it was a 'toothless tiger' and a 'sop to people in the district'.²³⁶ He continued:

I have a fundamental difference of opinion with Queensland Health. I do not believe this hospital belongs to Queensland Health. I believe this hospital belongs to the people of Bundaberg, and Queensland Health may have a certain responsibility for the running, but I do not believe that it should be controlled 100 per cent by Queensland Health.²³⁷

²²⁹ T1824 line 10

²³⁰ T1825-6

²³¹ T1823, line 20

²³² Exhibit 118, para 35

²³³ Exhibit 118, para 35; T1832

²³⁴ T1831-2

²³⁵ This allegation is corroborated by the evidence of the Chair of the District Health Council, Mr Chase, see T4372 to T4411

²³⁶ T1832

²³⁷ T1834

- 3.21 Dr Thiele expressed a concern that the form-filling and uniformity that accompanied centralisation occurred at the expense of personal relations:

I just philosophically believe that if you want to know what a patient feels, you don't send them a questionnaire of 20 questions three weeks later, you walk around the hospital and you say 'Mrs Jones, how are things going', and I firmly believe in a hands-on approach to the clinical situation. I almost became apoplectic when – and I think it was the start of the slide – when Queensland Health decided to accept the corporate model and we were going to refer to patients as clients. Now clients to me were somebody who dealt with the legal profession, occasionally accountants, and patients were something a little bit different. You know, one of the important things doctors do with patients is we lay our hands on people and there is something very realistic about that. People give us their trust in that regard...²³⁸

- 3.22 As mentioned earlier, after Dr Thiele resigned as Director of Medical Services, he continued to practise in Bundaberg and to attend the Base as a Visiting Medical Officer. He gave evidence that, by 2003, he had become uncomfortable even with this level of involvement. The training status of the Department of Surgery had been lost because there were no longer two fellows of the College present, as the College required. The registrars were lost and Dr Thiele found that there was a general erosion in the standards of the staff so that information was unreliable and communication was less sophisticated. In January 2004, Dr Thiele ceased to work as a Visiting Medical Officer at the Base and confined his role there to the supervision of an amputation clinic.²³⁹ He testified that, he felt very strongly that the events surrounding Dr Jayant Patel (whom he met briefly), described below, were 'waiting to happen' in the context of all these problems.²⁴⁰
- 3.23 The evidence of Dr Thiele was not the subject of any significant challenge by any party, nor was it inconsistent with any of the evidence received from other witnesses. It was strongly corroborated by the evidence of a number of doctors who worked alongside Dr Thiele at various times, namely Drs Anderson, Nankivell and Strahan.²⁴¹ In those circumstances, I accept it. I deal with the evidence of the other doctors below.

1999 – 2002: an unsafe system

- 3.24 Dr Anderson gave evidence that he was a Fellow of the Royal Australasian College of Surgeons, that he commenced working as the Director of Surgery at the Base in 1994, and that he worked with another Fellow of that College, namely Dr Nankivell, until he stepped down as Director of Surgery in September

²³⁸ T1847

²³⁹ T1854

²⁴⁰ T1852; See also the evidence of Dr Baker T6393

²⁴¹ As will be seen below, it was also supported by evidence of a general decline in standards at the Base leading up to 2003.

2000.²⁴² He commenced to work as a Visiting Medical Officer at the Base from December 2001 and that continues to the present day.

3.25 Dr Anderson said that, with the assistance of Dr Thiele in vascular surgery matters, he and Dr Nankivell built up a strong Department of Surgery. They satisfied the College's high standards in relation to, amongst other things, case load, education programs, supervision, and audit/peer review process.²⁴³ Indeed, the peer review process extended to the participation of Bundaberg surgeons in private practice, who attended for their own benefit.²⁴⁴ He said, in consequence, junior and senior registrars of the College would do fixed periods at the Base as part of their formal training.

3.26 Dr Anderson said there was considerable frustration amongst medical staff at the Base with the process of administrative decision-making. During Dr Thiele's term, the frustration was acute when Queensland Health refused to approve Visiting Medical Officer sessions for an orthopaedic surgeon, who wanted to live and work in Bundaberg, despite a pressing need for such a surgeon.²⁴⁵ Dr Anderson said that, after Dr Thiele's departure, he found that the workload was enormous.²⁴⁶ He was doing a one in two roster (that is, he was on call every second day and every second weekend) with Dr Nankivell. A new administration commenced in about June 1998, with the coming of a District Manager called Peter Leck, (and, later, Dr John Wakefield as the Director of Medical Services) and Dr Anderson gave evidence that there were a series of disputes that arose between the new managers and various staff specialists, leading to the departure of the latter.²⁴⁷ Dr Anderson asked for an additional surgeon because he considered the workload was unsafe and untenable, but this was refused. He spoke generally about the importance of Visiting Medical Officers to regional hospitals,²⁴⁸ the refusal of Queensland Health to employ them on funding grounds despite the high workload²⁴⁹ and the 'missed opportunities' in respect of particular practitioners, both because of funds and because of the time needed for local administration to receive a response from head office.²⁵⁰ He also gave evidence of extremely long waiting lists for endoscopies prior to August 2000 (when Queensland Health addressed the problem by arranging gastroenterologists from Brisbane to visit the Base regularly).²⁵¹ He made clear

²⁴² Dr Nankivell started at the Base in February 1995: T2742

²⁴³ Exhibit 199, para 12; T2742

²⁴⁴ Ibid; T2746

²⁴⁵ Exhibit 199, para 14; T2750

²⁴⁶ T2750

²⁴⁷ T2743; Dr Marsh May, Dr Malcolm Stumer and Dr Anderson himself

²⁴⁸ T2751-2

²⁴⁹ T2754, T2799

²⁵⁰ Exhibit 199, PEA14; T2770

²⁵¹ Following an initial endoscopy 'blitz' by the Brisbane gastroenterologists: T2801-2

that even minor pay issues for specialists could take considerable periods to resolve because of the time spent awaiting a response from head office.²⁵²

- 3.27 Dr Anderson became involved in his own dispute with management at the Base. By a letter dated 2 August 2000, the Acting District Manager outlined four complaints, namely that Dr Anderson was working in private practice when he was rostered to work at the Base, that he had lodged inaccurate timesheets, that he had removed an abdominal retractor, and that he had not provided adequate supervision to junior staff.²⁵³ She also indicated that she was considering that he be suspended without pay, pending an investigation. Dr Anderson wrote back on the following day. He acknowledged there was some substance to the first complaint, but explained it had arisen in circumstances where his private practice had grown over some years, and he had been offering to become a Visiting Medical Officer with five sessions, allowing for a new staff surgeon to be appointed. He denied the other allegations and set out detailed reasons for doing so.²⁵⁴ In particular, he indicated that the abdominal retractor was his private possession, albeit that he had allowed other surgeons to use it. He suggested that there was no reason to suspend him without pay, particularly having regard to his explanation, the disruption it would cause to patient services, and the stress it would cause to the other surgeon, Dr Nankivell.
- 3.28 On 4 August 2000, the Acting District Manager wrote again. She indicated that, notwithstanding Dr Anderson's response, it was her view that 'continuing your services during the period of investigation will prejudice the efficient and proper management of the Bundaberg Health Service District' and that accordingly, she was suspending him without pay. She indicated that he was not to 'present in the vicinity of the Bundaberg Hospital without [her] prior written permission', except to seek medical treatment for himself or his family.
- 3.29 Dr Anderson was aware that investigations conducted by Queensland Health could take months or years. He was told by the Acting District Manager that, if he resigned, the investigation would cease and he could take up private practice immediately.²⁵⁵ In the event, Dr Anderson stepped down as Director of Surgery on 16 August 2000 (only being appointed as a Visiting Medical Officer in December 2001), and his role as Director of Surgery was assumed by Dr Nankivell.
- 3.30 Dr Nankivell gave evidence that was particularly compelling. He started work as a surgeon at the Base in February 1995, became the Director of Surgery in September 2000, and eventually resigned in January 2002. His evidence was

²⁵² T2779

²⁵³ Exhibit 199, PEA2

²⁵⁴ Exhibit 199, PEA3 and see T2786-7; T2791

²⁵⁵ T2796-7; Exhibit 199, para 24

that Dr Thiele was an uncomplicated, 'old style' manager,²⁵⁶ with a high degree of optimism about the Base and the Bundaberg community,²⁵⁷ so that during Dr Thiele's term, it was a 'very positive hospital'.²⁵⁸ By the time of Dr Nankivell's departure in January 2002, he said, there had been a gradual deterioration so that '...morale was destroyed...everybody was distraught, basically. There was anger and bitterness. It was a destroyed hospital by the time I left'.²⁵⁹

- 3.31 Dr Nankivell said that he would work a one in two roster with Dr Anderson. Often the on-call work would run into the routine work so that the doctors were working very unsafe hours. The problem was exacerbated by a number of factors. First, if one doctor was to take recreational, sick or study leave, the other surgeon would find himself solely responsible for the entire catchment area of Bundaberg so that he might work 19 days in a row.²⁶⁰ Secondly, the Base lost its surgical training accreditation,²⁶¹ and with that, of course, its access to registrars. Thirdly, the Emergency Department was, in Dr Nankivell's view, a 'shambles'. It tended to be staffed by junior, under-resourced, doctors who did not have the time or experience to properly assess patients or communicate with the specialist. Indeed, sometimes at night the 'surgical registrar' would be an intern.²⁶² In consequence, the surgeon would need to attend in person to assess patients.²⁶³ Fourthly, in addition to ward patients, emergencies, and outpatients, the Base surgeons were required to provide access surgery in the renal unit when it was established.²⁶⁴
- 3.32 When Dr Anderson resigned, Dr Nankivell maintained, he had the 'shattering experience' of being virtually the only surgeon at the Base for most of three months. Queensland Health did not press surgeons from other districts into service, or even thank Dr Nankivell, or remunerate him, for the extra time he worked.²⁶⁵
- 3.33 Dr Nankivell also spoke passionately about the care delivered to patients. He exhibited to his statement letters dated 2 December 1997, 7 April 1998, 25 May 1999, 23 July 1999, 20 April 2000, 3 May 2000 and 24 July 2001, and mostly addressed to Base management, where he or Dr Anderson, set out concerns that patients were suffering unnecessarily poor outcomes because of the long waiting lists for endoscopies. He said that Queensland Health provided

²⁵⁶ T2940

²⁵⁷ T2942

²⁵⁸ T2938

²⁵⁹ T2938

²⁶⁰ T2944, line 30

²⁶¹ This occurred when Dr Anderson resigned and on the basis that there were no longer sufficient surgeons to meet the College's supervision requirements.

²⁶² T2940

²⁶³ T2940

²⁶⁴ T2957

²⁶⁵ See the letter to the Director-General, attached to Exhibit 199. Mr Leck confirmed in evidence that the funding did not allow for adequate anaesthetists and surgeons so there was nothing he could do to address fatigue complaints he received: T7186-7

guidelines about waiting lists which 'read beautifully' in 'beautiful manuals', but very little was done to ensure they were followed.²⁶⁶ Dr Nankivell spoke about how quickly cancer can spread and the importance of attending to endoscopy work quickly.²⁶⁷ He spoke about his personal distress at seeing patients suffering because they were left to wait too long on the list.²⁶⁸

- 3.34 Dr Nankivell also spoke about the chaos of the Outpatients clinic at the Base. Whereas he would like to see one new patient every half hour in the clinic, he was expected to see as many as 28 in two hours. He would sometimes only see one third of the patients on his list, and he might be assisted by an intern – an unregistered doctor- who was seeing patients without close supervision.²⁶⁹ He testified that, having worked so hard, what he really found 'soul destroying' was to be abused by patients, angry at waiting long periods for treatment. Dr Nankivell wrote to, and spoke with, the hospital management on a number of occasions about the 'shambles' that was the Outpatients clinic. By a letter dated 14 October 1999, he went so far, out of concern for staff safety, as to request a security officer and a closed circuit television for the area. He testified as follows about the circumstances surrounding that request:

We had a tiny area that people crowded in like a cattle market. There was not enough seats to sit on...if you've been waiting an hour, there's no seat to sit on, naturally you're cranky by the time you get there. Patients have often waited a year to see you anyway. [The security measures were necessary] because of the abuse that the girls at reception desk were suffering. I just got sick of seeing them in tears at the end of a clinic, because there was too many people to actually get through, and the patients would be crowding around like a shop market trying to give their personal – you know, you go to a reception and you say ...your name, your date of birth, all the usual things, with people standing around and – they get people ringing them up and they get abused, and I just got fed up with the abuse. I must say, I'm not blaming the patients. I'm not saying these are bad people. These are frustrated people at the end of their tether, and the staff are frustrated and at the end of their tether. The clerical resourcing was inadequate, and it really was a shambles.²⁷⁰

- 3.35 Dr Nankivell spoke about problems associated with having only one model – as a result of the centralisation of health governance – which did not allow for the major differences between the city and the country.²⁷¹ Like Dr Thiele, he gave the example of the orthopaedic surgeon, Michael Delaney, who might have been used as a Visiting Medical Officer. He explained that Dr Delaney was in his early 30's, was interested in the Base, and wanted to work in Bundaberg for the rest of his life, at a time when all the orthopaedic surgeons in Bundaberg were nearing retirement.²⁷² Dr Thiele tried to 'scrimp and scrape' so that there was enough

²⁶⁶ T2949

²⁶⁷ T2949

²⁶⁸ T2947

²⁶⁹ T2964

²⁷⁰ T2963-4

²⁷¹ T2941

²⁷² T2942

money to keep Dr Delaney as a part time Visiting Medical Officer, but the idea 'got squashed'. Dr Delaney, instead, entered full time private practice and quickly became busy.²⁷³

- 3.36 In the end, Dr Nankivell took the view that, as a result of the centralised model, he was just talking to the wrong people. When Queensland Health would send people to the Base, they would often be bureaucrats with quite a different paradigm.²⁷⁴ The quality assurance data which was collected and provided to him was all about finance rather than clinical care. He also noted that, where a hospital failed to work within budget, that was considered a failing by the manager in a key performance indicator, whereas he considered it might be a signal that the budget might be wrong.²⁷⁵ In relation to endoscopies, he noted that one letter attached to his statement and dated 22 May 2000 showed the Director of Medical Services observing that, for Queensland Health's purposes, endoscopies were not '...recognised as elective surgery activity'. Against that background, he gleaned, there was little incentive to fix the problem.²⁷⁶ He felt that administrators were interested in process (or 'ticking boxes' as he put it) rather than addressing glaring clinical issues like unsafe working hours.²⁷⁷
- 3.37 He was dismayed that he would deal with public servants from Brisbane, who were not medically qualified and did not know much about regional practice. He made the point that the problems that existed in Bundaberg, and their solutions, would have been immediately apparent to a clinician, and it was frustrating that he was dealing with people who did not necessarily know even elementary things such as that surgeons carried out endoscopies.²⁷⁸
- 3.38 The problem, as Dr Nankivell came to understand it, was that 'Charlotte Street' simply determined the budget and the Hospital was required to work within it.²⁷⁹ He had been told, he explained, that there was no funding model. One would expect, he said, that the Department would assess the local demographics and then, perhaps, apply some formula to ascertain their likely medical needs.²⁸⁰ He said that such an exercise was 'absolutely fundamental' to clinical and workforce planning but he was told, whilst working at the Base, that one didn't exist.²⁸¹ Instead, he said, he and Dr Thiele came to understand that they received money through an historical funding model 'which basically means you have been duded in the past, you are going to be duded next year'.²⁸² The funding model

²⁷³ T2942, line 50

²⁷⁴ T2941

²⁷⁵ T2944

²⁷⁶ T2946

²⁷⁷ T2989, line 40; T2990

²⁷⁸ T2966, line 50

²⁷⁹ T2949, line 45; T2953, line 30

²⁸⁰ T2988-9

²⁸¹ T2988-9

²⁸² T2943, line 15

also led to absurdities. The staff might run out of bandages early in the year, and have to ration them or, alternatively, they might find that they had not spent their budget as 30 June approached and they would have to work out quickly how to 'get rid of' the extra money.²⁸³

- 3.39 Dr Nankivell said that it was not just that there was underfunding, but that the funding was maldistributed. There were periods when there were no waiting lists at Hervey Bay, whilst Bundaberg had huge waiting lists. But there was no one exercising the 'primary school logic' of shifting resources to where they were needed.²⁸⁴
- 3.40 Dr Nankivell gave evidence that he complained repeatedly about the conditions. He did not blame local management because he appreciated the problems could only be resolved at higher levels.²⁸⁵ He said that the then Director of Medical Services worked 'very, very hard' to advance a business case for more funds but with little effect.²⁸⁶ Dr Nankivell spoke to the District Manager, the Zonal Manager and eventually the local member of Parliament, Nita Cunningham, but there was no improvement.²⁸⁷
- 3.41 He said that the system did not welcome complaints and that, even though he understood that if one talked outside the Queensland Health system, 'you get sacked',²⁸⁸ he and others went *en masse* to see Ms Cunningham in about 2000 because the conditions were so dire. He testified about concerns held by doctors, and even more so by nurses, that if they spoke out about problems publicly, they would be considered to have breached a Code of Conduct²⁸⁹ within Queensland Health and disciplined.
- 3.42 In about November 2001, Dr Nankivell provided a letter to Dr Stable, then the Director-General of Queensland Health. The letter appears as an annexure to his statement. He wrote in the letter of a number of very serious concerns, including no effective response by Queensland Health to surgical outpatient concerns (despite it being the number one priority at the Base), the endoscopy list remaining a 'disaster despite years of begging for help', the problem of abuse from frustrated patients, the Accident & Emergency Department remaining 'a shambles', and his view that he had operated on patients when, by reason of exhaustion, he was 'totally unfit' to do so.²⁹⁰ Despite the fact that Dr Nankivell

²⁸³ T2943

²⁸⁴ T2945

²⁸⁵ T2948

²⁸⁶ T2948-9

²⁸⁷ Exhibit 212, T3009. T2957-8; T2964

²⁸⁸ T2957-8; and see the discussion later about Queensland Health's Code of Conduct

²⁸⁹ T2996; This Code will be considered at length later.

²⁹⁰ See the letter to the Director-General attached to Exhibit 212

wrote as a very senior doctor in a major regional hospital, he says he received no reply from Dr Stable whatsoever.²⁹¹

- 3.43 Dr Nankivell said he had been particularly dismayed by the trite nature of one particular response to his complaints from the General Manager (Health Services) at Queensland Health, Dr Youngman. The author wrote that:

...there are no short term easy solutions. A decentralised state does have additional barriers, particularly to lifestyle as it is not possible to engage enough staff to facilitate a roster in some disciplines....

- 3.44 Dr Nankivell pointed out that there was no problem in finding good surgeons in Bundaberg: the two private hospitals were well staffed²⁹² and there were adequate doctors who might act as Visiting Medical Officers to the Base. Dr Nankivell was exasperated by the letter because he considered that the solution was, in fact, so simple:

...we needed more staff. Whether that was more full-time staff, more VMO staff...I don't really mind. We just needed more staff²⁹³.

- 3.45 Dr Nankivell said that he appreciated that the Director of Medical Services had lodged a business case for one full time surgeon and one part time surgeon with Queensland Health, and he could not understand how the logic behind that request could be refuted.

We were a busy growing area, we needed more money and it was just so obvious²⁹⁴...we documented unsafe working hours, we documented delayed diagnosis, we documented death. We had an expanding population, we had a bulk-billing population, we had a renal unit established, which was a great thing but a renal unit brings more surgery into town...what more did we need to prove?²⁹⁵

- 3.46 In the end, apparently out of frustration, Dr Nankivell gave notice in about October 2001²⁹⁶ that he intended to leave the Base and he did so in January 2002.²⁹⁷ Many witnesses have made clear that Dr Nankivell was a very good surgeon and that he had a strong commitment to the public health system.²⁹⁸ He explained, for his part, that he left his position at the Base because of the problems identified above, because it seemed that nothing was being done to address his concerns, and because the end result was that it was impossible 'to have any personal life or feel like [he] was doing [his] job to the best of [his ability]'.²⁹⁹

²⁹¹ T2964: he did learn through the District Manager that Dr Stable had received the letter.

²⁹² T2935

²⁹³ T2972

²⁹⁴ T2943

²⁹⁵ T2972-3 The District Manager, Mr Leck, testified: 'I also thought that there weren't sufficient general surgeons on the roster. And there had been various times when we had made requests corporately for additional funding so that we could increase the number of surgeons but there was nothing I could do when we had no money to do it.' T7134

²⁹⁶ T2937; Exhibit 212

²⁹⁷ Exhibit 212, para 4

²⁹⁸ See Baker, Thiele, Anderson, T5973, line 40, T6652, T3253

²⁹⁹ Exhibit 212, page 2

- 3.47 Dr Nankivell gave evidence that he was surprised that Queensland Health did not try to talk him out of his resignation. He was aware (as the evidence before the Commission confirms)³⁰⁰ that there has been some protests from patients and colleagues concerned by the resignation, but notwithstanding that fact, and that he had expressed his concerns at length in writing to Dr Stable, no attempt was made by Queensland Health to talk him out of the resignation.³⁰¹
- 3.48 Dr Strahan gave evidence that broadly supported the proposition that there was a gradual decline at the Base from the time when Barry Marshall was the District Manager and Dr Thiele was the Director of Medical Services.³⁰² He wrote an article in the AMAQ newsletter of September 2000, expressing concerns about the loss of many clinical directors from the Base, and maintaining that 'specialist medical staff morale in the hospital [was] at a low ebb'. In December 2001, he wrote an article in the Bundaberg News-Mail complaining about the state of the Base. He subsequently attended a meeting with the Minister for Health and the District Manager but, whilst it was communicated to him that the article was 'unhelpful', he was not informed that any improvements would be made. He said that he formed the view that administration, locally and centrally, were not interested in responding to criticism.
- 3.49 There were two more witnesses who gave evidence of the period leading up to 2003 in Bundaberg. The first was a Dr Sam Baker and the second was a Dr Chris Jelliffe.
- 3.50 Dr Baker had taken up a training position at the Base for six months in 1998 under Drs Nankivell and Anderson. He observed that the Department was 'extremely well run' and, in the first half of 2001, he returned (having gained his fellowship with the College) to work with Dr Nankivell. In the event, he became the Director of Surgery himself in November 2001, following Dr Nankivell's resignation, and he stayed in that position until he resigned himself in August 2002,³⁰³ ceasing employment in November 2002. Dr Baker gave evidence that he resigned because he 'had grave concerns about the management and their putting the budget in front of patient's safety'³⁰⁴ and, in the course of his testimony, he outlined a number of concerns.
- 3.51 Dr Baker spoke about major problems in the Base's Emergency Department in that it was often staffed, especially at night, by junior doctors who were inadequately supervised.³⁰⁵ He spoke about a concern that clinical decisions were made simply to make cost savings. In September 2001, Dr Baker

³⁰⁰ eg T2960, line 30

³⁰¹ T2960, line 10

³⁰² Exhibit 232

³⁰³ T6398, line 15

³⁰⁴ T6348, line 30

³⁰⁵ T6349, line 10

maintained, the Base's management informed theatre staff that, in an effort to achieve 100% utilisation of the operating theatres, a new roster was to be implemented. Dr Baker could not make sense of the plan. He considered that the real goal should be to treat more cases, not to utilise the theatres for longer periods, and indeed, the latter goal seemed harmful because there is no capacity to 'absorb emergencies'.³⁰⁶ The plan was particularly disturbing because the supporting 'business case' for head office³⁰⁷ contemplated 'realisable savings ...with the employment of fewer nursing staff in theatres', but Dr Baker could not see how the theatre could be utilised for longer – let alone how clinical care could be improved – with fewer nurses. He found it 'bizarre but not unusual with Queensland Health' that such a plan would be developed without consultation with the theatre staff,³⁰⁸ and he came to believe it was simply a cost-saving measure.³⁰⁹

- 3.52 Dr Baker gave another example of decisions that seemed to be informed by cost-savings. He said that he had noticed over his years of employment with Queensland Health³¹⁰ that, when somebody resigned, they were very slow to advertise for replacement staff. He had come to suspect that this was an attempt to save money at the expense of the remaining staff's workload. When he was offered the position of Director of Surgery, it appeared that, with the departure of Dr Nankivell, he would be working a 'one-in-one, 24 hours a day, seven days a week' roster at the Base until a second surgeon could be found, but Dr Baker made clear that he would not do so.
- 3.53 Dr Baker spoke about dangerous understaffing generally, especially anaesthetists, surgeons and nurses.³¹¹ He said, after the re-structuring of the theatre nursing roster, cases would be cancelled for lack of staff and this created a very frustrating work environment.³¹² He spoke about unsafe working hours and he explained that, when a surgeon is on call every second night, he or she might work up to 24 hours without sleep, and never really rest properly because of the roster.³¹³ He noted that management at the Base needed to clearly define the Department of Surgery's operations role but that had not been done.³¹⁴ He considered that the Base needed to develop a plan for the provision of services

³⁰⁶ T6360, line 20

³⁰⁷ Dr Baker gave evidence that Queensland Health required a business plan for those changes which might have a fiscal impact: T6359, line 40

³⁰⁸ T6359-60

³⁰⁹ T6361

³¹⁰ T6367

³¹¹ T6366; T6363

³¹² T6349

³¹³ T6366. Mr Leck acknowledged that there had been fatigue concerns relating to anaesthetists and surgeons. He acknowledged this posed a threat to patient safety but he maintained that, in the absence of adequate funding, there was nothing he could do: T 7186-8

³¹⁴ T6365

in the district and then ascertain the resources needed to sustain it. In fact, in his view there was a similar problem with services at the Base generally.³¹⁵

3.54 It seems that Dr Baker, like others before him, was not timid in voicing his concerns. When he was offered the position as Director of Surgery in November 2001, he made clear in correspondence that his acceptance was conditional on, amongst other things, certain systemic improvements, and, when he did not receive a prompt response, he gave three months notice of his resignation.³¹⁶ The development, following so closely upon Dr Nankivell's resignation and preceding a country Cabinet meeting in Bundaberg, attracted considerable local media coverage. Dr Baker said that he was called to a meeting on 30 November 2001 with Mr Leck and the then Acting Director of Medical Services,³¹⁷ and they discussed a number of ways in which Dr Baker might be supported by a second full-time surgeon. Dr Baker said that, at the conclusion of the meeting, Mr Leck told him that the Director-General of Queensland Health, Dr Robert Stable, was not happy with the 'media embarrassment' precipitated by his resignation, that Queensland Health was a large organisation that the Director-General would protect the organisation, and that 'we don't want to see your career affected'.³¹⁸ Dr Baker said that he asked Mr Leck if his words were a threat, but he received no response.

3.55 Dr Stable attended Bundaberg in early December 2001 at the time of the country Cabinet meeting and he arranged, through Mr Leck, to meet with Dr Baker at about the same time.³¹⁹ Other senior doctors from the Base – including Dr Charles Nankivell, Dr Peter Miach, and Dr Jon Joyner also attended the meeting, and concerns were expressed including about lack of resources and adequate surgical support.³²⁰ Dr Stable provided a folder showing a 7% funding increase to the Base and he considered some solutions to the concerns, including that Dr Anderson be re-employed as a Visiting Medical Officer.³²¹ Dr Baker subsequently withdrew his resignation³²² and worked at the Base for a further 11 months. It seems, however, that some of the problems identified at the time of his appointment as Director of Surgery – particularly the matter of supervision in the Emergency Department and the provision of certain equipment³²³ – remained when he left in November 2002.³²⁴ By a letter dated 13 October 2002 and copied to a number of third parties, Dr Baker wrote to the then Acting Director of

³¹⁵ T6364

³¹⁶ Exhibit 410, SPB 9-11

³¹⁷ T6385

³¹⁸ T6353, line 35, Exhibit 410, para 23

³¹⁹ Exhibit 410, paras 24 and 25

³²⁰ Exhibit 410, para 25, T6394

³²¹ Exhibit 410, para 25: at the earlier meeting with Mr Leck, it was explained that Queensland Health would not contemplate re-engaging Dr Anderson at the Base; T6395, line 10

³²² T6395, line 1

³²³ T6404

³²⁴ T6351, line 40

Medical Services at the Base, giving details of a death that had recently occurred shortly after a patient presented at the Emergency Department, maintaining that the incident was not an isolated one, and referring to concerns expressed by Dr Baker and others 'for the last 9 months' about inadequate supervision. He gave evidence that he received no response to the correspondence, apart from a comment from the Acting Director of Medical Services that the District did not take kindly to Dr Baker going outside management.³²⁵

- 3.56 Dr Baker gave evidence that there were monthly meetings at the Base of a body called the Medical Staff Advisory Committee and many of the issues set out above were raised by him and other staff in the presence of hospital management.³²⁶ He also gave evidence that, in the course of 2002,³²⁷ he and the Director of Anaesthetics were required to complete a quality assurance questionnaire about their respective departments. He understood that the form was to be sent by the Base to head office. The completed questionnaires were tendered in evidence and they included assessments such as 'care is delivered on an ad hoc basis as continuum of care is impossible with current staffing levels'; 'There is little direction from management with regards to strategic direction...They appear more interested in making targets than delivery of quality health care'; and 'Management continues to ignore safe working hours practices and the fact that the anaesthetics department is grossly understaffed'.³²⁸
- 3.57 Despite the scathing nature of those comments, and the high office of the authors, Dr Baker testified that he received no inquiries or requests for amplification from Base management or Queensland Health generally.³²⁹ The minutes for the Medical Advisory Committee Meeting dated 12 September 2002 record that at the previous monthly meeting, Dr Baker – in the presence of the District Manager and others – announced his resignation and 'commented that he did not wish to be told to provide a third world surgical service by the hospital management. He expressed an opinion that the Queensland Health management had no interest in providing a quality surgical service in the Bundaberg Health District'.³³⁰ Dr Baker gave evidence that he was never challenged or approached about those comments. Against this background, Dr Baker left the Base in November 2002 to practise privately in Bundaberg. He continued in that role until February 2003 when he moved to Townsville.³³¹ He gave evidence that he had left because he felt that his concerns about patient safety were being ignored and that Queensland Health management 'had no

³²⁵ Exhibit 410, para 10

³²⁶ T6351-2

³²⁷ The best evidence suggests it was about September 2002: see SPB14 to Exhibit 410

³²⁸ T6363-6366

³²⁹ T6369

³³⁰ Exhibit 415

³³¹ T6348, line 40

interest in providing a quality surgical service in the Bundaberg Health Service District'.³³²

- 3.58 Dr Jelliffe gave evidence that he worked from January 2001 until November 2002 as an anaesthetist at the Base. He had been employed on an area of need basis because, whilst he was a Fellow of the Royal College of Anaesthetists, he had not yet gained a fellowship in the Australian equivalent.³³³ As was normal in those circumstances, he had secured a Medical Practitioner's Visa Subclass 422, which was effectively a temporary working visa which included, as conditions, that he must remain with the same employer doing the same job.³³⁴
- 3.59 He said that, although the Base was working well when he arrived, he noticed, from September 2001, that morale deteriorated and staff began leaving.³³⁵ Whereas, at the outset of his employment, there were four full time anaesthetists at the Base, by March 2002 there were only two.³³⁶ Matters came to a head for him around April 2002 when the other anaesthetist, Martin Carter, took study leave, and he found himself covering for 8 days straight as the sole full time anaesthetist in the Base, responsible for emergencies, obstetrics, intensive care, and elective surgery.³³⁷ He testified that he became so severely fatigued that he had trouble eating, sleeping and making judgments.³³⁸ He took the view that his condition could compromise patient safety and he made a unilateral decision to cancel any elective surgery that might be delayed. He testified that he notified the Director of Medical Services' secretary and, on the same day, he was called to the District Manager's office. He was taken aback when the conversation commenced with the District Manager asking for a reminder as to Dr Jelliffe's visa status. Dr Jelliffe construed this comment as a threat, and certainly it is hard to see how it had any other purpose related to elective surgery lists or the District Manager's relationship with Dr Jelliffe.³³⁹ He said that he was aware of a general perception through the Base that management was not responsive to complaints and, prompted by this particular episode, he began making inquiries soon afterwards, about employment in other hospitals.³⁴⁰
- 3.60 The structure of the Department of Surgery in 2002 was as follows. There were two full time surgeons, and they were supplemented by a small number of Visiting Medical Officers.³⁴¹ The two full time surgeons had each been fellows of

³³² T6392, line 10

³³³ Exhibit 437, paras 2-4; T6648-9

³³⁴ T6649-50

³³⁵ T 437, paras 7-9

³³⁶ T6650-1

³³⁷ T6655-6

³³⁸ T6655-6

³³⁹ As it turned out, the threat, if it was one, could not be carried out because Dr Jelliffe had married his Australian partner, and his Subclass 422 visa had been replaced with a spouse visa.

³⁴⁰ T6653 and T6659

³⁴¹ T6661; T4170

the Royal Australasian College of Surgeons, and one of them would act as the Director of Surgery, which attracted, it would appear additional administrative work, and additional remuneration in the order of \$3,000.00 per annum.³⁴²

- 3.61 As Dr Nankivell made to depart in January 2002, the Base employed a surgeon called Dr Lakshman ('Lucky') Kumar Jayasekera in his place.³⁴³ Dr Jayasekera had obtained his primary medical degrees in Sri Lanka in 1970, and he was admitted as a Fellow of the Royal College of Surgeons in Edinburgh in 1983, practising in surgery since that time. He migrated from Sri Lanka to Australia in 1996, he became an Australian citizen in 1999 and he was admitted as a Fellow of the Royal Australasian College of Surgeons in 2000.³⁴⁴ He gave evidence that, since his arrival in Australia, he had practised in a number of Queensland public hospitals including Redcliffe, Nambour, Caboolture, Bundaberg and Toowoomba.³⁴⁵ Whilst employed at the Base, he was mainly engaged in general surgery.³⁴⁶ He was, in short, a well-qualified surgeon with long and relevant experience.
- 3.62 For most of 2002, then, the two staff surgeons at the Base were Dr Baker and Dr Jayasekera. Dr Anderson had been appointed as a Visiting Medical Officer and assisted in that capacity.³⁴⁷ Dr Jayasekera gave evidence that there was a period, before Dr Baker's departure from the Base (which, of course, occurred in November 2002), when Dr Baker took study leave for about two months.³⁴⁸ He was replaced by a Dr Kotlovsky,³⁴⁹ who had apparently obtained qualifications in Russia as a paediatric surgeon but whose qualifications had not been recognised in Australia.³⁵⁰ Dr Kotlovsky had migrated to Australia in 1991 and, since 1995, he had worked predominantly as a principal house officer or a non-accredited surgical registrar.³⁵¹ Effectively, he was neither a fellow of the Australian college nor a trainee under an Australian surgical programme.³⁵² He had never been employed as a surgeon in Australia and, indeed, the terms of his registration required that he be supervised.³⁵³
- 3.63 There was some controversy as to how Dr Kotlovsky's time at Bundaberg unfolded and the Commission is not in a position to resolve that evidence.

³⁴² T4171

³⁴³ Exhibit 308, para 9

³⁴⁴ Dr Jayasekera had been admitted to the Higher Surgical Training Program in 1998. Whereas a trainee would normally spend four years on the program but, given Dr Jayasekera's experience, the College admitted him to a fellowship after two years.

³⁴⁵ Exhibit 308, paras 1 to 8 and para 12

³⁴⁶ T5972, line 40

³⁴⁷ Exhibit 308, para 10

³⁴⁸ T5974, line 15; T5965, line 50, Exhibit 484

³⁴⁹ Dr Jayasekera said that Anatoli was the doctor's first name, and that he could not recall his second name. In fact we now know – from obtaining Medical Board records – that it was Kotlovsky.

³⁵⁰ Exhibit 484

³⁵¹ Exhibit 484: Dr Kotlovsky became an Australian citizen in 1994

³⁵² T5963, line 35, T5976, line 30

³⁵³ Exhibit 381, para 23; T4140-4141

Suffice to say that, over the course of his stay, there were times when he was not supervised by a surgeon, and this was perhaps to be expected since he was replacing Dr Baker, and Dr Jayasekera was the only other surgeon. It appears there was some consideration given to Dr Kotlovsky taking up a permanent position at the Base but that was not pursued.³⁵⁴

3.64 I mention this period for a number of reasons. In the first place, it seems to have signalled the first time, in recent memory at the Base,³⁵⁵ in which the role of the second staff surgeon was carried out by someone who was not a member of the Australian College. In the second place, the events that transpired should have reinforced something that Dr Nydam already knew, namely that overseas trained doctors who had not satisfied Australian formal standards were a 'mixed bag', or at least required supervision.³⁵⁶ Finally, it brought the Base to a position where it was no longer clear that there would be two Fellows of the College employed in the Department so that it could not retain its training status.³⁵⁷

3.65 I should say that it is not necessary for the purposes of this Inquiry to determine whether each and every factual matter raised above did in fact occur. I was, however, very impressed, by the evidence of Dr Nankivell, Dr Baker and Dr Jelliffe, and by the fact that the doctors spoke, by and large, cogently and consistently, about clinical problems and difficulty in securing managerial solutions. It is clear at the very least that, by late 2002, the relationship between the Base and its medical staff had become a very unhappy one. It is also clear that, by then, the provision of surgery was grossly inadequate and that the hours which surgeons and anaesthetists were being expected to work was putting patients' safety at risk.

Dr Jayant Patel

2002: The appointment of Dr Patel

3.66 With the departure of Dr Baker, Dr Jayasekera took over his responsibilities, and effectively became the Acting Director of Surgery.³⁵⁸ In August 2002, Dr Nydam arranged for the position of Director of Surgery at the Base to be advertised in The Courier-Mail and the Australian.³⁵⁹ The advertisement made clear that the closing date for applications was 16 September 2002, that the successful applicant would report directly to the Director of Medical Services, and that any

³⁵⁴ T4181

³⁵⁵ It will be recalled that, at least since 1995, the two surgeons at the Base had been fellows.

³⁵⁶ T4140, line 55

³⁵⁷ T1839; T2749

³⁵⁸ T5965, line 40

³⁵⁹ See the Base's Director of Surgery file

applicant should have 'qualifications as a general surgeon acceptable for specialist registration by the Medical Board'.³⁶⁰ Dr Jayasekera gave evidence that he was encouraged to apply for the position by Dr Nydam,³⁶¹ by Dr Anderson and by others.³⁶² He had some reluctance about doing so, first because he liked to 'keep a low profile' and avoid politics,³⁶³ and second, because he wanted a job closer to Brisbane where his family lived.³⁶⁴ Dr Jayasekera decided, however, after some encouragement from his friends, to apply. He spent a couple of days completing an application responding to the selection criteria and he made himself available for an interview.³⁶⁵ There were three applicants for the position and Dr Nydam determined that two of the applicants, a Dr Strekozov and Dr Jayasekera, comfortably satisfied all selection criteria.³⁶⁶ Each of them was interviewed by a selection panel consisting of Dr Nydam, the District Manager, namely Mr Leck, and Dr Anderson.

- 3.67 The panel decided to offer the position to Dr Strekozov but it appears that, after some weeks of consideration, Dr Strekozov rejected the offer.³⁶⁷ One might have expected, at that point, that the position would have been offered to Dr Jayasekera. He satisfied all the criteria, he had apparently worked satisfactorily at the Base since January 2002, he had been encouraged by the two clinicians on the selection panel to make application, and the Queensland Health protocol entitled the panel to appoint him without re-advertising.³⁶⁸ That course had the clear support of Dr Anderson but it was not adopted by Dr Nydam³⁶⁹ who, instead, re-advertised the position.³⁷⁰ The new advertisement gave a closing date for applications of 2 December 2002. No applications were received but, again, the position was not offered to Dr Jayasekera, apparently because he had intimated some ambivalence about the position.³⁷¹ Dr Jayasekera gave evidence that, if the position had been offered to him, he would have accepted it, albeit that he would have continued to look for a position closer to his family in Brisbane.³⁷² He gave evidence that he was humiliated by the failure of management to offer him a job.³⁷³ On 28 December 2002, he gave the Base three month's notice of his intention to resign but he gave evidence that this was

³⁶⁰ T4112, line 45; Exhibit 273

³⁶¹ T5970

³⁶² T5981

³⁶³ T5971

³⁶⁴ T5980

³⁶⁵ T5970, line 20

³⁶⁶ T4113; T4115-7

³⁶⁷ T4169; Exhibit 51, para 33

³⁶⁸ T4188; Exhibit 280

³⁶⁹ T4118

³⁷⁰ The Base's Director of Surgery file discloses that the position was advertised in The Courier-Mail on 14 November 2002 and in the Australian on 16 November 2002

³⁷¹ T4116, line 30; T4168. This was the evidence of Dr Nydam. Mr Leck's evidence, effectively, was that Dr Nydam told him Dr Jayasekera was unsuitable and he deferred to that position: T7140

³⁷² Exhibit 381, para 2; T5980, line 40

³⁷³ Exhibit 381, para 3

unrelated to the circumstances surrounding the directorship.³⁷⁴ Whether that be the case or not, it is clear that the overlooking of Dr Jayasekera was the source of tension between senior doctors and management.³⁷⁵ The minutes of the Medical Staff Advisory Committee for 13 February 2003 include a motion endorsed by six senior doctors, including Dr Jayasekera, in terms that:

This meeting:

Accepts the resignation of Dr Jayasekera with great regret and notes that this is one of many resignations leading to the effective demise of General Surgery at the Bundaberg Base Hospital.

Believe that this process has been largely due to the dictatorial, unresponsive, myopic and inflexible approach of management who have little regard for specialists, their needs or aspirations.³⁷⁶

- 3.68 Drs Jayasekera³⁷⁷ and Dr Anderson³⁷⁸ each gave evidence that, at the meeting, Dr Nydam and Mr Leck were asked to explain why Dr Jayasekera was not offered the position of director, but they did not respond. In the event, Dr Jayasekera left the Base on 30 March 2003 to take up a position at the Hervey Bay Hospital.
- 3.69 Dr Nydam said that he did not advertise the Director of Surgery position again, but, instead, he advertised for a 'Senior Medical Officer-Surgery'.³⁷⁹ Dr Nydam testified that the 'usual procedure' is to advertise internally and nationally, before the hospital seeks an Area of Need declaration and looks for overseas candidates through recruitment agencies and foreign press.³⁸⁰ He did not refer, however, to any such national advertisement in the instant case (excluding the Director of Surgery material) and there is none in evidence. The Position Description that was distributed³⁸¹ listed the job as 'Senior Medical Officer-surgery', noted that the 'purpose of position' included 'to provide surgical services for the Bundaberg Health Service District', indicated that the officer 'reports directly to the to the Director of Surgery, Bundaberg Base Hospital' and omitted any reference to 'qualifications as a general surgeon acceptable to the Medical Board for specialist registration'.³⁸² The only qualifications required, according to the Position Description, were that the applicant have 'experience in the provision of surgical services' and could be registered as a medical practitioner in Queensland.³⁸³

³⁷⁴ T5980

³⁷⁵ See the evidence of Dr Anderson at T2779 which suggested that this position may have been an effort to put a positive spin on the situation and see 4122

³⁷⁶ Exhibit 199, attachment 'PEA13'

³⁷⁷ T5966, line 30

³⁷⁸ T2760, line 10

³⁷⁹ T4118, line 45

³⁸⁰ Exhibit 51, paras 7 to 11

³⁸¹ Exhibit 40

³⁸² See Exhibit 40

³⁸³ See Exhibit 40

- 3.70 It is as well to consider, at this juncture, the changes that had been wrought upon the Department of Surgery. In recent history, and much like any significant regional hospital in Australia³⁸⁴, the Director of the Department of Surgery at the Base had always been a fellow of the College. That director worked closely with another staff surgeon who was also a fellow of the College and, indeed, the Department (because it satisfied the College's requirements for offering a training post) had the further benefit of assistance from surgical registrars, as well as Visiting Medical Officers. By early 2003, there had been a diaspora of many good surgeons. Indeed, it was worse. Surgeons had not only left, but many had left in such unhappy circumstances that they were 'wounded soldiers',³⁸⁵ and Queensland Health could not assume that they would necessarily assist the Base, if asked. Now, the situation had reached a point where the Base needed two new surgeons, with, presumably, one of them to act as the Director, but it was not even advertising for a specialist surgeon. It sought merely someone with 'experience in the provision of surgical services' which, as a description, applies to any number of junior and overseas trained doctors.
- 3.71 Dr Nydam's recollection is that he would have sent out a group email to several recruiting agencies in relation to the SMO position.³⁸⁶ Wavelength Consulting Pty Ltd ('Wavelength') was one such agency. One of the Wavelength directors, Dr John Bethell, gave evidence that the company runs a medical recruitment business from offices in Sydney, that it has 14 staff (including its two directors) and that where it arranges doctors for the client employers, it receives a commission equivalent to 15% of the doctor's first year salary package.³⁸⁷ He said that the company does not generally advertise within Australia because those doctors tend to organise themselves.³⁸⁸ He said that more than 95% of the doctors they recruit are from overseas³⁸⁹ and that the majority are junior doctors bound for regional areas.³⁹⁰ He confirmed that, to his knowledge, there was a worldwide shortage of doctors and candidates from traditional source countries – such as the UK, Canada and the US - were becoming fewer.³⁹¹
- 3.72 Dr Bethell gave evidence that the Base had been Wavelength's 'client' in the past, and the Terms and Conditions upon which Wavelength rely were tendered in evidence.³⁹² Clause 6 deals with the 'Responsibilities of Wavelength Consulting' and provides:

³⁸⁴ See the evidence of Dr de Lacy

³⁸⁵ Dr Nankivell commented: '*...one of the problems with Queensland Health is its full of wounded soldiers. Dr Anderson is a wounded soldier, so am I...whenever you talk to people at meetings, everyone's got their bad story to tell. Everybody at some point's been done in by the system or feels that way*': T2957.

³⁸⁶ Exhibit 51, para 14

³⁸⁷ Exhibit 41, para 30 and see T691

³⁸⁸ T684

³⁸⁹ T691

³⁹⁰ T700, line 1

³⁹¹ T700, line 40

³⁹² Exhibit 42

Wavelength Consulting will refer Candidates to the Client on the basis of the information provided to it by the Candidate. Wavelength Consulting will use reasonable endeavours to establish the accuracy of information provided to it by the Candidate, however the Client must make and rely upon its own enquiries with regard to matters the Client considers relevant in determining to engage the Candidate.

Wavelength Consulting will not be liable in any way for any loss or damage to property or for injury or death of a person or for any other lost cost, damage, delay, or loss of profit arising directly or indirectly from any acts or omissions of a Candidate introduced by Wavelength.

- 3.73 Dr Bethell said that he was first approached by Dr Nydam, with a verbal request to refer a surgeon for the SMO position at the Base, on 14 November 2002.³⁹³ He gave evidence that some time soon afterwards, he received the position description for the job, and that his normal practice would be to record the position on Wavelength's database and then speak with known candidates.³⁹⁴
- 3.74 It seems that, almost immediately after Wavelength received notice of the position, Dr Patel approached the company through its website, expressing an interest in working as a general surgeon in Australia.³⁹⁵ Dr Bethell then telephoned Dr Patel in Portland, Oregon, in the United States, and, in the course of that conversation, Dr Patel described himself as a general surgeon with some experience in paediatric, vascular and laparoscopic surgery.³⁹⁶ On 13 December 2002, Dr Bethell sent Dr Patel generic information about Bundaberg and the Base by email, and on the same day, Dr Patel sent his curriculum vitae. Dr Bethell's evidence was that he considered Dr Patel to be very well qualified³⁹⁷ and that he sent the curriculum vitae to Dr Nydam at the Base. He noted, in particular, that Dr Patel maintained that he had held a position as staff surgeon at the Kaiser Permanente Hospital in Oregon for some 12 years, that he had held academic positions, that he'd been the head of a surgery residency programme and that he had been widely published in well-recognised journals.³⁹⁸
- 3.75 Dr Nydam recalls receiving Dr Patel's curriculum vitae, and recalls also speaking by telephone to Dr Patel on two occasions between 13 and 20 December 2004. The curriculum vitae repeated the claims already made by Dr Patel. It stated, amongst other things, that Dr Patel was a US citizen, that he was a fellow of the American College of Surgeons and that he was aged 51. Dr Patel had provided six references to Dr Bethell.³⁹⁹ They were 'open' references in that they were addressed 'to whom it may concern' and they dealt with the authors' experiences in Oregon with Dr Patel over the last ten years, rather than matching him to any

³⁹³ Exhibit 41, para 4, T683

³⁹⁴ Exhibit 41, para 5; T672

³⁹⁵ Exhibit 41, para 6

³⁹⁶ T675, line 20

³⁹⁷ T695, line 30

³⁹⁸ T694

³⁹⁹ T678 and see Exhibit 41, para 12

given position. Dr Bethell gave evidence that it was Wavelength's policy to carry out a minimum of two verbal reference checks.⁴⁰⁰ Dr Bethell testified that he spoke to Dr Patel about this matter and that Dr Patel nominated three referees, being three of the doctors who had provided the open references.⁴⁰¹ Dr Bethell said that he spoke with a Dr Peter Feldman and a Dr Bhawar Singh and that they both spoke very favourably about the applicant.⁴⁰²

- 3.76 It should be said that the references were effusive in their praise for the skills, knowledge and industry of Dr Patel, even by the normal standards of such documents. A Dr Edward A Ariniello, former Chief of Surgery at the Kaiser Permanente Hospital in Portland wrote that Dr Patel had:⁴⁰³

...demonstrated that he is one of the most well read and well informed of all our surgeons (22), and his superior skill was also demonstrated in the operating room. He is entirely selfless in his determination to be available for call, consultations and problems...He will be difficult or impossible to replace. I can recommend Dr Patel without any reservations whatsoever.

- 3.77 A Dr Peter M Feldman, staff surgeon at Kaiser Permanente, wrote that:⁴⁰⁴

I have many good things to say about Dr Patel. He has been a wonderful colleague over the years and has been a very hard worker. He has a well above average interest in his work, and a well above average knowledge of surgery. I would judge Dr Patel to have very high moral standards...

- 3.78 An anaesthetist from the Kaiser Permanente Hospital, Dr Bhawar Singh, wrote that:⁴⁰⁵

[Dr Patel's] balanced judgment, surgical skills and decisive steps, especially in the management of high risk complex procedures, has always been appreciated by anesthesiologists and other members of the OR Team. Dr Patel's professional expertise, passion and energy for quality patient care coupled with ethical and best practice advocacy won him the vote of his colleagues for a Distinguished Physician Award.

- 3.79 There were also tributes from a Dr Wayne F. Gilbert of Portland, a Dr J T Leimert, Chief of the Department of Hematology-Medical Oncology at Kaiser Permanente, and a Dr Leonora Dantas of the Department of Internal Medicine at Kaiser Permanente.⁴⁰⁶

- 3.80 Moreover, the notes of the telephone calls to Drs Feldman and Singh appear to bear out the written references, albeit that, in retrospect, some remarks seem ominous. It is recorded that Dr Feldman explained that he had known Dr Patel for 5 to 6 years and that he was 'extremely knowledgeable, above average

⁴⁰⁰ T696, line 10

⁴⁰¹ T696, line 10

⁴⁰² Exhibit 41, para 12

⁴⁰³ Exhibit 51, attachment KN4

⁴⁰⁴ Exhibit 51, attachment KN4

⁴⁰⁵ Exhibit 51, attachment KN4

⁴⁰⁶ Exhibit 51, attachment KN4

interest in surgery, *sometimes took on complex cases handed to him by colleagues, found it hard to say no*'. He is said to have continued:⁴⁰⁷

Worked together in busy surg. depart. Extremely good natured guy. Handled routine emergencies well. Well regarded by patients – like him. 'Can do' guy. Vast majority of colleagues liked and appreciated him. *He had a falling out with a very few of the surgeons at Kaiser*. Not aware of any problems with theatre staff. Hard working guy wonderful colleague – I missed him when he left, nothing in personal life of concern.⁴⁰⁸

[my underlining]

3.81 Dr Singh is recording as saying:

Very good, very skilful surgeon. Deliberate in decision making surgery. Asked advice appropriately. Would ask for opinions if necessary. Good general and paediatric surgical skills – some thoracic. Worked together 1- 2 times a week. Dealt with emergencies – controlled way. Actively involved in training junior surgical staff. To my knowledge patients held him in high esteem. Gets on with doctors. Generally got along well with nursing staff – a perfectionist so got upset if things not ready for him eg equipment. However was professional in manner. Very conscientious and hardworking. Nothing of concern in his personal life. Suitable for general surg job.

3.82 Dr Bethell made the telephone calls to the referees himself and he gave evidence that nothing in those conversations caused him any concern.⁴⁰⁹

3.83 Dr Bethell says that he may have spoken to Dr Nydam about the outcomes of those calls in accordance with his general practice but, certainly, it was Dr Nydam's evidence that he received the notes of those checks by facsimile on Friday 20 December 2002.⁴¹⁰ He said that he 'took the curriculum vitae at face value' and considered it to be comprehensive.⁴¹¹ He had received a number of applications from overseas trained doctors, but he was impressed by the one from Dr Patel, and another application received from a Dr James Gaffield, each surgeons who had been working in America, because they had 'first world experience'.⁴¹² Dr Nydam finally settled upon Dr Patel because he had considerable experience in general surgery, whereas Dr Gaffield had developed a special interest in plastic surgery.⁴¹³

3.84 By an email dated Friday 20 December 2002, Dr Nydam wrote to Dr Bethell that he had the authority of the District Manager to offer a one year contract to Dr Patel and that a letter of offer would be drafted on the Monday.⁴¹⁴ By a formal letter from the Base's Human Resources Section and dated 24 December 2002,⁴¹⁵ Dr Patel was offered the position of Senior Medical Officer, Department

⁴⁰⁷ Exhibit 51, attachment KN4

⁴⁰⁸ See Exhibit 51, attachment KN4

⁴⁰⁹ T680

⁴¹⁰ Exhibit 51, para 17

⁴¹¹ Exhibit 51, attachment KN4

⁴¹² Exhibit 51, para 21

⁴¹³ T4126, line 50

⁴¹⁴ Exhibit 43

⁴¹⁵ Exhibit 51, attachment KN9

of Surgery for twelve months, subject to Medical Board and Immigration Department approval, and by email dated 28 December 2002, that offer was accepted. On 3 January 2003, Wavelength informed Dr Nydam in correspondence that Dr Patel could commence his position on 1 April 2003.⁴¹⁶

- 3.85 Wavelength's Terms and Conditions provided that, by way of remuneration, it would receive a sum equivalent to 15% of the successful candidate's salary. In this case, that meant that Wavelength received a sum of \$15,006.60 from Queensland Health.⁴¹⁷
- 3.86 There were a number of matters that might well have caused Wavelength concern about Dr Patel's application. In the first place, the curriculum vitae received by the company in December 2002 stated that Dr Patel's last employment (being with the Kaiser Permanente Hospital) had ceased in September 2001, which meant that he had been unemployed for some 15 months.⁴¹⁸ In the second place, the references were somewhat unsatisfactory in that the most recent was dated June 2001 and they did not explain how Dr Patel came to be leaving Kaiser Permanente.⁴¹⁹ In the third place, when Dr Patel had cause to send a further curriculum vitae in January 2003, it contained an amendment under the title 'positions held' so that Dr Patel was said to have continued in employment with Kaiser Permanente until September 2002.⁴²⁰ In the fourth place, it might have been considered strange that a doctor should choose to emigrate from the United States to Australia when practitioners in the former country are paid so handsomely.⁴²¹
- 3.87 Dr Bethell gave evidence that he raised the first point with Dr Patel. He was told by way of response that, even though he was only 51, Dr Patel had decided to retire and did so in September 2001, before subsequently developing an interest in working overseas.⁴²² Dr Bethell said that the prospect of a doctor retiring at the age of 50 did not seem implausible because American doctors tend to make significant amounts during their careers, under some pressure, and retire at a young age.⁴²³ The discrepancies between the two curricula were not noticed by Dr Bethell (and, presumably, they would have had a big impact, having regard to Dr Patel's earlier explanation) and the causes for scepticism with Americans emigrating did not strike him.

⁴¹⁶ Exhibit 51, para 23

⁴¹⁷ Exhibit 51, KN9, Exhibit 41, para 30: note that Wavelength did not receive any additional money if the contract was extended.

⁴¹⁸ T679, line 1

⁴¹⁹ Exhibit 51, attachment KN4

⁴²⁰ Compare Exhibit 51, KN3 with Exhibit 46

⁴²¹ T679

⁴²² T679, line 20; Dr Bethell specifically raised this issue in an email to Dr Nydam – Exhibit 43 – but it was not pursued.

⁴²³ T679

- 3.88 Once the position had been accepted, there were, of course, a number of steps that needed to be taken so that Dr Patel could practise in Queensland. The first, of course, was that the Minister's delegate needed to determine that the position was situated within an area of need pursuant to s135(2) of the *Medical Practitioner's Registration Act 2001*. The second was that the Medical Board needed to grant registration and the third was that Dr Patel needed to secure a temporary working visa from the Department of Immigration and Ethnic Affairs. It was the practice of Wavelength to co-ordinate the various applications and, by the letter of 3 January 2003, the company indicated that it would do so in Dr Patel's case.⁴²⁴ Under cover of that correspondence, it provided the Base with the relevant employer form for each body, and asked that Dr Nydam sign and return them.
- 3.89 Dr Bethell explained that the task of arranging the various applications was carried out by 'a staff member who looked after the administrative paperwork'.⁴²⁵
- 3.90 It was necessary for Dr Patel to complete separate applications for registration to the Medical Board and to the Department of Immigration. On 6 January 2003, Dr Patel provided a completed application for registration (form 2A) to Wavelength, together with supporting material, as required by the Medical Board's guidelines. That material included the prescribed fee, certified copies of all medical degrees, a detailed curriculum vitae, and a Verification of Licensure.⁴²⁶ It seems that the Board also received Queensland Health's position description and a 'controlled substance registration certificate'.⁴²⁷ The form required that applicants set out their personal details, qualifications, experience, and the contact details of two referees.⁴²⁸ At about the same time, Dr Nydam completed the Hospital's application for Dr Patel to be registered (form 1A) and returned that to Wavelength. By a letter dated 17 January 2003, Wavelength forwarded those documents to the Medical Board, together with a letter from the Base formally seeking registration and the January version of the curriculum vitae.⁴²⁹ The letter sought that Dr Patel's application for an area of need position as a Senior Medical Officer be considered at the Board's next meeting.⁴³⁰ The correspondence noted that an Area of Need declaration and a Certificate of Good Standing (which, in Oregon, is known as the Verification of Licensure) would follow.⁴³¹

⁴²⁴ T697; Exhibit 51 KN7

⁴²⁵ T697, line 2

⁴²⁶ Exhibit 51, attachment KN4

⁴²⁷ Exhibit 41, paras 16 and 17

⁴²⁸ Exhibit 24, MDG14

⁴²⁹ Exhibit 24, MDG13

⁴³⁰ Exhibit 24, MDG17

⁴³¹ Exhibit 24, MDG12

3.91 Dr Patel's application for registration stated that he had been employed by Kaiser Permanente until September 2002. It relevantly included the following questions:⁴³²

- Have you been registered under the Medical Practitioner's Registration Act 2001 or the Medical Act 1939 (repealed) or have you been registered under a corresponding law applying, or that applied in another State, or Territory, or a foreign country, and the registration was affected either by an undertaking, the imposition of a condition, suspension or cancellation in any other way.
- Has your registration as a health practitioner ever been cancelled or suspended or is your registration currently cancelled or suspended as a result of disciplinary action in any State or Territory or in another county.

3.92 To each of those questions Dr Patel answered 'no'.

3.93 Dr Patel faxed the Verification of Licensure to Wavelength on 19 January 2003, and then mailed the original. For its part, Wavelength sent a facsimile of the Verification of Licensure to the Board on 21 January 2003 and mailed the original on 29 January 2003.⁴³³ The document carried the words 'Limitations none; Extensions none' but it also included a sentence which read: 'Standing: Public Order on File See Attached'. The attachment was not included in either version of the document provided by Dr Patel, and Wavelength did not notice that omission.⁴³⁴ It was Dr Bethell's evidence that, in his experience with certificates of good standing, or their equivalent, comparable jurisdictions tend to either issue them, or they do not: he had not, it seems, come across qualified certificates.⁴³⁵

3.94 At about the same time, Dr Nydam completed the form 1 required of the Base, and Dr Patel completed the form 2 required of doctors, together with the formal request, for the Area of Need application.⁴³⁶ The application included the January version of Dr Patel's curriculum vitae, indicated that the position for which he was sought was Senior Medical Officer, Surgery at the Bundaberg Base Hospital, and specified that the requested period was 1 April 2003 to 1 April 2004. The completed forms were provided to Wavelength and, on 8 January 2003, Wavelength sent them to Dr Michael Catchpole, then one of the Ministerial delegates (all of whom were employed within the Workforce Reform Branch of Queensland Health) and the Principal Medical Advisor.⁴³⁷ It was approved on 17 January 2003 and apparently faxed to Wavelength's offices in Sydney, from where it was forwarded to the Medical Board.

⁴³² Exhibit 24, MDG14

⁴³³ Exhibit 24, paras 29 and 30; Exhibit 24, MDG22 and MDG23

⁴³⁴ Exhibit 41, para 17; T705

⁴³⁵ T697-8; T705, line 10-30. There was evidence, however, that certificates issued in the United States commonly take the form of a 'status report' requiring careful scrutiny: Exhibit 24, MDG3.

⁴³⁶ Exhibit 24, MDG16, MDG17, MDG21

⁴³⁷ Exhibit 58, page 8

3.95 When the application came to the Medical Board, it was assessed by a Registration Officer called Ainslie McMullen who was, according to the Deputy-Registrar of the Board, a very experienced and methodical member of the staff.⁴³⁸ By a statement provided to the Commission, she has explained that she was employed as an administration officer and she would receive, collate and check applications.⁴³⁹ She would consider the area of need applications, in particular, with the aid of a checklist developed for that purpose.⁴⁴⁰ If the application was found to include all appropriate documents, she would forward it to the Registration Advisory Committee meeting for consideration, after which it was provided to the Medical Board (which, of course, also met twice a month), for confirmation of the decision.⁴⁴¹

3.96 Ms McMullen has no specific recollection of considering Dr Patel's application. Unfortunately, again, it seems that the significance of the note about the attachment was not seen⁴⁴² or not understood. Ms McMullen has indicated that it was her experience that certificates of good standing were either granted or they were not (as Mr Demy-Geroe testified) and that she cannot recall observing anything untoward about the Verification of Licensure. She has explained that she was fortified in her 'view' by Dr Patel's answers to the questions concerning his disciplinary history.⁴⁴³ Alongside the field in the registration checklist of 'under investigation or conditions/undertakings in place' Ms McMullen circled 'no'⁴⁴⁴ and it seems that she simply overlooked the reference on the Verification to the attached 'public order'. The application was sent to the Registration Advisory Committee meeting, which appears to have met on 3 February 2003. It seems that the members agreed that he ought not be 'represented as a specialist'.⁴⁴⁵ A report from that meeting records that

Dr Patel is seeking special purpose registration under section 135 to fill an area of need as a SMO in surgery at Bundaberg Base Hospital from 1 April 2003 to 31 March 2004. Queensland Health is in support.

Recommended that Dr Patel be approved special purpose registration under section 135 to fill an area of need as a SMO in surgery at Bundaberg Base Hospital from 1 April 2003 to 31 March 2004, subject to completion of registration requirements.⁴⁴⁶

3.97 The minutes for the Board of 11 February 2003 record that it made an order in precisely the terms of the recommendation.⁴⁴⁷

⁴³⁸ Exhibit 24, para 32; T439

⁴³⁹ Exhibit 421, para 4

⁴⁴⁰ Exhibit 421, para 8

⁴⁴¹ Exhibit 24, paras 31, 34-5, 36-7; Exhibit 421

⁴⁴² Ms McMullen's statement sheds little light on the issue, but having regard to the checklist answers, the better view is that Ms McMullen simply failed to notice the lack of an attachment: see also Exhibit 24, MDG 4, para 5.3

⁴⁴³ Exhibit 421, paras 13-16

⁴⁴⁴ Exhibit 24, MDG24

⁴⁴⁵ Exhibit 24, para 36

⁴⁴⁶ Exhibit 24, MDG25

⁴⁴⁷ Exhibit 24, MDG26

- 3.98 On 12 February 2003, the Medical Board wrote to Dr Patel and indicated relevantly that:⁴⁴⁸

You have been granted special purpose registration as a Medical Practitioner in Queensland pursuant to section 135 of the Medical Practitioner's Registration Act 2001 to enable you to practise the profession in an area of need decided by Queensland Health for the period 1 April 2003 to 31 March 2004, subject to completion of registration requirements. These are as follows

Interview with a Board member

...Registration is contingent upon you practising as a Senior Medical Officer in surgery at Bundaberg Base Hospital or any other public hospital authorised by the Medical Superintendent during the period of your registration. You should also note that the above approval is for a specific purpose, to be undertaken in the defined period, after which your resignation will cease. Any further period will require a fresh application for registration and further consideration by the Medical Board.'

- 3.99 It follows from what I have said that, apart from checking the documents provided to it in the way I have described, the Medical Board made no assessment of Dr Patel's skill or competence to enable it to safely conclude, as it was required to do by s135(2), that he had a medical qualification and experience suitable for practising in the position at the Base. That occurred in circumstances where the Board had not even ascertained whether some other body (Wavelength Consulting Pty Ltd or Queensland Health) had approached Dr Patel's referees. I shall say something more about this and its consequences later in this report.

- 3.100 Wavelength then sent the Area of Need determination, and the Medical Board approval for registration, to the Department of Immigration, together with a Form 55 by which the Base made application to sponsor Dr Patel for a temporary working visa, subclass 422 (known as a 'medical practitioner's visa').⁴⁴⁹ Dr Patel was required to lodge his own application for the visa from the United States.

- 3.101 The Form 55, executed by Dr Nydam, indicated that the Base sought to employ Dr Patel as a Senior Medical Officer full time for one year. Where the form asked if any efforts were made to obtain suitable staff from the Australian workforce, the reply made was:⁴⁵⁰

'Position has been advertised a number of times over the past 6 months. There have been no Australian applicants. This doctor is considered to be suitable with his overseas qualifications.'

- 3.102 Dr Nydam was asked to explain this statement. He maintained that his recollection was that the position of Senior Medical Officer - Surgery at the Base had been advertised in the newspaper. He conceded, however, that having

⁴⁴⁸ Exhibit 24, attachment MDG27

⁴⁴⁹ Exhibit 44, para 17

⁴⁵⁰ Exhibit 44

considered the relevant files, there was no record of such an advertisement.⁴⁵¹ There was only a record of advertisements seeking candidates for the position of Director of Surgery, and even then, of course, it was not true to say that there had been 'no Australian applicants'.

3.103 Dr Nydam gave evidence that he had approached three recruitment agencies about the Senior Medical Officer – Surgery position and that he understood that the agencies would 'advertise this position as part of the recruitment process'. He did not suggest that this advertising would happen within Australia, nor did he advance any basis for the understanding, and Dr Bethell gave evidence that at least his company never submitted advertisements to the public press, apparently because Australian doctors tend to organise themselves locally rather than going through an agency.⁴⁵²

3.104 In the event, the temporary working visa was granted and Dr Patel arrived in Australia on 31 March 2003. He attended the Medical Board's offices in Brisbane, where he had a brief interview with an officer but, as Mr Demy-Geroe of the Board frankly conceded, that interview is more of a 'meet and greet' session, than any attempt to test the practitioner.⁴⁵³ A certificate of registration under s135 was issued shortly afterwards and it provided relevantly that the 'special purpose activity' was 'to practise as a Senior Medical Officer in surgery at Bundaberg Base Hospital or any other public hospital authorised by the Medical Superintendent on a temporary basis'.⁴⁵⁴ Dr Patel then proceeded to Bundaberg and took up the position in the Department of Surgery. On the same day, 1 April 2003, the Board sent Dr Patel and the 'Medical Superintendent' at the Base, a letter which read relevantly:

You have been granted special purpose registration as a Medical Practitioner in Queensland pursuant to section 135 of the Medical Practitioners Registration Act 2001 effective from 1 April 2003 until 31 March 2004. ...Special purpose registration enables you to practise as a Senior Medical Officer in surgery at Bundaberg Base Hospital or any other public hospital authorised by the Medical Superintendent on a temporary basis. It is advised that you are not registered as a specialist. Any variation to your practice would require further approval by the Board.⁴⁵⁵

3.105 It will be remembered that, on 28 December 2002, the remaining surgeon at the Base, namely Dr Jayasekera, resigned and, in those circumstances, it became necessary to employ a second surgeon. The Base offered that position to Dr Gaffield who, of course, had applied for the position awarded to Dr Patel. An agreement was reached with Dr Gaffield on similar terms to those reached with

⁴⁵¹ See the statement of Dr Nydam dated 19 October 2005, paras 13 and 14

⁴⁵² T684. The assertion by Dr Nydam in January 2003 that he had advertised a number of times over the last six months, moreover, is difficult to reconcile with the evidence that he only approached Wavelength Consulting, and presumably the other agencies, in November 2002.

⁴⁵³ Exhibit 225, para 19

⁴⁵⁴ Exhibit 24, MDG31

⁴⁵⁵ Exhibit 469

Dr Patel, except that Dr Gaffield was not to commence employment until 28 April 2003.

Defects revealed in the process of appointment

- 3.106 In all these facts concerning the appointment of Dr Patel, there are a number of serious defects revealed. I will consider the role of the various 'gatekeepers' in turn.

Wavelength

- 3.107 The process adopted by Wavelength for checking references seems seriously flawed, particularly when, as seems to be the case, they did not expect that the employer would carry out any reference checks of its own. In the first place, one would expect that recourse to referees would not be limited to those selected by the applicant and that, as a bare minimum, the doctor's last known supervisor might be contacted. In the second place, care might have been taken to ensure that referees provided current references, preferably in the context of the particular position for which the practitioner was applying.
- 3.108 If Wavelength had made enquiries in Oregon independent of people to whom it was directed by Dr Patel, it seems entirely possible that it would have been apprised of many of the shortcomings which became apparent in Bundaberg. This seems all the more likely given Dr Feldman's comments that Dr Patel 'sometimes took on complex cases handed to him by colleagues, found it hard to say no', and that he had a 'falling out' with 'a very few surgeons at Kaiser Permanente'.
- 3.109 When Wavelength was subsequently preparing the various applications for Dr Patel to work in Queensland, it could have done so with considerably more diligence. If that had occurred, it would have noticed that the curriculum vitae provided in January 2003 was inconsistent with the one provided in December 2002 (where it referred to continuing employment at Kaiser Permanente until September 2002 in place of September 2001), with the references suggesting that Dr Patel was preparing to depart in June 2001, and with the specific instructions given previously that Dr Patel did, in fact, retire in September 2001. Wavelength would also have noticed, if it conducted a thorough check that, although Dr Patel had provided two copies of the Verification of Licensure, they each omitted the attachment. If it had secured the attachment, it seems it would have learnt the information that became apparent when an internet search of the

Oregon Board of Medical Examiners site was conducted in early 2005.⁴⁵⁶ A search of the name Jayant Mukundray Patel shows, alongside the field of 'standing', the words 'public order on file'. Under the heading 'Board actions taken between April 1, 2000 and December 1, 2000', there appears the following entry:

PATEL, Jayant M, MD15991, Portland, Orr: A stipulated order was entered on September 12, 2000. The order restricted licensee from performing surgeries involving the pancreas, liver resections, and ileoanal pouch constructions.

3.110 On the same page, the term 'stipulated order' is defined as:

An agreement between the Board and a licensee which concludes a disciplinary investigation. The licensee admits to a violation of the Medical Practice Act, and the order imposes actions the Board and licensee agree are appropriate. Stipulated orders are disciplinary actions.

3.111 If further enquiries had been made, the full terms of the stipulated order would have been revealed. They included that:

- (a) On 25 June, Kaiser Permanente filed a report with the National Practitioners Data Bank in the United States concerning Dr Patel;
- (b) Following extensive peer review of 79 patient charts, Kaiser restricted Dr Patel's practice to exclude surgery involving the pancreas, any resections of the liver, and construction of the ileoanal pouch;
- (c) Kaiser restricted Dr Patel's practice further by requiring that he obtain second opinions preoperatively before undertaking all complicated surgical cases (which was defined to include 'abdominoperineal recessions, oesophageal surgeries, gastric surgeries and soft tissue malignancies');⁴⁵⁷
- (d) The Board of Examiners conducted their own investigation and, before it, Dr Patel acknowledged that he had made surgical errors;
- (e) The Board's investigation of four particular patients showed violations of the Oregon legislation and, in particular, revealed wound dehiscence, a colostomy that was performed 'backwards', three deaths soon after surgery – one after an operation known as a 'Whipple's' procedure, and significant bleeding intraoperatively;
- (f) Dr Patel had agreed to sign a Stipulated Order which incorporated the restrictions imposed by Kaiser Permanente.⁴⁵⁸

3.112 The order was amended for technical reasons on 1 November 2000.

3.113 It can be expected that doctors will work between different jurisdictions and that this feature will be even more pronounced amongst incompetent doctors. In

⁴⁵⁶ See Exhibit 226, para 76 and GF21, and see Exhibit 24, para 4

⁴⁵⁷ T4306

⁴⁵⁸ Exhibit 24, MDG9

those circumstances, Wavelength might have insisted that doctors provide Certificates of Good Standing from each jurisdiction in which they have practised. If Wavelength had adopted that course, it may have discovered information suggesting that Dr Patel had been licensed to practise medicine in the State of New York in May 1980, and that the Board for Professional Medical Conduct ordered that he be stricken from the 'roster of physicians' in that State on 5 August 2001 after he agreed to surrender his license. The company would have learnt that a Statement of Charges, dated 5 April 2001, precipitated that development⁴⁵⁹ and that it read as follows:

Jayant M Patel ...was authorised to practise medicine in New York state on May 23, 1980 ...

Factual Allegations

A. On or about September 7, 2000, the Board of Medical Examiners, State of Oregon ('hereinafter 'Oregon Board'), by a Stipulated Order (hereinafter 'Oregon Order'), limited Respondent's license to exclude surgeries involving the pancreas, any resection of the liver, and any constructions of ileoanal pouches, and required Respondent to obtain a second opinion on complicated surgical cases, based on gross negligence, and negligence on more than one occasion.

B The conduct resulting in the Oregon Board disciplinary action against Respondent would constitute misconduct under the laws of New York state...

Specification

Respondent violated New York...Law...by having been found guilty of improper professional practise or professional misconduct by a duly authorised professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state...

3.114 An formal order of 5 August 2001 read relevantly as follows:

Upon the proposed agreement of Jayant M. Patel MD to Surrender his licence as a physician in the State of New York, which proposed agreement is made a part hereof, it is AGREED to and ORDERED, that the proposed agreement and the provisions thereof are hereby adopted; it is further ORDERED, that the name of the Respondent be stricken from the roster of physicians in the State of New York...⁴⁶⁰

3.115 Inquiries may also have revealed that it appears Dr Patel was disciplined in 1984 by the New York State Board for Professional Medical Conduct 'for entering patient histories and physicals without examining patients, failing to maintain patient records, and harassing a patient for cooperating with the New York board's investigation', receiving, amongst other things, probation and a fine.⁴⁶¹ Although the exact details of those findings are not known to the Commission, it is clear that the Statement of Charges issued by the State Board set out five cases in which Dr Patel set out a history, a physical examination, progress note

⁴⁵⁹ The notations on the New York website make clear that the license has been surrendered pursuant to disciplinary action: see Exhibit 24, MDG 3, para 4.5, and MDG9

⁴⁶⁰ See the statement of Exhibit 225, GF21, and see Exhibit 24, MDG3, para 4.4

⁴⁶¹ See *Regulatory Action Against Jayant M. Patel M. D.*, Stephen Barrett, <http://www.casewatch.org/foreign/patel/patel.html>;

and or an admission order 'without personally examining the patient'; that he had practised the profession of medicine with negligence and incompetence on more than one occasion, and that he had, amongst other things, neglected a patient in need, and 'failed to maintain a record for each patient which accurately reflected the evaluation and treatment of the patient...'.⁴⁶² Inquiries may also have revealed that the allegations led to Dr Patel's dismissal from the University of Rochester's surgical residency program.⁴⁶³

- 3.116 The orders set out above (at least those for the years 2000 and 2001) are freely and immediately available on the internet. Certainly, at the time of writing this report, it was possible to obtain them simply by using the "Google" search engine for the words 'Jayant Patel'. Moreover, several witnesses gave evidence that this was also the case in early 2004 and 2005.⁴⁶⁴ One nurse, Ms Michelle Hunter, gave evidence that, by the middle of 2004, she had misgivings about Dr Patel and she did a "Google" search which revealed the restrictions in Oregon. She said that she mentioned the results to other nurses but not more widely because she understood that the job of assessing Dr Patel's competence belonged to 'whoever registers him, and management'.⁴⁶⁵
- 3.117 Whilst there may be a number of practitioners bearing the name of Jayant Patel, any serious enquiry would have noted that the applicant for the Bundaberg post, and the practitioner subject to the charges, were one and the same, having regard to the year of birth, 1951, the middle name 'Mukundray', and the address of 3739 NW Bluegrass Pl, Portland, Oregon, 97229.
- 3.118 It was Queensland Health, and in this case the Base, and the Medical Board, not Wavelength, which had assumed responsibility for patient safety in public hospitals in Queensland. They could not escape that responsibility by accepting, without further inquiry, the reliability of the information passed on to them by Wavelength, a body which stood to gain from Dr Patel's appointment, particularly in the light of the concerning matters to which I have referred.

Queensland Health and the Base

- 3.119 As regards the Base, there were more serious failings, particularly having regard to its knowledge of the position for which Dr Patel was destined.
- 3.120 Wavelength, the Medical Board, and the Department of Immigration might have expected, if they turned their minds to such things, that as a Senior Medical Officer – Surgery, Dr Patel was to be supervised by a doctor of equal or superior

⁴⁶² http://www.oregonlive.com/pdfs/oregonian/malpractice/new_york_medical_board_records.pdf

⁴⁶³ See 'Patel's Disturbing Record at Kaiser';

http://www.oregonlive.com/oregonian/malpractice/index.ssf?/base/front_page/1131093370226790.xml&coll=7

⁴⁶⁴ See the evidence of Dr Keating

⁴⁶⁵ T2041, line 40

standing. They might have assumed that the supervisor, i.e., the Director of Surgery, would have been a fellow of the Royal Australasian College of Surgeons, as had certainly been the case at the Base at least since 1994.⁴⁶⁶ Dr Nydam, however, well knew that such an assumption would be incorrect. Dr Baker had left the Base at the end of November 2002. Dr Jayasekera acted as the Director of Surgery from that time, but he announced his resignation on 28 December 2002, and he had departed on 30 March 2003, just before Dr Patel arrived. Indeed, given that Dr Gaffield was not due to commence employment until 28 April 2003, there would be a period of almost one month when Dr Patel did not even have the potential for conferring with a second staff surgeon.

- 3.121 The position descriptions provided for Dr Patel and Dr Gaffield each stipulated that that they would report to the 'Director of Surgery' but, absent some Visiting Medical Officer acting in the role (and that was not suggested by Dr Nydam), that could not be true. Moreover, Dr Gaffield was clearly considered a less appropriate candidate than Dr Patel and, as Dr Nydam eventually conceded under cross examination, he had never contemplated appointing Dr Gaffield as the Director of Surgery, so that it could not have been expected that Dr Patel would be reporting to him. In short, the Base knew, well before Dr Patel's registration or employment, that he would not be reporting to anyone. Dr Nydam effectively conceded that this was the case.⁴⁶⁷
- 3.122 Dr Strahan gave evidence that, on 1 April 2003, the day Dr Patel arrived at the Base, the latter was introduced to him as the 'Director of Surgery'. By an email dated 9 April 2003, Dr Nydam wrote to his Human Resources staff, 'Are we paying Jay Patel a Director's allowance? If not, could we do so please as he is the Director of Surgery'. Dr Nydam maintained in his evidence that, upon Dr Patel's arrival, he was only appointed the 'acting' Director of Surgery but this is difficult to reconcile with the email. More importantly, if that was his role, one might have reasonably expected that there would be plans afoot to secure a substantive Director of Surgery, but that was not the case. In fact, Dr Nydam conceded that there had been no attempt to advertise for a Director of Surgery since the closing date of 2 December 2002, and that no plans to do so were ever made after Dr Patel commenced employment. Indeed, the situation was worse. In July 2003, Dr Geoff de Lacy, a general surgeon, a fellow of the College and a former Director of Surgery of the Queen Elizabeth II Hospital, moved to Bundaberg and approached management at the Base about working there as a Visiting Medical Officer. He might have been considered for the position of Director of Surgery but his approach was rebuffed altogether. Dr Nydam gave evidence that it would have been 'fantastic' to have Dr de Lacy at the Base as a Visiting Medical Officer Director of Surgery but that did not occur.

⁴⁶⁶ See the evidence of Dr Anderson and Dr Nankivell

⁴⁶⁷ T4129

- 3.123 In the end, Dr Nydam conceded that he had intended, at least from December 2002, to appoint Dr Patel to the Director's position. He said that this was on the basis that he understood he could take that step without convening an Appointments Committee because the appointment was temporary (albeit, indefinite).⁴⁶⁸ He maintained that he hoped, in time, that Dr Patel would have applied for a fellowship in the Australian College and that, at that point, he could be formally appointed as the Director of Surgery. Effectively, from about December 2002, even though Dr Patel was only employed on a twelve month contract, there was no intent to look for any other permanent Director of Surgery whilst he was there.⁴⁶⁹
- 3.124 It is difficult to avoid the inference that this informed his approach to Dr Jayasekera. Although the latter was a very well qualified surgeon and a fellow of the Australian College, the Base had been able to negotiate a relatively modest wage for him. When Dr Baker's position became vacant, it became more fiscally attractive to keep Dr Jayasekera at his then remuneration, and bring in an outside surgeon to fill the other spot. Indeed, that became more attractive still when the second surgeon could be an overseas trained doctor, remunerated on the lower pay scale.
- 3.125 Whether that speculation be correct or not, it is clear that Dr Patel had been 'earmarked' for the position of the Director of Surgery⁴⁷⁰ so that, upon taking up his place, he could not be reporting to that person. That had two very important consequences. First, the Base had provided the Position Description for 'Senior Medical Officer – Surgery' to the Medical Board⁴⁷¹ with the effect that, in considering Dr Patel's suitability, they were entitled to believe that he would be working in a supervised capacity, when in fact that was not the case. Secondly, and more immediately, it meant that the Base should have insisted on very rigorous inquiries in the appointment process. The Base knew that Dr Patel would be working for twelve months in circumstances where he:
- a) was in regional hospital setting;
 - b) was situated some 385 kilometres from the nearest tertiary hospital;
 - c) was responsible for some 80,000 potential patients;
 - d) was conducting emergency and elective surgery;
 - e) had, as his closest peer a more junior, overseas trained surgeon;

⁴⁶⁸ T4133, line 40

⁴⁶⁹ T4129

⁴⁷⁰ See T4129

⁴⁷¹ See Exhibit 421, para 12(h)

- f) was not involved, in any way, with the Royal Australasian College of Surgeons, or the policies set out in the Area of Need Assessment of Specialists guidelines;
- g) as a semi-retired Indian-educated, , American-trained doctor, could be expected to encounter significant cultural challenges;
- h) as a semi-retired Indian-educated doctor he would remain unsupervised;
- i) he was unlikely to be the subject of review by a credentialing and privileging committee in the foreseeable future.

3.126 The failure of Dr Nydam to alert the Medical Board to the absence of any Director of Surgery at any time before 12 February 2003 (when registration was to be approved) was thoroughly unacceptable. The failure of the Base and Queensland Health to inquire into Dr Patel's history was negligent.

3.127 Queensland Health should have been especially vigilant, at the very least, to see that Wavelength's recourse to referees was not limited to those selected by the applicant, and that Dr Patel's last known supervisor was contacted. Indeed, it hardly seems appropriate that this task should be delegated wholly to the recruiting agency - Dr Nydam did not suggest that he did more than peruse the notes of the calls⁴⁷² - when the agency has a commercial interest in 'placing' the candidate, the agency may have protected itself to some extent with terms and conditions which include a disclaimer (as was the case here),⁴⁷³ and the recruiting officer may lack the medical, or local, knowledge to ask appropriate questions or explore answers. The Vice-President of the Royal Australasian College of Surgeons gave evidence that poorly performing practitioners may have 'different outcomes' if they are appropriately managed⁴⁷⁴ and it is self evident that a doctor may have had talents which flourish in one environment but not another.⁴⁷⁵ Against that background, the questioner really needed to be able to explain the conditions at Bundaberg (in terms of intensive care support, proximity to a tertiary hospital, closeness of supervision, makeup of work, etc.) if the suitability of the candidate was to be assessed meaningfully.

3.128 The evidence discloses a general lack of vigour on the part of Queensland Health in attempting to attract or retain a local surgeon at the Base. The interest from Dr Jayasekera in the position of Director was not reciprocated; the position of Senior Medical Officer - Surgery was not advertised locally; the Department of Immigration was told that the position had been advertised a number of times over the past six months without attracting Australian applicants when that was simply untrue. As to the last point, it might be said for the Base that it was

⁴⁷² Exhibit 51, para 17

⁴⁷³ T676, Exhibit 42, clause 6

⁴⁷⁴ T4327-8, T4337

⁴⁷⁵ See the evidence of Dr Woodruff.

inclined to treat the results of the Director of Surgery advertisements as indicative of the likely results for the Senior Medical Officer position. The difficulty with that approach is that this is not what the Department of Immigration was told and that, in any case, Dr Jayasekera made plain that there were reasons why a surgeon might be attracted to the Senior Medical Officer position but not that of Director of Surgery.⁴⁷⁶

- 3.129 Dr Nydam has indicated that he spent 'many sleepless nights worrying about how [he] was going to fill rosters' and that he was regularly in contact with the Directors of Medical Services in other districts, trying to identify locum staff.⁴⁷⁷ He testified:

One of the reasons why the 18 months I spent as the Acting Director of Medical Services was probably the worst 18 months of my life was because I felt very much as though I was a member of the senior executive of a military...Except I was in the German army and when I was asking for lieutenants, I was getting sergeants, and when I was asking for 18 year olds, I was getting 14 year olds. So the military analogy is that if you have a captain who falls in the field, you trump up anybody.

- 3.130 Given the history of the Department of Surgery at the Base (including the availability of a number of fellows of the Australian College), the hospital's treatment of Dr Jayasekera, and the absence of any national advertising for the Senior Medical Officer position, it would be disingenuous to blame the appointment of Dr Patel on some general medical workforce shortage.
- 3.131 In the circumstances, I have made certain findings and recommendations against Dr Nydam and they appear later in this report.

The Medical Board

- 3.132 The Medical Board was charged by statute with considering Dr Patel's suitability to practise. One would expect that, in assessing that suitability, there would be a range of factors to be taken into account, including the applicant's formal education, the circumstances of his or her experience, the level of supervision he or she could expect, and, in the light of these matters, the nature of the position in issue.
- 3.133 Any serious inquiry by the Medical Board of the Base would have alerted it to the fact that Dr Patel would be working in the circumstances set out above. Even on the information to hand, it could expect that he would be conducting surgery in a regional setting despite having never practised in Australia before.
- 3.134 In those circumstances, in considering Dr Patel's suitability for the 'practising the profession in the area', the Medical Board should have:

⁴⁷⁶ T5971, line 30

⁴⁷⁷ see the statement of Dr Nydam dated 19 October 2005, para 9 and see T4119

- a) Conducted its own enquiries of Dr Patel's referees;
- b) Approached Dr Patel's last supervisor;
- c) Insisted that Certificates of Good Standing be provided from all jurisdictions in which Dr Patel had practised;
- d) Insisted that Certificates of Good Standing be provided directly by the issuing authorities so there was no opportunity for tampering;
- e) Made enquiries of the Base to ascertain the likely functions of the Senior Medical Officer post, and matched them against Dr Patel's strengths and weaknesses;
- f) Identified the name of the Director of Surgery to whom Dr Patel was to report, and confirmed that the person was a fellow of the Royal Australasian College of Surgeons;
- g) Inserted a condition requiring that there be regular reports going to Dr Patel's performance;
- h) Inserted a condition requiring that Dr Patel be subjected to an appropriate credentialing and privileging process before he commenced employment;
- i) Conducted internet searches.

3.135 Any reasonable enquiry would have revealed that Dr Patel had lied in the application about his disciplinary history. If that had been revealed, the dishonesty alone should have persuaded the Board that Dr Patel was not a suitable person for registration.⁴⁷⁸ Certainly, Dr Nydam gave evidence that it was his position that 'any person who lies, who misrepresents themselves, who makes a positive effort to defraud who they really are, has got a level of morality that excludes them from any interest no matter how technically brilliant they are',⁴⁷⁹ and it can be expected that the revelation of the lie might have resulted in another candidate being preferred. The Board, effectively, made no independent inquiry. Its 'checks' were limited to the perusal of material provided by the candidate and the hospital, and then largely by an administrative officer. Whereas the Base apparently perused notes of discussions between Wavelength and the referees, the Board did not even take that step. It neither contacted people in Oregon itself, nor satisfied itself that any other participant had done so thoroughly, or indeed at all.

3.136 As indicated above, I do not accept that the Board was excused from performing its statutory role because it lacked the resources. If that was the case, the Board should have informed the Minister accordingly.

⁴⁷⁸ But there is some suggestion in the Board's own material that it might simply have allowed registration in a supervised setting: Exhibit 24, MDG3, para 5.3

⁴⁷⁹ T4110

- 3.137 In consequence of these findings, and of findings made in Chapter Four, it will be necessary to make recommendations with respect to the Medical Board. These are set out later.

A general conclusion about these defects

- 3.138 In the end, the single most breath-taking feature of the quality control measures taken before Dr Patel's appointment was this. He was to stay at the Base for exactly two years (1 April 2003 to 1 April 2005) and in that time, he saw 1457 patients, and no doubt had an enormous impact upon the quality of life of many more Queenslanders. Notwithstanding that circumstance, the inquiries into the authenticity of his qualifications were almost entirely limited to the brief work of a private recruiting firm in Paddington, Sydney, which stood to gain by his appointment and which warned Queensland Health by its terms and conditions to make its own enquiries.

Dr Patel's employment at the Bundaberg Base Hospital

Application of the credentialing and privileging process to Dr Patel

- 3.139 In Australian hospitals, and indeed, most hospitals throughout the world,⁴⁸⁰ the fact that a person holds medical qualifications is not regarded as entitling that person to carry out all procedures or activities offered by the facility. Instead, hospitals adopt a practice of imposing restrictions on the treatment that their doctors are authorised to provide by reference to a number of factors.
- 3.140 In the first place, in an increasingly specialised profession, it may be that the practitioner's qualifications or experience are confined to a particular area of medicine. Doctors are engaged in a 'craft' and, wherever possible, it is preferable that procedures be carried out by people who have the knowledge of likely complications, and recent advances, that come with regular involvement.⁴⁸¹ In the second place, it may be that there is another practitioner who is reasonably available and who has developed such a well-regarded practice in a procedure, that it makes little sense for his or her colleagues to engage in it. This will apply, even more so, if there is a facility in a particular region – such as a children's hospital or a rehabilitation centre – that is staffed by a number of people specialising in a particular field.⁴⁸²

⁴⁸⁰ T2851; T4139; T1843; T1859; T1864; T2846

⁴⁸¹ T6976, T6902, line 40

⁴⁸² T2847

- 3.141 In the third place, the scope of treatment a doctor can provide may require restriction having regard to the resources available within a hospital.⁴⁸³ Medical practitioners may be significantly impeded performing certain procedures effectively if, for instance, they do not have a certain level of pathology or radiology services. Some surgery may require a stay in intensive care post-operatively – especially where there are complications – and it may be that the type of surgery that is to be performed at a hospital needs to be restricted because the intensive care facilities (whether by way of beds, specialists, or equipment) cannot cope.
- 3.142 The hospital's resources, of course, include staff, and a practitioner may have limitations set by his or her access to complementary experts in other fields, junior doctors, and experienced nursing staff. A practitioner in internal medicine, for instance, may be better able to advise a patient on possible treatment options if he or she can talk to surgeons, oncologists, radiologists, etc. about the likely consequences of taking different courses. Indeed, the optimal treatment path may be arrived at only after a discussion between a team of expert health providers. In that context, it may be appropriate to restrict the procedures that a doctor can provide at a particular facility because the patient would be better served by attending a larger hospital where a multi-disciplinary approach can be adopted.
- 3.143 In the fourth place, the issue of whether the treatment is elective or emergency, and how easily the patient can be transferred to another facility, will be crucial. In a remote setting, the general practitioner in the local hospital may be called upon in an urgent situation to perform neurosurgery simply because there is no one better qualified close by. If, on the other hand, a person in that same setting is suffering from the early stages of a brain tumour, it could properly be expected that he or she be transferred to a tertiary hospital and into the care of a qualified neurosurgeon. It follows, of course, from this consideration and others identified above that one doctor may have different sets of privileges at different hospitals.
- 3.144 Finally, it may be that the procedures that a doctor can provide should be restricted as a result of actual knowledge of the doctor's competence, the currency of his or her knowledge or by reference to the doctor's commitment to continuing medical education.
- 3.145 To formalise the consideration of these matters, hospitals have in place a process called 'credentialing and privileging'. The Commission heard evidence that, upon arrival at a facility, a doctor should be required, in the first place, to submit details of his or her qualifications and experience to a committee of peers, and to respond to any questions that the committee may have. The committee

⁴⁸³ T2847

should then make recommendations to hospital management, having regard to the applicant's credentials and the resources of the hospital (in the context of the wider matters raised above), as to those procedures which the practitioner should be authorised, or 'privileged', to carry out.

3.146 It seems that the specificity of the privileges can differ substantially. Some institutions choose to grant privileges expressed broadly by simply setting out an area of medicine (such as 'general surgery including gastroscopy/colonoscopy')⁴⁸⁴ whilst others choose to express themselves narrowly and strictly so that, for instance, the privileges may be confined to particular, identified types of treatment.⁴⁸⁵

3.147 In July 2002, Queensland Health issued a document entitled 'Credentials and Clinical Privileges Guidelines for Medical Practitioners'.⁴⁸⁶ It was accompanied by a Queensland Health Policy Statement on the same issue and it was expressed to replace an earlier version published in 1993. The Guidelines remain current and relevantly provide that:

1 It is recognised that rural practitioners 'need to use a more comprehensive range of skills than their urban counterparts' and the Guidelines were developed with that in mind;⁴⁸⁷

2 The principle purpose of the process is to ensure that:
only those practitioners who are appropriately qualified, trained and experienced will undertake clinical care within the constraints imposed by the available resources, including staff and equipment, and the physical facilities available within the healthcare facility concerned.⁴⁸⁸

3.148 'Credentials' represent the formal qualifications and experience of the candidate and may be evidenced by a range of documents;⁴⁸⁹

(a) 'Clinical Privileges' represent the range and scope of clinical responsibility that a practitioner may exercise within the facility;⁴⁹⁰

(b) The process of assessing credentials and recommending privileges is to be undertaken by peers, that is other medical practitioners;⁴⁹¹

(c) The process should be conducted for new doctors, at regular intervals of three years, and as soon as possible upon request;⁴⁹²

⁴⁸⁴ Exhibit 410, SPB3, T6922, line 40

⁴⁸⁵ See T1843, line 35

⁴⁸⁶ Exhibit 279

⁴⁸⁷ See the foreword to the Guidelines

⁴⁸⁸ Paragraph 1 of the Guidelines

⁴⁸⁹ Paragraph 2.2 of the Guidelines

⁴⁹⁰ Paragraph 2.3 of the Guidelines

⁴⁹¹ Paragraph 2.4 of the Guidelines

⁴⁹² Paragraph 4 and 7 of the Guidelines

- (d) The recommendations should be provided to:
- the recruitment and selection/appointment committee, in the case of a new practitioner; or
 - the district manager in the case of an existing practitioner;⁴⁹³
- (e) The final decision as to privileges will be made by the District Manager, having regard to the committee's recommendations, as well as the 'administrative and resource implications for the facility';⁴⁹⁴
- (f) Clinical privileges should be defined before the completion of the appointment process;⁴⁹⁵
- (g) In any case, they should be defined before a doctor commences any admissions or treatment within the hospital;⁴⁹⁶
- (h) Overseas candidates for positions must be informed that any appointment is subject to the successful awarding of privileges;⁴⁹⁷
- (i) Where it cannot 'be confidently established' that a person has the necessary qualifications and experience for a given position, the person should be required to undergo a period of specialist supervision;⁴⁹⁸
- (j) The committee should be chaired by the Director of Medical Services and it should include two other medical practitioners at the hospital;⁴⁹⁹
- (k) In addition to the 'core membership' set out above, it 'should include' a representative from various named bodies (including the relevant college) 'where appropriate';⁵⁰⁰
- (l) The documentary evidence to be reviewed by the committee should go to, amongst other things, eligibility for qualifications, registration, professional good standing, satisfactory references and physical and mental fitness to practise;⁵⁰¹
- (m) A mechanism should exist for the granting of temporary privileges for short-term appointees such as locums, without recourse to the full committee and the District Manager might delegate this power to the Director of Medical Services;⁵⁰²

⁴⁹³ Paragraph 2.4 and 6 of the Guidelines

⁴⁹⁴ Paragraph 2.4 of the Guidelines

⁴⁹⁵ Paragraph 6.1 of the Guidelines

⁴⁹⁶ Paragraph 6.1 of the Guidelines. This is also the subject of an undertaking between the District and Queensland Health, signed by the District Manager: T7128; Exhibit 467

⁴⁹⁷ Paragraph 2.3 of the Guidelines

⁴⁹⁸ Paragraph 2.5 of the Guidelines

⁴⁹⁹ Paragraphs 5.2 and 5.3 of the Guidelines

⁵⁰⁰ Paragraph 5.3 of the Guidelines

⁵⁰¹ Paragraph 6.2 of the Guidelines

⁵⁰² Paragraph 7.3 of the Guidelines

(n) Privileges may be granted for a probationary period, and subject to evaluation at the end of that time,⁵⁰³

(o) The members of the committee are to be indemnified for their decisions.⁵⁰⁴

3.149 The Base had certainly engaged in the practice of privileging doctors in earlier times. Dr Thiele gave evidence that a committee dedicated to that process existed during his administration⁵⁰⁵ and Dr Baker provided the Commission with a letter dated 12 June 2001 in which the Director of Medical Services at that time, Dr John Wakefield, informed Dr Baker of recommendations as to the privileges he should be granted.⁵⁰⁶

3.150 For reasons that are not clear, however, the practice seems to have fallen into disuse at the Base from about 2002, and it had not been revived by the time of Dr Patel's arrival on 1 April 2003.⁵⁰⁷ The Guidelines, of course, required that the letter of offer sent to Dr Patel and dated 24 December 2002 make clear that his appointment was subject to the privileging process. That did not occur. I consider that they also required – having regard to the uncertainties as to Dr Patel's past – that any privileges awarded to him be subject, initially, to supervision or even a probationary period. That also did not occur. At the very least, the Guidelines required that Dr Patel be subject to the credentialing and privileging process prior to commencing to provide treatment but, again, that did not occur.

3.151 When Dr Patel arrived, Dr Nydam was continuing as the Acting Director of Medical Services.⁵⁰⁸ He testified that he considered that Dr Patel did not require credentialing and privileging because he was a 'locum'.⁵⁰⁹ I can see no foundation for that view: Dr Patel was employed on a 12 month contract with a status of 'temporary full time'⁵¹⁰ and the Guidelines clearly contemplate, in any case, that even temporary employees, including locums, were to be subjected to a form of credentialing.⁵¹¹

3.152 Dr Nydam gave evidence that, 'Given Dr Patel was a senior health professional, I assumed he would operate within the scope of his experience and prior practise as a General Surgeon'.⁵¹² He said that, in those circumstances, any guidance given to Dr Patel was confined to the telephone conversations they had together prior to Dr Patel's appointment (which, he believes, would have concerned

⁵⁰³ Paragraph 7.2 of the Guidelines

⁵⁰⁴ Paragraph 9.1 of the Guidelines

⁵⁰⁵ T1843, line 40

⁵⁰⁶ Exhibit 410, SB3

⁵⁰⁷ T4136

⁵⁰⁸ Dr Keating was appointed to the permanent position of Director of Medical Services on 14 April 2003: Exhibit 448, para 3

⁵⁰⁹ T4142

⁵¹⁰ Exhibit 51, KN9

⁵¹¹ Exhibit 279, para 7.3

⁵¹² Exhibit 51, para 37

‘surgical workloads, the scope of clinical workload, staffing levels and a general discussion about the Bundaberg area itself’).⁵¹³ Given those remarks, the fact that the process had fallen into disuse, and some general comments in Dr Nydam’s initial statement to the effect that he simply had no recollection of the process being conducted,⁵¹⁴ it seems most likely that Dr Nydam never considered the issue of privileging Dr Patel or making the letter of offer subject to that process.

- 3.153 In the event, on 31 March 2003, Dr Patel was interviewed by an officer of the Medical Board in Brisbane to satisfy the only ‘condition’ of his registration. That interview, as discussed earlier, was effectively a ‘meet and greet’ session with the Board’s representative. Dr Patel then travelled to Bundaberg and reported to the Base on the following day. Notwithstanding the circumstances of Dr Patel’s registration with the Board, it is clear that he immediately assumed the position of the Director of Surgery. That conclusion is supported by the evidence of Dr Strahan that Dr Patel was introduced to him by that title on that day, by the email sent by Dr Nydam to his Human Resources staff on 9 April 2003,⁵¹⁵ instructing them to pay Dr Patel a ‘Director’s allowance...as he is the Director of Surgery’, and by the simple fact that there was no other practitioner who was acting as the Director, nor any plans afoot to recruit one.⁵¹⁶ It was not denied by any witness.
- 3.154 If the lack of any privileging made for a poor start to Dr Patel’s employment, it was compounded by other matters. There was no handover from the previous Director of Surgery or even an existing staff surgeon. Further, the Base did not offer any induction course regarding the hospital itself or the Queensland public health system generally, to overseas doctors,⁵¹⁷ so that it seems that Dr Patel was left to learn of his circumstances by a process of ‘osmosis’.⁵¹⁸
- 3.155 It hardly needs to be said that this preparation was far from satisfactory. Dr Nydam had not communicated with Dr Patel about matters of substance for over three months, and then only in the context of long distance phone calls to a prospective employee. Dr Patel was a foreign trained doctor whose work no one had observed; he had no specialist qualifications that were recognised in Australia; indeed, he had no experience in this country; he had not worked for over a year; and he was coming to a very senior position in a relatively large regional hospital where he would not be supervised but he would supervise others. All this, moreover, was in circumstances where the Base had not carried out any checks for itself into Dr Patel’s background. Notwithstanding these matters, he was permitted to commence treating patients without the most

⁵¹³ Exhibit 51, paras 18,19 and 37

⁵¹⁴ Exhibit 51, para 36

⁵¹⁵ Exhibit 58, KN12

⁵¹⁶ See the evidence of Dr Nydam discussed previously

⁵¹⁷ T4099 - There was evidence that an induction course of sorts was provided for interns.

⁵¹⁸ T4099, line 20

cursory compliance with the practice of credentialing and privileging. Further, it seems, he was given no specific instructions as to important matters such as the availability of other institutions; when or how patients might be transferred; the extent of the support the Base could give; the protocols that the Department of Surgery might observe with the Department of Medicine or the Intensive Care Unit (amongst others); or the role of the tertiary hospitals and the assistance that might emanate from that source.

3.156 I make findings and recommendations in relation to these matters later in this report.

3.157 On 14 April 2003, that is two weeks after Dr Patel's arrival, Dr Darren Keating arrived at the Base and took up the permanent role of Director of Medical Services. The position description pursuant to which Dr Keating was appointed provided, amongst other things, that:

- (a) The Director of Medical Services reported directly to the District Manager
- (b) The Director of Medical Services was to 'facilitate the development and effective performance of clinical services in the District';
- (c) Whilst the position would operate with a 'significant degree of independence', nevertheless 'continual consultation would occur with the District Manager... and other executives within the District's facilities and agencies';
- (d) The Director of Medical Services would participate in a number of District Committees and would be the Chair of the Credentials and Privileges Committee.

3.158 Dr Keating had an impressive background. He had been awarded his primary medical degrees from the University of Melbourne in 1986; he had a Masters in Health Services Management from the Charles Sturt University in New South Wales; he had over ten years experience in clinical areas including internal medicine, emergency medicine and general practice; he had been a Commanding Officer in various units of the Australian Army between 1993 and 2000; and he had served in Somalia, East Timor, Germany and Bosnia.⁵¹⁹ Dr Keating had come directly from a position as a Senior Medical Officer in the Port Hedland Regional Hospital, Western Australia, but his induction to Bundaberg could only be described as minimal. He gave evidence that Queensland Health provided no orientation or training to the Base, no manual, and that he received only a brief handover from Dr Nydam.⁵²⁰ It seems that, on his first day, he had a walking tour of the Base, he was introduced to some of the staff at a lunchtime

⁵¹⁹ Exhibit 448, T6808-9

⁵²⁰ T6932

meeting and he arranged, independently, to meet the directors of the various clinical departments.⁵²¹ Asked further about the guidance given to him at the outset, Dr Keating said:

I familiarised myself with the procedures as I went along. I literally was thrown in to work straight away, I was learning as I went...I came on the 9 o'clock plane [on 14 April 2003], was picked up by Mr Leck and was in a meeting at 9.30am.

- 3.159 Again, in my view, the preparation for the position was wholly inadequate. The failure to instruct Dr Keating at length about the many complex issues associated with running the Base is, in my view, inexcusable when it is considered that the Director of Medical Services was effectively the second-in-charge, and the first medical officer, of a facility which employed some 850 people, enjoyed an annual budget of \$56 million, and had enormous responsibilities for the Bundaberg District community. It is simply unthinkable that a person would be appointed to a similar position in the private sector with such little preparation, and the fact that the Director of Medical Services was responsible for *public* patients and *public* funds does not work in mitigation.
- 3.160 It will be recalled that the Director of Medical Services position had essentially remained vacant since Dr John Wakefield's departure towards the end of 2001,⁵²² and one can readily appreciate that a number of issues concerning medical administration might have required attention. Dr Keating certainly testified that he found that the credentialing and privileging process in respect of Senior Medical Officers had lapsed. He set about developing a policy that might comply with the Guidelines considered earlier, and he did so in conjunction with the Director of Medical Services at Hervey Bay, Dr Terry Hanelt.⁵²³ Dr Keating gave evidence that the purpose of organising the credentialing and privileging process across the two districts was to ensure 'a critical mass of practitioners was available to undertake the process and to use scarce resources efficiently'.⁵²⁴ I glean that the creation of a larger pool was considered attractive because there would be a greater number of 'peers' who might sit on a committee, because committees might assess a greater number of practitioners, and because those 'privileged' might move between the two facilities.⁵²⁵
- 3.161 The new local policy was tendered in evidence. It was expressed to have been initiated by Dr Keating and to be effective from 1 January 2003.⁵²⁶ It provided relevantly as follows:

⁵²¹ Exhibit 448, para 5

⁵²² Exhibit 437, para 8

⁵²³ Exhibit 448, para 354

⁵²⁴ Exhibit 437, para 355

⁵²⁵ Insert the transcript references for Dr Nydam and Dr Keating T6923

⁵²⁶ See Exhibit 276. There was no evidence as to exactly when the policy was created, but it seems to have been between April and June 2003, having regard to the commencement of Dr Keating's employment and the terms of later correspondence such as DWK82.

Criteria to be used in evaluating privileges

The Applicant

Possession of (or eligibility to obtain) professional registration with the Medical Board of Queensland;

Qualifications and training appropriate to the privileges applied or;

Clinical experience and competence in the appropriate field of expertise;

Professional good standing including professional indemnity status, specialty College support, professional referee comments and peer recommendations;

Commitment to past and continuing professional education and quality assurance activities; Physical and mental fitness to practice (sic)

The Health Care Facility

Facilities, equipment and financial resources available;

availability of necessary support services;

Role delineation of the facility

3.162 It provided that privileges were to endure for a period of three years, except that the initial appointment would be subject to a one year probationary review, and a review might be undertaken, in any case, where the Director-General, the District Manager, the Director of Medical Services or the Department Director, requested the same on clinical grounds.

3.163 Dr Keating's evidence was that, when he arrived in Bundaberg, Dr Patel was introduced to him as the Director of Surgery. He was not given to understand that Dr Patel was merely acting in that role, nor that there was any documentation that required attention, and he understood that the appointment was complete.⁵²⁷

3.164 Dr Keating was aware, however, that Dr Patel had not been privileged.⁵²⁸ It might have been hoped that he would investigate the circumstances of Dr Patel's appointment and attend to that step straight away in accordance with the Guidelines, but that did not happen. It might have been hoped that, once the new local policy was developed in or about June 2003,⁵²⁹ Dr Keating would have ensured that Dr Patel was subjected to the process described therein immediately, but that did not happen either.

3.165 By a letter dated 11 June 2003, the District Manager of the Base, Mr Leck, granted 'interim privileges' to Dr Patel. The letter read relevantly:

The formal process of obtaining Credentials and the granting of Clinical Privileges will be undertaken in the Bundaberg Health Service District in the near future. Until this process is completed, interim privileges have been granted on the recommendation of the Director of Medical Services. These privileges will lapse when the formal process is completed.

⁵²⁷ Exhibit 448, para 21

⁵²⁸ T6830

⁵²⁹ This is apparent from the correspondence subsequently sent to staff.

As per the advice of the Director of Medical Services, I hereby confer privileges in General Surgery for the hospitals within the Bundaberg Health District.⁵³⁰

- 3.166 Dr Keating gave evidence that, in granting – or, at least, recommending – temporary privileges, he had not carried out any investigation. He said that, since Dr Patel ‘had been employed through a specialist recruitment company’, he assumed that Dr Patel’s experience and references ‘had been checked and that he was considered qualified for the position of Director of Surgery’.⁵³¹ By a letter dated 26 June 2003, Dr Keating wrote to Dr Patel, underlining the importance of credentialing and asking that Dr Patel complete and return a formal application.⁵³² On the same day, Dr Patel completed the Application for Clinical Privileges (Specialists).⁵³³ Under the heading of Clinical Privileges Requested, he wrote ‘General Surgery, Endoscopy’. He nominated the same referees as had appeared in his application for registration (but added Dr Leonara Dantas, also from Kaiser Permanente) and he attached his curriculum vitae. Dr Keating wrote again on 6 November 2003, seeking that Dr Patel provide copies of his ‘diplomas and board certificates’.⁵³⁴
- 3.167 In the event, the general process of credentialing and privileging was not implemented at the Base in respect of any medical practitioners until the last quarter of 2004.⁵³⁵ Even then, it was not implemented in respect of any surgeons. By this time all the privileges granted by the previous Director of Medical Services had ‘completely run out’.⁵³⁶
- 3.168 By a letter dated 29 July 2004,⁵³⁷ Dr Keating had written to Dr Patel, relevantly, that:

In June 2003, I wrote to you requesting completion and submission of an application for clinical privileges...Under the [combined Fraser Coast Health Service District and Bundaberg Health Service District] policy, which is primarily directed by Queensland Health policy the clinical privileges committee must include a relevant specialist nominated by the specialist college. With the introduction of this policy throughout Queensland, all colleges have been inundated with requests for nominations of suitable persons to sit on such committees. At present, the colleges have been unable to provide the appropriate nominations ...we are looking to complete the process as soon as possible pending the nomination of appropriate personnel by colleges. Thank you for your patience in this matter.

- 3.169 Dr Keating gave evidence that was consistent with the terms of the letter. He said that the Base had encountered problems garnering nominees from the various Colleges. Some Colleges were forthcoming with nominees (eg, the

⁵³⁰ Exhibit 448, DWK82

⁵³¹ Exhibit 448, para 360

⁵³² Exhibit 448, DWK82

⁵³³ Exhibit 455

⁵³⁴ Exhibit 448, DWK82; T6926

⁵³⁵ T6927, line 30

⁵³⁶ T6928, line 30

⁵³⁷ Exhibit 448, DWK82

Colleges responsible for physicians and obstetricians) and the Committee met for the first time in November 2004 to consider practitioners in those areas.⁵³⁸ Even then, however, the Royal Australasian College of Surgeons had not provided a name. It seems that enquiries were made by Dr Gopalan, the Assistant Director of Medical Services at Hervey Bay Hospital. He wrote by email on 15 July 2004 to Dr Keating and Dr Hanelt that:

I have contacted the college of surgeons in Victoria who referred me (sic) to the college branch in QLD. Following my discussions with them, they informed me that they had been swamped with applications from other area health services. Importantly they had a new chairman now and at this stage they are unable to suggest a suitable candidate as there are problems including indemnity of the college representatives for any fallout from the review. I got a call yesterday from the college informing me that they were now awaiting advice from the college headquarters in Melbourne. I will keep you posted, however I think we should get together and review our own staff applications. Can you provide me with a number of suitable dates?⁵³⁹

3.170 Dr Keating gave evidence that, first, he understood that the inclusion of a College representative to review a practitioner of that specialisation was mandatory; second, that he did not understand that the policy permitted him to appoint a specialist to the committee without the College's approval; and thirdly, he assumed that Queensland Health was aware of the problem (and, presumably, he assumed that it was working towards a solution).⁵⁴⁰ Against the background set out above, Dr Keating did not attend to having Dr Patel credentialed at any time in the course of his employment.

3.171 It is my view that Dr Keating's failure to privilege Dr Patel demonstrated a serious dereliction of duty. Neither the Guidelines, nor the Queensland Health policy mandated that the Committee include a person nominated by the relevant College in every case. The language of the relevant provision – paragraph 5.3 – is clearly advisory rather than mandatory, as one would expect in a document entitled 'guidelines'. Section 5.1 of the Guidelines provided in part:

There should be a core membership of practitioners constant for all applications considered. Additional members *should be invited as required*, depending on the size and complexity of the facility, with representation from relevant professional and other bodies as dictated by the principle of peer representation. Representation from an 'industrial organisation' is not appropriate. The committee may be structured at a health care facility, district or cross district or zonal level. '

[my emphasis]

3.172 Section 5.3 of the Guidelines also provided:

The actual composition of the committee will vary depending on the discipline of the applicant(s) under consideration and the type of facility involved, but should

⁵³⁸ T6928; The minutes of the meeting were tendered as an Exhibit.

⁵³⁹ Exhibit 448, DWK 79

⁵⁴⁰ Exhibit 448, paras 356-9

include, in addition to the core membership, a representative from the following, where appropriate:

- Relevant clinical/professional college (such as Royal Australian College of Surgeons, Royal Australian College of Physicians, Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, Australian College of Emergency Medicine).
- University representative for positions at teaching hospitals or other health facilities with an academic presence.
- *Relevant clinical department (larger facilities).*
- For rural facilities a representative of the Rural Faculty, Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine or the Rural Doctors Association of Queensland.
- *Other medical practitioners co-opted as appropriate by the committee:*

The respective colleges and professional associations will nominate a representative to the committee. The district manager may refer the name to the committee for consideration as to whether the committee regards the nominee as inappropriate such as when a conflict of interest may apply.

- 3.173 Each of the bulleted subparagraphs in section 5.3, in my view, should be read disjunctively. The flexibility to meet local circumstance was also emphasised in the Foreword to the Guidelines.

The guidelines allow for flexibility to meet local circumstances occurring in each Queensland Health District. However, the guideline's essential principles are to be observed in establishing the appropriate mechanisms and committees to oversee the process.

- 3.174 Furthermore, even if the inclusion of a College representative on the committee was mandatory, that provided no reason to stop the process. What seems to have been forgotten is that the exercise of privileging is not the creation of Queensland Health and was not devised for its benefit. It is, as the Guidelines themselves make clear, a measure to enhance patient safety. It aims to ensure that doctors only provide treatment in circumstances where they can competently do so. In those circumstances, there is no reason why Dr Keating could not have asked one of the many surgeons in Bundaberg or Fraser Coast (and who were Fellows of the College) to sit on the Committee. Even if the Guidelines bore the interpretation that Dr Keating attributed to them, it was simple common sense that the Base should make ad hoc arrangements for substantive privileging until such time as the College nominated a representative. The surgeons who the Base might have approached in the Bundaberg and Fraser Coast areas alone included Brian Thiele, Geoff de Lacy, Pitre Anderson, Sean Mullen and Morgan Naidoo.

- 3.175 As will be described at length later, in February 2005 Queensland Health sent an investigative team, headed by its Chief Health Officer, Dr Gerry FitzGerald, to Bundaberg in response to a complaint about Dr Patel. Dr Keating concedes that, at that time, Dr FitzGerald, suggested that he co-opt a local surgeon for the

committee, in the absence of a College nominee. Dr Keating seems to have decided against that course because:

...I was focussed on making sure that the process that we began was – is transparent and as accountable as possible, and I didn't wish to run into a situation where we would be accused of mates credentialing mates and we wanted to make sure that this was an open and transparent process for all the specialties as well. And I didn't want to have one specialty saying 'Oh, you look like you have cut corners here as opposed to another specialty'. And you know specialties, the specialist in specialties can do that.⁵⁴¹

3.176 That explanation is far from satisfactory. It would obviously be ideal that the surgeon sitting on the committee have the mandate of the College but, where that could not be achieved – especially in the circumstances in which Dr Patel was practising - the Base needed to make its own choice of an independent surgeon. If it was thought that such a surgeon could not be located in the Fraser Coast/Bundaberg districts, there was a large number of general surgeons available in Brisbane and Townsville, including of course some with experience in the Base like Dr Baker, Dr Jayasekera and Dr Nankivell. Dr Keating gave evidence that he never approached 'central zone' or Queensland Health's central office in Brisbane about the problem in obtaining College nominees and that is particularly hard to understand given the view expressed in his correspondence of 29 July 2004 that the problem was a State-wide one.

3.177 It is impossible to know whether, if the credentialing process had been carried out for Dr Patel at some point during his employment (ie, 1 April 2003 to 1 April 2005), his disciplinary history in the United States would have been revealed. In my view, there is a very real prospect that this would have occurred. In the first place, the committee might have insisted upon seeing the Verification of Licensure and noticed the reference to the 'stipulated order' and the absence of any attachment. In the second place, if an approach had been made to Dr Patel's supervisor at Kaiser Permanente, and the purpose of the approach made clear, it is difficult to see how that person would not have explained that Dr Patel's privileges had been restricted by that hospital in 1998/9, and that those restrictions were then incorporated in an order of the Oregon Board of Examiners in 2000. In the third place, there is a real prospect that Dr Thiele might have been approached since he knew the Base well, had been working there as a Visiting Medical Officer, and had very extensive experience in the United States, and he might have brought a high degree of scrutiny to the process.⁵⁴² Dr Patel claimed that he had carried out his surgical residency programme at the University of Rochester, New York State between 1978 and 1984.⁵⁴³ Dr Thiele testified that he was very well acquainted with the Chairman of the program, with

⁵⁴¹ T6929, T7067-8

⁵⁴² Mr Leck testified that he held Dr Thiele in high regard and he agreed that, if the process had been invoked, Dr Thiele might have been invited to sit on the committee: T7159

⁵⁴³ See Exhibit 51, KN3 and T1844

the 'philosophy' behind the training there, and with the scope of general surgery programmes across the United States at different times.⁵⁴⁴ He maintained that he could have called the hospitals where Dr Patel claimed to have worked, ascertained the extent of his privileges,⁵⁴⁵ and 'fairly quickly determined whether what was on the paper was real or whether there was some problem with it'.⁵⁴⁶

- 3.178 The likelihood that the credentialing and privileging process might have involved some real scrutiny is supported by the work of the Committee to the extent that it did function. Mr Leck gave evidence that he and Dr Nydam were concerned that, in the past, the process involved little more than 'rubber stamping'. He said they were keen to change that situation with the new policy,⁵⁴⁷ and it seems that they did. The minutes of a meeting of the Committee on 26 November 2004 relate to applications for credentialing from the internal medicine doctors at the Base and at Hervey Bay Hospital, almost all of whom were Fellows of the Royal Australian College of Physicians. Despite their standing, the Committee insisted that various evidence be provided before the award of privileges would become unconditional.⁵⁴⁸
- 3.179 There is a fourth reason for considering that the credentialing process might have provided some early warning as to Dr Patel's limitations if it was invoked. As Dr Keating conceded, the Committee would have been entitled to consider data going to Dr Patel's actual conduct during his time at the Base.⁵⁴⁹ As will be seen below, there was a steady stream of complaints in the course of Dr Patel's employment and this might well have provoked a committee to make fuller inquiries.
- 3.180 The further issue which arises is whether, if Dr Patel had navigated the credentialing process, his privileges might have been narrower than those he requested and those he had obtained on an interim basis. Dr Keating has certainly given evidence that, at the Base, the privileges were not allocated in any detailed way.⁵⁵⁰ As will be seen below, however, there were concerns early in Dr Patel's time at the Base that he was undertaking procedures too complex for its resources (particularly its intensive care facilities), and it seems possible that an independent surgeon might have at least considered whether restrictions were warranted for complex elective surgery.

⁵⁴⁴ T1843-4

⁵⁴⁵ T1843

⁵⁴⁶ T1844

⁵⁴⁷ T7159; See also Dr Nydam's evidence at T4142

⁵⁴⁸ Exhibit 277; T7160

⁵⁴⁹ T7066

⁵⁵⁰ T6922

Dr Patel works at the Base

- 3.181 Soon after the commencement of Dr Patel's employment, he was joined by James Gaffield, and the two Americans became the staff 'specialists' within the Base's Department of Surgery. They were assisted by Dr Anderson who was, of course, engaged as a Visiting Medical Officer, working in urology. Dr Patel was given the more senior position of Director of Surgery and, although that might sometimes be considered an administrative role, there was no doubt that the Base considered Dr Patel to be the senior surgeon and treated him accordingly.⁵⁵¹
- 3.182 One could understand that the people of Bundaberg might have thought that, since the two Americans were carrying out almost all of the general surgery at the Base, they were not supervised, and one of them was the Director of the Department, they must be Fellows of the Royal Australasian College of Surgeons, or recognised as having equivalent qualifications by the Medical Board. That, of course, was not the case.
- 3.183 Dr Patel's time at the Base was, on any view, a stormy one. The competency of Dr Patel was the subject of testimony from three independent surgeons, and their opinions will be considered later in this report. There were a number of complaints made about Dr Patel during his term at the Base and they are set out below, not with a view to assessing whether any complaint was well-founded but, rather, to consider whether they were harbingers of problems which the Base might have identified.

Patient receives wrong procedure

- 3.184 The first complaint concerned an incident on 14 May 2003. A patient, identified before the Commission as P74, was admitted to the Day Surgery Unit at the Base so that Dr Kingston⁵⁵² could perform a right epididymectomy. Whilst the patient was waiting for that procedure, Dr Patel 'inadvertently' conducted a gastroscopy upon him, being a procedure for which he had not consented and for which he had not been scheduled.⁵⁵³ Dr Kingston apologised on behalf of the hospital and it seems that no harm was done.⁵⁵⁴ Dr Keating conducted an investigation and found that there were inadequate checks in the transfer of the patient from the Day Surgery Unit to the Operating Theatre.

⁵⁵¹ T6824

⁵⁵² Dr Kingston was a Visiting Medical Officer who did minor surgery at the Base

⁵⁵³ T6939, Exhibit 448, para 316

⁵⁵⁴ Exhibit 448, DWK76

James Phillips; the first oesophagectomy

- 3.185 The second complaint concerned a 46 year old man called James Phillips (also known as P34). He had a potentially curable lesion in the oesophagus so that an oesophagectomy (in which a portion of the oesophagus is surgically removed) was one treatment path for consideration. The circumstances were complicated, however, by his renal condition: Mr Phillips was receiving dialysis through a graft but the graft itself was suffering from stenosis (that is, it was closing over) and there was a 'very good chance' that major surgery would lead to thrombosis (the development of a blood clot), preventing dialysis.⁵⁵⁵ In those circumstances, the operation was 'as difficult an oesophagectomy as one could envisage'⁵⁵⁶ and a question arose as to whether the patient should be transferred to the Princess Alexandra Hospital in Brisbane. The transfer might have been attractive because the Brisbane hospital had a sophisticated renal unit, staff that included specialist oesophagectomists, and much greater facilities for post-operative intensive care.⁵⁵⁷
- 3.186 Dr Patel, however, performed an oesophagectomy on Mr Phillips at the Base on about 19 May 2003 and Mr Phillips survived that operation. The Nurse Unit Manager of the Intensive Care Unit, Ms Toni Hoffman, was involved in the post-operative care for Mr Phillips and she gave detailed evidence on the subject.⁵⁵⁸ Ms Hoffman had held her position as the most senior nurse in the Intensive Care Unit for almost three years and she had been a nurse practising in Intensive Care for 22 years. She said that she was present when the Operating Theatre staff 'handed over' Mr Phillips to the Intensive Care Unit. Ms Hoffman recalled that the patient was very unstable, that his blood pressure was so low it could not be recorded and that the anaesthetist commented that 'this is an expensive way to die'.⁵⁵⁹ Mr Phillips was given significant quantities of adrenalin (which, the Commission heard, is used to increase, or sustain, blood pressure)⁵⁶⁰ and he was maintained on ventilator support.⁵⁶¹ The course of treatment was complicated by the fact that he required constant dialysis and there was some conflict between the doctors as to how the patient should be managed. In the event, Mr Phillips progressed to brain death.⁵⁶²
- 3.187 Ms Hoffman gave evidence that there were a number of aspects to the case which caused her great concern and, in consequence, she approached her 'line

⁵⁵⁵ See T4293; Dr Woodruff said that the stenosis was in the order of 70%

⁵⁵⁶ T4293

⁵⁵⁷ T4293

⁵⁵⁸ T39; Exhibit 4, para 9

⁵⁵⁹ T39-40

⁵⁶⁰ T46

⁵⁶¹ Ms Hoffman gave evidence that Mr Phillips was receiving 25 milligrams of adrenalin per minute and 100% oxygen: see Exhibit 4, para 9. She also gave evidence that the patient's blood pressure had not been recordable for 45 minutes before his arrival in Intensive Care.

⁵⁶² Exhibit 4, para 9

manager' the Director of Nursing, Glenys Goodman who made an appointment for them to visit Dr Keating in his office.

3.188 It should be said that it was not suggested that Ms Hoffman had any history of making complaints to her line manager. She said, in effect, that if she had done so before it was 'quite uncommon', and no evidence was received to the contrary.⁵⁶³

3.189 Ms Hoffman recalled that in late May or early June 2003, she met with Dr Keating in his office in the company of Ms Goodman, and that she returned a couple of days later with Dr Joiner, a General Practitioner with a particular interest in anaesthetics who was a Visiting Medical Officer to the Base. Ms Hoffman's evidence was that she raised three areas of concern with Dr Keating. First, she said that Dr Patel was habitually 'rude, loud, and did not work collaboratively with the ICU medical staff'. She said that he did not seem to be on the same 'wavelength' as other staff who were working in the Intensive Care Unit, that there was a 'whole bravado about things and things didn't match up', and that his choice of drugs and treatment seemed to be '20 years behind' contemporary thinking.⁵⁶⁴ Ms Hoffman gave evidence that, at the first meeting, she:

..attempted to paint an overall picture of the problems we were encountering in the Intensive Care Unit with Dr Patel including our observations as to the way Dr Patel interacted and spoke which indicated that something was not right. I also recall advising that Dr Patel appeared to be very old fashioned in his treatments...I recall Dr Keating saying that we had to allow that Dr Patel was from another country. I specifically recall advising Dr Keating that it was more like we were coming from two different planets.⁵⁶⁵

3.190 The second issue Ms Hoffman raised was that whilst, in the course of his stay in Intensive Care, Mr Phillips was obviously extremely unwell and the nursing staff were providing this information to the family (which was known to them from Mr Phillips' dialysis sessions), Dr Patel was telling the family, and writing in the chart, that the patient was 'stable'.⁵⁶⁶ Ms Hoffman was concerned that this statement was inaccurate and that it caused unnecessary tension.⁵⁶⁷

3.191 The third issue she raised was to question whether oesophagectomies should be carried out at the Base when it lacked appropriate Intensive Care facilities for patients undergoing major surgery. Ms Hoffman gave evidence that the Base's Intensive Care Unit lacked an intensivist, had only three ventilators, generally did not have adequate nursing staff to cope with more than two ventilated patients,

⁵⁶³ T43

⁵⁶⁴ T42, line 30

⁵⁶⁵ Exhibit 4, para 9

⁵⁶⁶ This caused considerable tension with the nursing staff because they were very familiar with the patient from his time on renal dialysis and they were telling his relatives that the patient was unstable T40, line 1.

⁵⁶⁷ T6944; T47; T40, line 1

and should really transfer patients after 48 hours of care.⁵⁶⁸ Against that background, she suggested a patient receiving an elective oesophagectomy (and a complex one at that) should have been transferred to a tertiary hospital.

3.192 Ms Hoffman's recollection was that, at the first meeting, she spoke predominantly (but not exclusively) about the overall behaviour of Dr Patel, rather than the decision to perform oesophagectomies.⁵⁶⁹ Ms Hoffman's recollection is that the specific issue of oesophagectomies was addressed more squarely during the second meeting.⁵⁷⁰ She said that when the issue did arise, Dr Keating told her that Dr Patel was a 'very experienced surgeon, very used to doing these sorts of surgery, and that no, it was important we keep him in the hospital so it was important we worked with him and did what he wanted, basically'.⁵⁷¹

3.193 Dr Keating has a somewhat different recollection of events. He recalls a meeting with Ms Hoffman and Ms Goodman. His recollection, however, was that, at this meeting, Ms Hoffman voiced concerns which primarily concerned Dr Patel's tendency to make disparaging comments about the Intensive Care Unit nursing staff. His memory was that, in response, he told Ms Hoffman to make an appointment with Dr Patel so that she could explain the limitations of the Intensive Care Unit, and the need for all concerned to work as a team. He said he followed up this advice in discussions with Dr Patel.⁵⁷²

3.194 Dr Keating's recollection was that he did have a meeting with Dr Joiner in which Dr Joiner expressed concerns that the Base was not doing sufficient oesophagectomies to maintain competency, and that the ICU did not have the necessary resources for the post-operative support required by the operation. Dr Keating did not recall Ms Hoffman being present at this meeting and his recollection was that the meeting with Dr Joiner did not occur until after the events set out in the paragraphs that follow immediately below.

Claim that wrong part of ear removed

3.195 The third complaint about Dr Patel was received on 2 June 2003, and concerned a patient known before the Commission as P151. He said that he had a consultation with Dr Patel in April 2003 to discuss the removal of cancer to his ear. They discussed the location of the cancer (which was clearly visible, he maintained, from his general practitioner's previous attempts at excision) and he then attended the Base for an operation on 20 May 2003. He complained that,

⁵⁶⁸ This was in accordance with the Guidelines of the Joint Faculty of Intensive Care Medicine – Exhibit 6 – according to which the Base had a Level One ICU. See also Exhibit 9

⁵⁶⁹ T43

⁵⁷⁰ T43

⁵⁷¹ T46

⁵⁷² Exhibit 448, para 48

when he was discharged from the Base and looked in a mirror, he found that the operation had been carried out to a very different part of his ear.⁵⁷³ Dr Keating spoke with Dr Patel about the complaint and it was agreed that Dr Patel would review the patient. In the event, the review was apparently carried out by a different doctor, who apparently agreed, on the basis of an examination and the biopsy results, that the procedure had been conducted in the wrong place.⁵⁷⁴ A further operation was carried out to the ear on 22 July 2003 and the complaint progressed no further.⁵⁷⁵

The second oesophagectomy

3.196 In June 2003, a fourth complaint was made. It concerned a 63 year old male patient known before the Commission as P18 who, despite the controversy attending the operation to Mr Phillips, was the subject of an oesophagectomy performed by Dr Patel in early June 2003. This second oesophagectomy was accompanied by serious complications. There were two incidents of wound dehiscence,⁵⁷⁶ three returns to the Operating Theatre, and the patient had an extended stay in Intensive Care, commencing 6 June 2003. Ms Hoffman gave evidence that, whilst a patient would normally spend 2 to 3 days in intensive care post-operatively if this surgery went well, P18 was in the Intensive Care Unit at the Base for 14 days.⁵⁷⁷ She also gave evidence that there was an arrangement made to transfer the patient to a Brisbane hospital but that hospital required confirmation from Dr Patel, as the treating surgeon, that the transfer was warranted, and he declined, at least initially, to give that consent. By the time Dr Patel was amenable to that course, according to Ms Hoffman, the bed in Brisbane had been lost.⁵⁷⁸

3.197 By an email dated 19 June 2003,⁵⁷⁹ Ms Hoffman outlined her concerns to Dr Keating. The email relevantly read as follows:

I am writing to inform you of the situation that currently exists in ICU with the post-op patient, P18. As you are aware, P18 underwent an oesophagectomy on the 6th of June. He subsequently returned to theatre twice for wound dehiscence. He again returned to theatre last evening for repair to leaking jejunostomy. He remains ventilated on .55% Fio2 and 5 peep. He is becoming more haemodynamically unstable and has been commenced on inotropic support which is currently being increased. *I am writing due to my continuing concern over the lack of sufficient ICU backup to care for a patient who has undergone such extensive surgery.* Both the RBH and the PAH have expressed concern

⁵⁷³ Exhibit 226, GF19

⁵⁷⁴ Exhibit 226, GF19, letter of 11 June 2003

⁵⁷⁵ Exhibit 448, paras 318 and 319.

⁵⁷⁶ More will be said of wound dehiscence later. The word comes from the latin 'dehiscere' meaning 'to gape', and describes a post-operative wound opening up – either superficially or completely – and usually because of infection or poor closure technique. It is a relatively rare complication and Ms Hoffman gave evidence that she had only come across an incidence of dehiscence 'probably about once' in her career

⁵⁷⁷ It will be seen that the patient also had an extended stay in a Brisbane hospital

⁵⁷⁸ Exhibit 4, para 21

⁵⁷⁹ Exhibit 4, TH3

about this surgery being done in our facility without this backup. *There remains unresolved issues with the behaviour of the surgeon which is confusing for the nursing staff.* At present,, whilst there is consensus regarding transferring the patient to Brisbane, there are no beds to be found anywhere in the state. *I am very worried that this patients care has been compromised by not sending him to Brisbane on Tuesday, and whilst I realise it is easy to be wise in hindsight, and I do not wish to make an issue of this, I would like this to be noted.* I believe we are working outside our scope of practice, for a level one Intensive Care Unit.

The reality of the situation which currently exists in ICU is we now have an extremely ill patient who may or may not deteriorate further and the bulk of the responsibility for trying to liaise with the two teams has been left to a very junior (but excellent) JHO. The ongoing issues regarding the transfer of patients and the designated level of this ICU may need to be discussed at a later date. *The behaviour of the surgeon in the ICU needs also to be discussed, as certain very disturbing scenarios have occurred.* The current status is that we are awaiting a bed in a tertiary ICU.

[my emphasis]

- 3.198 Ms Hoffman was not alone in her concerns. Dr Keating's recollection is that it was at this stage that he was approached by Dr Joiner. His records suggest that the meeting occurred on the morning of 17 June 2003 and he recalls that Dr Joiner raised three issues. In the first place, he suggested that the Base's Intensive Care Unit could not give the intense, long term support that was needed for oesophagectomies. In the second place, he suggested – on the basis of medical literature – that a hospital could not maintain its competency with the procedures unless they were doing at least 30 each year. In the third place, he considered that the patient required transfer to Brisbane but he noted that Dr Patel was resisting that course.
- 3.199 As mentioned, Dr Patel eventually resiled from his position in relation to a transfer, and the patient was in fact transferred to the Mater Hospital in Brisbane on 20 June 2003. Soon afterwards, Dr Keating was also approached by the most senior intensivist there, Dr Peter Cook.⁵⁸⁰ Dr Cook gave evidence that, when his Hospital received P18, he became very concerned that a surgeon at the Base would be embarking on such a complicated operation, and he expressed that concern in a letter to the Executive Director of the Mater Public Hospital.⁵⁸¹ He also telephoned Dr Keating and his recollection was that he talked about the same issues raised in the letter.⁵⁸² He was concerned as to whether the Base had 'sufficient ancillary services' to give the post-operative care needed for such a complex operation. He also raised a query as to the 'accreditation of the surgeon'.
- 3.200 Dr Cook said that the operation report showed that the staff had identified palpable lymph nodes and this made him wonder whether surgery was ever an

⁵⁸⁰ T3013-5

⁵⁸¹ Exhibit 218, Appendix A2: the letter also makes clear that P18 remained in Intensive Care at the Mater in Brisbane until 30 June 2003. Ms Hoffman gave evidence that he died on 8 January 2004: T51

⁵⁸² T3015

appropriate option. Against that background, he queried with Dr Keating whether the treating surgeon was appropriately trained, and had adequate currency of experience, to perform the operation.⁵⁸³ Dr Cook said that he does not believe that he raised the issue of the lymph nodes specifically with Dr Keating. He recalled that he did tell Dr Keating that the very fact that a surgeon would consider the Base an appropriate place for this operation made him wonder about the surgeon's competence.⁵⁸⁴ Dr Cook gave evidence that, after the telephone conversation, he decided to document his concerns to Queensland Health because he was not convinced that the procedure would be proscribed.⁵⁸⁵

3.201 Dr Keating gave evidence that he spoke to Dr Cook on 1 July 2003 after Dr Cook had telephoned the District Manager in Bundaberg, Mr Leck.⁵⁸⁶ He conceded that Dr Cook raised concerns about oesophagectomies being carried out at the Base. Dr Keating said, by way of response, that he would raise the issue with the Director of Surgery (Dr Patel), the Director of Anaesthetics (Dr Carter)⁵⁸⁷ and the Credentials and Privileging Committee (which, of course, had not yet met, and would not meet for more than one year). Dr Keating says that he spoke to Dr Patel and Dr Carter and he took away from those conversations that oesophagectomies might proceed at the Base.

3.202 I accept that Dr Keating might quite properly have understood that Drs Patel and Carter considered that oesophagectomies might proceed at the Base. It seems unlikely that Dr Patel would have questioned his own judgment in proceeding with the operations for Mr Phillips and P18. Further, Dr Carter gave evidence that, at that time, he believed the surgery could be carried out at the Base by a competent surgeon and he had no reason to doubt Dr Patel's competence and confidence.⁵⁸⁸

3.203 It is, however, concerning that Dr Keating appears not to have responded to Ms Hoffman's email (even to identify the 'very disturbing scenarios' to which she referred)⁵⁸⁹ or returned to Dr Cook. It is also concerning that, since Dr Keating could not refer the matter to a Credentials and Privileging Committee,⁵⁹⁰ and did not otherwise seek the advice of an independent surgeon,⁵⁹¹ he had no way of knowing whether Dr Patel's decision to retain the patient for surgery was an appropriate one. There was, in my opinion, a distinct lack of vigour in his inquiries.

⁵⁸³ T3013; T3138

⁵⁸⁴ T3139

⁵⁸⁵ T3139

⁵⁸⁶ Exhibit 448, para 52

⁵⁸⁷ It should be noted that Dr Carter was not present at the Base when either of these oesophagectomies was performed: T3997

⁵⁸⁸ Exhibit 265, para 39

⁵⁸⁹ T6980; T53

⁵⁹⁰ T6980-81

⁵⁹¹ T6980

- 3.204 The oesophagectomies continued. Two more would be performed by Dr Patel at the Base (each with a terrible outcome) before the issue was re-visited.

Wound dehiscence

- 3.205 The next complaint about Dr Patel concerned his attention to cleanliness and emanated from the Base's Infection Control Co-ordinator, a registered nurse called Gail Aylmer⁵⁹². Ms Aylmer gave evidence that she was the Nurse Practice Co-ordinator for the Surgical Ward at the Base from 14 April 2003 to 11 May 2003. She said that, during this period, she would accompany Dr Patel on rounds but she observed that he would not wash his hands between examining patients, even if he was handling their dressings and touching their wounds.⁵⁹³ She said that she spoke to Dr Patel about the importance of adopting basic infection control techniques but his behaviour did not change.

- 3.206 Ms Aylmer became the Infection Control Co-ordinator on 2 June 2003 and, later that month, several nurses in the Department of Surgery commented that the incidence of wound dehiscence had been unusually high in the last couple of months. The word 'dehiscence', I should interpolate, comes from the latin verb *dehiscere*, 'to gape'. In medicine, it describes a phenomenon where a surgical wound comes undone. It may be a complete dehiscence, where the wound opens up all the way through the abdominal wall. It may be a superficial dehiscence where the fascia or skin comes undone. It may even be an inside out dehiscence, where the abdominal wall comes undone (so that the organs move through the breach) but the fascia remain intact. The Commission received evidence that the phenomenon is usually related to one of two causes, namely infection or poor wound closure technique.

- 3.207 Ms Aylmer testified that, when she made inquiries into the level of wound dehiscence in the Department of Surgery, she found that, whereas one might expect a 'run' of up to 2 or 3 incidents in a two month period, there were in fact 13 reported incidents.⁵⁹⁴ She addressed the issue in her report to the Leadership and Management Committee dated 7 July 2003, which read relevantly as follows:

Concern re high number of abdominal wound dehiscence since early May – currently investigating 13 patient charts at the moment ? technique ? fault with closure product used...would like to implement that all wound dehiscence in the future are automatically swabbed for culture (and sensitivity).

- 3.208 Ms Aylmer recalled that, shortly after the meeting, she compiled a report (which showed that the majority of wound dehiscence incidents were suffered by Dr

⁵⁹² Exhibit 59, para 1

⁵⁹³ Exhibit 59, para 6; T970

⁵⁹⁴ T975

Patel's patients) and provided the same to Dr Keating.⁵⁹⁵ Later that day, Dr Patel visited her with the report in hand.⁵⁹⁶ 'Ms Aylmer gave evidence that she was surprised and taken aback by the visit because she had expected that any communication would be between Dr Keating and her. She said that, although Dr Patel did not bring any patient records with him, he went through her report and offered explanations for each patient there recorded. Ms Aylmer gave evidence that she was in no position to argue with Dr Patel about the causes of particular cases, and she accepted his explanations.'⁵⁹⁷ 'On the following day, she sent Dr Keating an email saying that, upon investigating the 13 reported incidents, she had been able to exclude all but 4, and she had now discussed those remaining 4 with Dr Patel. 'She wrote in the email that Dr Patel had admitted to technique problems with two patients, and he gave 'very reasonable' explanations for the other two, so that she had 'no further concerns'.⁵⁹⁸ Her testimony, however, was that she was uncomfortable that she was put in the position of discussing this issue with Dr Patel when it could only really have been reviewed by another surgeon.⁵⁹⁹ It should be said that this discomfort was not manifest in the email.

Ian Fleming

3.209 The sixth complaint concerned a patient called Ian Fleming or P126, and was received on 28 October 2003. Mr Fleming gave evidence before the Commission that he had suffered from diverticulitis and diverticular disease since about 2001, and that he experienced symptoms of increasing severity. He met with Dr Patel in April 2003 and he conducted an operation known as a sigmoid colectomy on 19 May 2003. Mr Fleming gave evidence that he noted bright red bleeding with bowel movements after the operation, and told Dr Patel but he was discharged, in any case, on 22 May 2003. He returned to the Hospital on 28 May 2003, for the removal of the staples around the operative wound on his stomach. By that time, he said, there was swelling and a dark red discoloration around the wound, and he was in agony. Mr Fleming said that he showed and described his condition to Dr Patel, but Dr Patel told him he was fine. He removed the staples and told Mr Fleming, in effect, that he should get on with his life.⁶⁰⁰

3.210 Mr Fleming testified that, on the evening of 29 May 2003, the wound 'blew out', and he was immediately admitted to the Hospital. By that stage, the staff were recording that he was suffering from a wound infection and he noted that, whilst

⁵⁹⁵ Exhibit 59, para 12

⁵⁹⁶ T975

⁵⁹⁷ T976-7; T979

⁵⁹⁸ Exhibit 60

⁵⁹⁹ T1025; Exhibit 59, para 13

⁶⁰⁰ Exhibit 114, para 10

the nurses were keen to use a suction pump and wound dressings to drain the site, Dr Patel denied their requests. The wound did not heal, despite the use of antibiotics. Mr Fleming's evidence was that Dr Patel visited his bedside with an entourage of young doctors, and became agitated with the lack of healing to the wound. Mr Fleming testified that, shortly afterwards, one of three young doctors appeared at his bedside and said he had been sent by Dr Patel to 'fix this up'. He proceeded, said Mr Fleming, to separate the wound without anaesthetic.

3.211 Mr Fleming testified that he was discharged on 4 June 2003 but that his wound did not heal until August 2003 (and his abdominal pain did not stop at all). He said that he called the executive offices of the Base on 28 October 2003 to ask about how he might make a complaint in writing. The person receiving the call, 'Joan', said that complaints could be made over the telephone and she took a detailed message. Mr Fleming said that he made four complaints, namely that:

- (a) Dr Patel failed to diagnose the wound infection when the staples were removed;
- (b) Dr Patel failed to accede to the nurses' requests that a suction pump and special dressings be used;
- (c) No anaesthetic or pain relief was used when the wound was re-opened; and
- (d) He was still bleeding internally.⁶⁰¹

3.212 Mr Fleming said that he was called by Dr Keating two days later and the conversation commenced with Dr Keating introducing himself and saying, 'I hear you have lodged a complaint against Dr Patel. I must tell you that he is a fine surgeon and we are lucky to have him here in Bundaberg'. Mr Fleming said they spoke for 30 to 40 minutes, during which time Mr Fleming spoke to his four complaint headings but that Dr Keating was belittling and condescending.⁶⁰² Dr Keating testified that, from reading his notes of the conversation with Mr Fleming, he believes that they spoke primarily about the continued bleeding. A handwritten note of the first call, taken by the receptionist, reads in part 'Dr Patel performed operation. As a result of the operation, open wound, discharge, Dr Patel removed staple. Excruciating agony. Couldn't stand up. Nurse up there told him opinion incision blew open thurs. Fri nite. No anaesthetic. Open incision up...passing blood'. I find it extremely unlikely that Mr Fleming canvassed those issues with the receptionist but failed to discuss them with Dr Keating, and I note that Dr Keating does not put his position so highly. On balance, I accept that Mr Fleming did raise all four matters with Dr Keating on 30 October 2003.

⁶⁰¹ Exhibit 114, para 22

⁶⁰² Exhibit 114, para 29. Mr Fleming said that Dr Keating did arrange for him to attend a follow up consultation at the Base in relation to the bleeding problem.

Patient P198

3.213 The seventh complaint disclosed by the records was received on 21 November 2003. It concerned a patient identified as P198. He complained to Dr Keating that he had suffered swelling and bruising to his scrotum after Dr Patel performed an operation to repair an inguinal hernia. Dr Keating gave evidence to the effect that he considered this to be an accepted complication of the procedure and he did not seek Dr Patel's input in responding to the patient. Against that background, he said, he provided an explanation, reassurance, and a plan for review.

Dr Smalberger

3.214 The eighth complaint⁶⁰³ appears to be one that emanated from a young doctor at the Base called Dawid Smalberger. Dr Smalberger was registered as a specialist physician in his country of origin, South Africa, and moved to the Base in May 2003, to work in the Department of Medicine. He gave evidence that, late in that year, whilst he was working in the Department of Medicine at the Base, he had an altercation with Dr Patel which led to him making a complaint to Dr Keating. There was a patient (known before the Commission as P51) who was admitted to the Department with a heart attack. His haemoglobin was very low and, given that he had been involved in a truck accident in the previous weeks, Dr Smalberger considered that it was important to rule out trauma to the chest or stomach. He sent the patient for a chest x-ray and a CT scan and it seems that, whilst the patient was there, Dr Patel came across him. He called Dr Smalberger to say that he had studied the CT scan (although he was not invited to do so), believed that the spleen was in two pieces, and had determined to carry out a splenectomy.

3.215 Dr Smalberger was concerned that the patient would be at grave risk in any operation given that he had just suffered a heart attack, and he told Dr Patel so. He arranged to meet Dr Patel in the Intensive Care Unit and they studied the CT scan films there together but Dr Smalberger could see no evidence that the patient needed a splenectomy (and he considered that the patient's condition was entirely inconsistent with the diagnosis).⁶⁰⁴ He said that the patient did not need an operation but needed to be transferred to Brisbane for a coronary angiogram. He became very concerned when, as the discussion was continuing, an anaesthetist arrived and Dr Smalberger realised that Dr Patel had already made arrangements to operate. The patient had been admitted under Dr Smalberger's care and he refused to allow the surgery. He was considerably junior to Dr Patel and the refusal was not well received. At the foot of the

⁶⁰³ It seems that this complaint was made 'close to Christmas 2003': T1971

⁶⁰⁴ T1969-70

patient's bed, in the patient's hearing, and with nursing staff nearby, Dr Patel told Dr Smalberger that his opinion was the 'most stupid thing' he had ever heard.⁶⁰⁵

- 3.216 Dr Smalberger did not discuss the case further with Dr Patel. He arranged the transfer to Brisbane and the staff there subsequently confirmed that the patient's spleen was intact and that the angiogram showed severe stenosis of one artery, requiring the insertion of a stent.
- 3.217 Dr Smalberger said that he had never made a complaint about another doctor in his career but he was so concerned about Dr Patel's lack of clinical competence and his unprofessional conduct⁶⁰⁶ that he visited Dr Keating in his office and asked how he might lay a formal complaint. He gave evidence that he explained in detail to Dr Keating the clinical circumstances of his conflict with Dr Patel.⁶⁰⁷ In particular, he mentioned his concerns about Dr Patel intervening in the patient's case without invitation, and his apparent commitment to operating upon a patient with a heart problem.⁶⁰⁸ He said that Dr Keating listened and said he would raise the matter with Dr Patel. He did not ever tell him how to lodge a written complaint, nor did he ever return to Dr Smalberger with the results of the discussion but, Dr Smalberger said, he was approached by Dr Miach (who supported his position) and his relationship with Dr Patel improved.
- 3.218 Dr Keating gave evidence about this matter. He said that Dr Smalberger approached him with a concern that he had been treated poorly by Dr Patel and that he sought advice about how to re-establish a working relationship. He said that he told Dr Smalberger that the problem could be handled in one of three ways, and Dr Smalberger asked that the third course be adopted, namely Dr Keating approach Dr Patel on Dr Smalberger's behalf. Dr Keating said that he reminded Dr Patel of the need to treat colleagues fairly, and that he received no further complaints from Dr Smalberger. Dr Keating recalled that Dr Smalberger also complained about Dr Patel's interpretation of a CT scan but Dr Keating put this down to a 'professional difference of opinion'.⁶⁰⁹
- 3.219 The two versions of the conversation are not dramatically different, and it is unnecessary to state a preference. On any view, Dr Keating was informed of Dr Patel's dogmatic and unprofessional manner, and of the dispute as to the diagnosis disclosed by the CT scan. It is difficult to believe that Dr Keating was not also informed of Dr Patel's conduct in approaching the patient without solicitation, and in preparing for surgery in circumstances where it put the patient at risk and the diagnosis was not supported by any external signs. In my view, it

⁶⁰⁵ Exhibit 133, para 11; T1997

⁶⁰⁶ T1971

⁶⁰⁷ T1972; It should be noted that Dr Smalberger was not sure if, at the time of the meeting with Dr Keating, the results had come back from Brisbane, vindicating his position: T1988

⁶⁰⁸ T1997

⁶⁰⁹ Exhibit 448, para 181.

is clear at the very least that those things could have been ascertained by any level of inquiry.

‘Doctors don’t have germs’

- 3.220 The ninth complaint emanated from the Base’s Renal Unit. That Unit, it will be recalled, had been established during Dr Thiele’s administration. It was headed by an eminent nephrologist, Dr Peter Miach, and it seems to have been relatively stable in the sense that it had retained Dr Miach, and many of the nursing staff, for well over 5 years. The Nurse Unit Manager for the Renal Unit, Ms Robyn Pollock, gave evidence that she had occupied that position since 1998.⁶¹⁰
- 3.221 The Unit employed 7.3 full time nursing staff and they were mostly engaged in caring for patients receiving haemodialysis or peritoneal dialysis, as well as providing follow up for transplant victims.⁶¹¹ Wherever possible, it is understood, the Base would try to provide patients with the option of dialysis by catheter – that is, where fluids are introduced into the patient through a catheter surgically inserted in the peritoneum – because this dialysis could be managed by patients at home, and increased their independence.
- 3.222 Ms Pollock testified that, not long after Dr Patel arrived at the Base, he approached the Renal Unit offering his services in placing catheters, and he then began to visit the Unit regularly. There had been concerns for some time that Dr Patel did not observe proper standards of sterility when dealing with patients.⁶¹² This was an issue of particular sensitivity to the staff of the Renal Unit because, the Commission was told, chronic renal disease tends to suppress the body’s immune system. The issue came to a head on the morning of 25 November 2003. Two patients in the Renal Unit, known before the Commission as P52 and P53, who were having blood flow problems with the central line used for haemodialysis. The line was attached to each patient by means of a catheter which entered the neck, and led to the internal jugular vein. Dr Patel attended the Unit so that he might undertake the task of placing a guide wire into the catheters to dislodge any blockages. Three of the core nursing staff were working that morning, and they subsequently reported a number of concerns to Ms Pollock.
- 3.223 The nurses arranged the two patients on beds adjacent to each other, and they set up two trays of equipment between the beds. They had a number of issues with Dr Patel’s conduct. It seems he did not wash his hands before commencing the procedures, and ignored a request to do so. Indeed, he responded to the

⁶¹⁰ The formal title since March 2002 for the head nurse was Nurse Unit Manager: see Exhibit 70

⁶¹¹ Exhibit 70, para 4.

⁶¹² See, in particular, the evidence of Ms Aylmer set out above

nurse making the request that 'Doctors don't have germs'. He did agree to a request, however, to wear gloves.⁶¹³

3.224 When Dr Patel started the physical examination of the patients, he did not wash his hands, nor change gloves, between patients, nor did he observe the normal practice of replacing the bungs covering the catheters as soon as the procedures were completed to reduce the risk of infection. Further, having used a syringe on one patient and returned it to the patient's tray, he made to use the syringe on the other patient, until he was stopped by the nurses. Even then, the nurses subsequently related to Ms Pollock, Dr Patel seemed put out and said words to the effect of, 'I'm doing you a favour'.

3.225 The nurses completed an incident form, and Ms Pollock contacted the Base's Infection Control Nurse, Ms Aylmer, to discuss their concerns. The result was that Ms Pollock and Ms Aylmer made an appointment to see Dr Keating and met with him on 27 November 2003.⁶¹⁴ Ms Pollock related the matters set out above and Ms Aylmer, for her part, related other complaints she had received from staff concerning Dr Patel's attention to sterility. Ms Pollock gave evidence that Dr Keating said he would speak to Dr Patel about the incident in the renal unit but that it was difficult to do more in the absence of clear data that Dr Patel's patients were suffering, disproportionately, from infection. It seems that Dr Keating did speak to Dr Patel⁶¹⁵ but Dr Patel denied the nurses' version of events and subsequently ceased acknowledging Ms Pollock.⁶¹⁶

3.226 It is to be noted that the issue of Dr Patel's attention to sterility issues did not cease at this point. Ms Aylmer became aware that, contrary to what seemed to be accepted good practice, Dr Patel would leave the hospital buildings in his theatre attire so that he might smoke in the car park.⁶¹⁷ She also became aware that the theatre staff generally were wearing their theatre attire freely outside the theatre complex. She wrote emails to Dr Patel and Dr Carter on 5 and 15 November 2004 about a protocol, but she came to the view that, whilst Dr Patel was feigning support, he was undermining the process. By an email dated 3 February 2005, and copied to Dr Keating, Ms Aylmer wrote that she was concerned that staff were still wearing their theatre attire outside and then walking straight back into theatre, that she had received reliable reports that Dr Patel was disparaging about the new protocol (which was agreed in December 2004), and that she intended to post signs in theatre advising of the new requirements. Dr Patel did not respond.⁶¹⁸

⁶¹³ Exhibit 70, para 10

⁶¹⁴ Exhibit 70, para 13

⁶¹⁵ Exhibit 59, GA7

⁶¹⁶ Exhibit 70, para 16

⁶¹⁷ T998

⁶¹⁸ T997

Confrontation in the Intensive Care Unit

- 3.227 There was a further dispute or complaint concerning Dr Patel on about 8 March 2004.⁶¹⁹ One of the anaesthetists, was a doctor of South African origin called Dieter Berens. He testified that he moved to Bundaberg in January 2004 and had worked regularly from that time with Dr Patel. He said that he had some general misgivings about Dr Patel. He said that, whilst he was quite efficient with some procedures, his medical knowledge was not up to date, he could be aggressive with staff when operations were attended by complications, and he was not always entirely honest about problems.⁶²⁰
- 3.228 Dr Berens testified that there was a particular incident in which he was concerned by a decision made by Dr Patel to give blood to a certain patient in intensive care.⁶²¹ He testified that he confronted Dr Patel and asked him to explain the grounds for his decision, but Dr Patel declined to do so and said that the only person to whom he would be explaining himself was Dr Keating. The altercation became heated and Dr Berens walked out of the Intensive Care Unit, saying that Dr Patel could look after his own patients.⁶²² Dr Berens testified that, soon after this conversation, a Nurse McClure asked Dr Berens to return to treating patients in the Intensive Care Unit and he explained that, whilst he was upset with Dr Patel's continual interference, he was prepared to do that. Nurse McClure (who was apparently supportive of Dr Berens' position) said she would be informing Dr Keating of the situation. Dr Berens said that he was called to Dr Keating's office and he gave Dr Keating a 'rundown' of what had occurred.⁶²³ He said that he told Dr Keating about the subject of the dispute but was not asked to go into any detail.⁶²⁴ Dr Keating told him that he and Dr Patel should sort it out between themselves.⁶²⁵

Insertion of Peritoneal Catheters

- 3.229 As mentioned earlier, the Renal Unit at the Base offered haemodialysis and peritoneal dialysis. Evidence was received from the nurse in charge of peritoneal dialysis, Lindsay Druce. She testified that there would be 8 to 10 of these patients at any one time. She said that she was on maternity leave between November 2002 and November 2003 so that she did not meet Dr Patel when he first arrived at the Base. When she returned from leave and received a handover, however, she noted a number of problems with peritoneal catheters. She set about performing an exhaustive study of all patients who received

⁶¹⁹ Exhibit 448, para 79

⁶²⁰ Exhibit 128, para 6

⁶²¹ T1946

⁶²² T1946

⁶²³ T1915

⁶²⁴ T1954

⁶²⁵ Exhibit 128, para 9

catheters in 2003. She testified that what she discovered was that, for every single patient who had a catheter placed by Dr Patel in that year, there had been a complication.⁶²⁶

3.230 Ms Druce gave evidence that she approached Dr Miach to explain the problem and, in consequence, she commenced compiling a report on what she had found. She also spoke to Dr Patel, hoping to deal with the issue informally, but she said that he responded to her concerns by stating that he was the surgeon and walking out of the unit. In those circumstances, she continued working on the report.⁶²⁷

3.231 In the meantime, there was a tragic event. There was a patient known before the Commission as P30 who had received a catheter inserted by Dr Patel. The catheter had migrated and Dr Patel then conducted an operation to address the migration and insert a permacath. In the course of that operation, Dr Patel perforated the thoracic vein and the patient died.⁶²⁸ Ms Druce gave evidence that she was distressed by this development. No other patient had died at the Base from the insertion of a permacath, and in her opinion, the need for an operation and the poor outcome of the operation were both consequences of a lack of competence on Dr Patel's part.

3.232 In January 2004, Ms Druce told Dr Miach about the results of the death of P30. She also provided him with a copy of her completed report, entitled 'Peritoneal Dialysis Catheter Placements – 2003' ('the catheter report').⁶²⁹ The report took the form of a simple table, setting out the name of each patient, the name of the surgeon, the date the catheter was placed, the catheter problem; the ultimate outcome, the catheter position, and the nature of the infection. It showed that:

- (a) There were six peritoneal catheters placed at the Base in 2003 and they were all placed by Dr Patel;
- (b) Every patient had experienced problems in that the catheter had migrated (3), or become infected (2) or there was impaired outflow drainage (1);
- (c) Each of the catheters was placed sideways or upwards (whereas good practice is that the catheters are inserted facing downwards to increase drainage and reduce the chance of infection);
- (d) Three of the patients had required further surgical intervention, two had died and one required an intravenous drip for infection.

⁶²⁶ Exhibit 67, para 4

⁶²⁷ Exhibit 67, para 5

⁶²⁸ Exhibit 67, para 6

⁶²⁹ The report appears on the record as Exhibit 67, attachment LD1 and Exhibit 18

- 3.233 As mentioned above, the Director of Medicine at the Base was a physician called Peter Miach. Dr Miach was, on any view, an eminently qualified doctor. He had been a Fellow of the Royal Australian College of Physicians and a Fellow of the Royal Australasian College of Physicians since the early 1970's. He had spent some years carrying out research in the field of nephrology in both the Austin Hospital, Victoria, and a large nephrological hospital in Paris. He also had a Doctorate in Philosophy from the University of Melbourne. He had been a senior lecturer at the University of Melbourne and the University of Queensland and he had been an examiner and censor for the Royal College of Physicians (of which he was awarded a fellowship).
- 3.234 Dr Miach gave evidence that he had worked as the Director of Medicine at the Base since August 2000. He said that he had observed Dr Patel from the start of his employment in April 2003 and was alarmed by a number of matters. He related a number of incidents which caused him to doubt Dr Patel's competence. The matter concerning Dr Smalberger set out above was one such incident. It came to his attention because Dr Smalberger was one of his staff. The matter concerning P34 was another. Dr Miach gave evidence that it was generally not considered viable to perform major surgery such as an oesophagectomy on a patient with significant 'co-morbidities' – that is, unrelated medical problems. P34 had been Dr Miach's patient because of his renal problems. When he developed cancer in the throat, Dr Miach decided to seek a surgical opinion as to whether surgery was a realistic option so that he could advise the patient fully. He said he was extremely disturbed when Dr Patel proceeded to conduct an oesophagectomy, without returning to Dr Miach, much less providing an opinion.
- 3.235 There were a number of other incidents related by Dr Miach in his evidence. One concerned a patient called P33, an elderly man who was admitted with a heart attack. In the course of treatment for a renal problem, the staff had perforated his jugular vein, and Dr Patel then arrived in the ward, insisting that he should operate. The nursing staff then called Dr Miach to dissuade Dr Patel. He said he arrived at the patient's side, Dr Patel was still insistent. In Dr Miach's view, the patient was very unlikely to survive surgery with his heart condition. He told Dr Patel that he would not permit him to operate, and he told the staff to arrange a transfer to Brisbane after they had stemmed the bleeding non-surgically.
- 3.236 Dr Miach also related a disturbing incident in which he went to theatre to watch Dr Patel do a 'pericardial window'.⁶³⁰ When he arrived, he found that – contrary to usual practice – Dr Patel had not anaesthetised the patient, who was screaming in apparent pain.⁶³¹

⁶³⁰ This is an operation where the surgeon puts a hole into the pericardial space and drains that area

⁶³¹ Exhibit 21, para 86

- 3.237 Dr Patel had claimed, when he initially came to the Base, that he 'did everything'. As can be imagined, Dr Miach became increasingly sceptical of that claim. When he received the Catheter audit in January 2004, he acted quickly. In the first place, before he went on sabbatical leave that month, Dr Miach informed one of the locum doctors, a Dr Knapp, that if any renal patients needed surgery, he should 'stay clear' of Dr Patel. Dr Miach said that he had also informed Dr Strahan, Dr Smalberger, the Clinical Forum Meeting, and the nursing staff, at least by early 2004, that Dr Patel was not to operate on his patients. This was no idle comment. Dr Miach gave evidence that, as far as he was aware, Dr Patel did not operate on any of his patients whilst he was on leave. He said that he never referred another patient to Dr Patel even when he returned from leave.
- 3.238 In the second place, Dr Miach testified, he took the catheter report to the executive. He could not be sure whether he took this step before he left on leave, or after his return in April 2004, but he had a very specific memory of the event.⁶³² In any case, his evidence was that certainly by the later date he had delivered the report to Dr Keating. He said that he received no response and, when he raised the issue with him on 21 October 2004, Dr Keating questioned ever having received the report. Dr Miach said he provided it to Dr Keating again but that again he received no response.
- 3.239 Dr Keating gave evidence that he was not aware, at any time during Dr Patel's employment at the Base, that Dr Miach had declined to allow his patients to be operated upon by Dr Patel.⁶³³ I find that statement implausible for a number of reasons. In the first place, the matter was the subject of some conversation around the Base. Certainly, Dr Strahan, Dr Smalberger, Dr Gaffield, Ms Hoffman,⁶³⁴ Ms Pollock,⁶³⁵ Ms Druce,⁶³⁶ Dr Athanasiov and others, each gave evidence that they were aware of Dr Miach's directive. Ms Pollock also gave evidence that Dr Miach had reiterated his position on other occasions. She said that she was the minute taker at a Medical Clinical Services meeting held in June 2004 and attended by Level 3 nurses when Dr Miach informed the group that 'Dr Patel is not to operate on my patients'.⁶³⁷ It is extremely hard to believe that, in a 140 bed regional hospital, the fact that the Director of Medicine had prohibited the Director of Surgery from operating on his patients on the grounds of competence, had escaped the notice of management. This is all the more so given that the situation persisted from January 2004 until Dr Patel's departure in

⁶³² T292

⁶³³ Exhibit 448, para 119

⁶³⁴ Exhibit 4, para 48

⁶³⁵ Exhibit 70, para 20

⁶³⁶ Exhibit 67, para 17

⁶³⁷ It should be noted, however, that Dr Miach then told Ms Pollock, 'Don't minute that': Exhibit 70, para 21

April 2005. Certainly, a number of doctors gave evidence that they were aware at least of this: that Dr Miach would not send any of his patients to Dr Patel.⁶³⁸

3.240 In the second place, Ms Druce gave evidence that the renal unit nurses communicated the Miach directive to the Acting Director of Nursing, Patrick Martin, during a meeting on 10 February 2004. Mr Martin met on the same day with Dr Keating and, although it was denied by Mr Martin and Dr Keating, one suspects that Dr Miach's directive might have been discussed at the second meeting.

3.241 There was a third point. Dr Miach's stance necessitated a major administrative adjustment. It will be recalled that Dr Patel had been placing the peritoneal catheters for the Renal Unit. Dr Miach's refusal to allow Dr Patel to operate on his patients put the whole peritoneal dialysis programme in jeopardy. The position became even more dire when, whilst Dr Miach was on leave, 'Brisbane' declined to place the catheters, apparently on the basis that there was adequate surgical assistance for the task at the Base.⁶³⁹ Against that background, Ms Pollock and Ms Druce showed disarming ingenuity. Queensland Health has a contract with a company called Baxter Healthcare Pty Ltd, according to which the company supplies almost all the fluids that are used in peritoneal dialysis. I infer that the contract is quite a lucrative one.⁶⁴⁰ Ms Druce approached the Baxter representative and suggested that he take some action to ensure the proper placement of catheters in the future. Initially, the Baxter representative thought that Dr Patel might be sent to Brisbane for training but the idea was not pursued when it seemed that Dr Patel had little interest in the medical aspect of that excursion.⁶⁴¹

3.242 In March 2004, the Baxter representative suggested a solution based on a Western Australian model. In essence, Baxter would pay for the patients' out-of-pocket expenses in having the catheters inserted at a private hospital, but the patients would then return to the Base to participate in the peritoneal dialysis program. There would be no charge to the Base, and it effectively meant that patients at the Base were receiving private health care funding from Baxter.⁶⁴²

3.243 On 15 June 2004, there was a meeting attended by, amongst others, Dr Miach, Dr Keating, Dr Thiele, and the Baxter representatives, at which it was agreed that the patients would be sent to the Friendlies Hospital in Bundaberg and the procedure would be carried out, at Baxter's expense, by Dr Thiele. None of those who attended could recall Dr Keating being told that the reason for the

⁶³⁸ T2051, and see the evidence of Dr Carter

⁶³⁹ Exhibit 70, para 33

⁶⁴⁰ Ms Druce gave evidence that, to her knowledge, the 'consumables' per patient costs between \$2,000.00 and \$3,000.00 per month: Exhibit 67, para 24

⁶⁴¹ Exhibit 67, para 20

⁶⁴² Exhibit 67, para 27

arrangement was Dr Patel's incompetence but, as Dr Thiele noted, there had never been any other reason.⁶⁴³

- 3.244 Dr Keating also gave evidence (consistent with his comment to Dr Miach set out above) that he had never received the catheter report prior to 21 October 2004. He said further that, when he did receive it, the implications were not clear: although it set out 6 patients with complications, the size of the sample group was not entirely clear. In other words, the report did not inform Dr Keating whether the complications represented a 100% failure rate, or something less.
- 3.245 I must say, again, that I found Dr Keating's evidence implausible. The renal unit nurses gave evidence that they communicated their concerns about the peritoneal catheters independently of Dr Miach. Ms Druce had, of course, completed her report by January 2004⁶⁴⁴ and she then sent an email to Ms Pollock on 4 February 2004 requesting an appointment to discuss, amongst other things, the 'cessation of peritoneal dialysis catheter placement at Bundaberg Base Hospital'. It was as a result of that email that the two nurses met with the Acting Director of Nursing, Patrick Martin, on 10 February 2004.
- 3.246 Both nurses said that they discussed the catheter report with Mr Martin in some detail, and also informed him about Dr Miach's directive that Dr Patel not operate on the renal patients.⁶⁴⁵ Ms Druce said that she took the report with her to the meeting and they discussed its contents. She said the meeting ended with Mr Martin saying he would take the report and the other concerns to Dr Keating and Mr Leck. Mr Martin gave evidence that he did not recall the provision of a report at the meeting but he did recall general information being provided about the failure of tenckhoff catheters, that he communicated that information to Dr Keating, and that Dr Keating then said that the nurses would need to provide evidence to support their complaints.⁶⁴⁶ Ms Pollock said that she did receive an email from Mr Martin saying that Dr Keating needed more data but she asked Mr Martin what further information could possibly be provided about the six cases, and he did not answer.⁶⁴⁷
- 3.247 In short, not only was Dr Miach adamant that he gave Dr Keating a copy of the report in April 2004, but the two nurses were adamant that they had given the report to Mr Martin and provided him with a summary of its contents. That evidence was supported by Mr Leck who gave evidence that the catheter report appeared on his desk in or before June 2004 and he promptly discussed it with Dr Keating, who said it was not a concern.⁶⁴⁸ I do not accept Dr Keating's claim

⁶⁴³ I should mention that Ms Druce gave evidence that, with the introduction of the 'Friendlies' arrangement, there have been no migrations and there was reduced infection.

⁶⁴⁴ See Exhibit 67, para 16

⁶⁴⁵ Exhibit 67, Exhibit 70

⁶⁴⁶ Exhibit 139

⁶⁴⁷ Exhibit 70, para 32

⁶⁴⁸ T7223

that the meaning of the report was ambiguous. It did not suggest anywhere that the cases were randomly chosen. On the contrary, the report's title, 'Peritoneal Catheter Placements – 2003' suggests that it constituted an exhaustive list of placements and that view was confirmed by the notation below the six entries, being 'x6 Peritoneal Dialysis Catheter Placed 2003'.

- 3.248 In the end, it seems enough to say this, with respect to the catheter report: even if one accepts that the executive had not been given notice of the precise problem, it was certainly put on enquiry. Dr Keating acknowledged that Dr Miach informed him in late April or early May 2004 of his concerns about the peritoneal catheter placements by Dr Patel to support the Baxter proposal described above.⁶⁴⁹ Dr Keating maintained that he asked for more data and that, in fact, the catheter audit (which Dr Miach had himself received) was not forthcoming.
- 3.249 The matter came to a head on 21 October 2004 when Dr Miach and Dr Keating argued vigorously as to whether Dr Miach had provided Dr Keating with a copy of the catheter report.⁶⁵⁰ Dr Miach provided Dr Keating with a copy of the report on the following day. Dr Keating testified that the import of the document was not clear to him but that he did not return to Dr Miach for clarification. Instead, he informed Mr Leck that the 'data ...provided by Dr Miach in support of his concerns about Dr Patel's surgical expertise in the insertion of Tenckhoff catheters' was 'poor quality'.⁶⁵¹
- 3.250 Dr Keating also acknowledged that Mr Martin told him in February 2004 that the Renal Unit nurses were raising concerns about complications associated with peritoneal dialysis. He said that he asked for data 'to back up the concerns' and chose not to raise the matter with Dr Patel until that data was forthcoming.⁶⁵² Dr Keating acknowledged that, when Mr Martin communicated the nurses' concerns, he responded with a comment to the effect that, 'If they want to play with the big boys – bring it on'.⁶⁵³ Perhaps unsurprisingly, when Mr Martin relayed that comment to the nurses, they interpreted it as being less than supportive of their position.⁶⁵⁴ In any case, on any view, Dr Keating was notified by the Nurse Unit Manager of the Renal Unit, Ms Pollock, and the Director of Medicine, Dr Miach, that they were each concerned with Dr Patel's performance in relation to catheter placement.

⁶⁴⁹ Exhibit 448, para 204: It should be noted that Dr Keating maintains that the impact of this information was reduced by Dr Miach explaining that he had had problems with other surgeons in the past.

⁶⁵⁰ Exhibit 448, para 218

⁶⁵¹ Exhibit 448, DWK66

⁶⁵² T6951

⁶⁵³ Exhibit 448, para 202

⁶⁵⁴ Ms Pollock gave evidence that her recollection was that she had already provided Mr Martin with the six documented cases and she could not see what additional data could be presented: Exhibit 70, para 32

Geoffrey Smith

- 3.251 On 27 February 2004, a complaint was received from a Geoff Smith. Mr Smith was concerned, in particular, that Dr Patel had carried out a procedure to remove a large melanoma on Mr Smith's shoulder with local anaesthetic, knowing that local anaesthetic had little effect on Mr Smith. When Mr Smith made protestations of pain, Dr Patel declined to stop the procedure.
- 3.252 Dr Keating sent a letter of apology to Mr Smith and also, he said, counselled Dr Patel about his manner with patients.⁶⁵⁵

Vicki Lester

- 3.253 Ms Lester had certain procedures carried out by Dr Patel between September and December 2003 in circumstances where the treatment seemed clearly unsatisfactory. In particular, Dr Patel told her that certain pain was a result of a 'negative attitude' when there was, in fact, a physiological basis. Dr Patel had conducted an investigation and decided that there was no packing in a wound, but a subsequent x-ray ordered by the general practitioner showed that he was wrong.⁶⁵⁶ Further, when he operated on Ms Lester subsequently, he declined to use anaesthetic, and she experienced, she said, severe pain.
- 3.254 In March 2004, it was necessary for Ms Lester to undergo further surgery and she applied to Dr Keating for a patient travel subsidy so that she might have the procedure performed at the Rockhampton Base. He refused the application on the basis that the surgery was available locally, and Ms Lester paid for the trip herself. He made no attempt, he said, to ascertain whether Ms Lester's complaint regarding the wound packing was well-founded.⁶⁵⁷
- 3.255 In March 2005, Ms Lester had persisting problems and she complained to Dr Keating formally about Dr Patel. She never received a substantive response to that letter.

Patient P131

- 3.256 This patient made a complaint to Dr Keating on 2 July 2004. She was a 66 year old lady who had presented at the Base with an itchy breast. On her first visit, she was seen by Dr Gaffield who recommended a biopsy. When she returned for the biopsy, however, she was seen by Dr Patel who said it was unnecessary. He said she was suffering from eczema and prescribed steroid cream. Apparently when she came to the Base on an unrelated complaint, the doctor insisted on a biopsy and cancer was diagnosed in the breast. The patient

⁶⁵⁵ Exhibit 174, attachment GS1

⁶⁵⁶ T6954

⁶⁵⁷ T6955

complained that Dr Patel had failed to properly identify the problem but Dr Keating sent a letter saying that he thought the treatment was appropriate.⁶⁵⁸

The return of wound dehiscence

3.257 The Nurse Unit Manager of the Surgical Ward, Dianne Jenkin, gave evidence that, in April 2004, she became concerned that there was a high incidence of complete wound dehiscence in her ward. At a committee meeting held on 9 June 2004 (and attended by, amongst others, Dr Keating and Mr Leck), she provided a report on the topic. It suggested that all surgeons at the Base between January 2003 and January 2004 had at least one patient with wound dehiscence, but that there were many more for Dr Patel's patients.⁶⁵⁹ Dr Patel presented his own report to a committee meeting of 18 August 2004 (attended by Mr Leck). It showed that 9 of his patients had developed wound dehiscences and one patient had a major complication of a fistula near a colostomy, necessitating a 70 day stay at the Base. Ms Jenkin gave evidence that, at the meeting, Dr Patel contended that this incidence was 'within range' for a two year period. She stated that he did not produce any scientific data as to expected ranges. Moreover, the use of a two year period seemed dubious since he had only been employed 17 months earlier, and he had taken extended leave between April and August 2004.⁶⁶⁰ It was agreed that wound dehiscence would be recorded in the future through the adverse incident system, but otherwise, Ms Jenkin said, the matter was closed.⁶⁶¹

Linda Parsons

3.258 On about 4 September 2004, a patient called Linda Parsons sent a letter of complaint to the Base following an operation performed by Dr Patel on 15 March 2004. In that correspondence, Ms Parsons complained that the surgical staples were removed prematurely causing the wound to dehisce, that Dr Patel's junior had then packed the wound when it clearly required sutures, that Dr Patel's junior had failed to properly anaesthetise her when he subsequently administered stitches and that, when she later returned to the Base with an infection, she was not given adequate care or information.⁶⁶²

3.259 In response to her written complaint, Ms Parsons was called by a clerical person at the Base and asked to attend a meeting in the Executive section of the Base. She attended with a friend called Vicki Hall and they were met by Dr Nydam, the Acting Director of Medical Services at that time. Dr Nydam said that the junior

⁶⁵⁸ See Exhibit 448, para 338; Exhibit 225, GF19

⁶⁵⁹ Exhibit 494, DJJ7

⁶⁶⁰ Exhibit 494, para 53

⁶⁶¹ Exhibit 494, paras 54 and 55

⁶⁶² T 1733 – T1734.

doctor who had treated Ms Parsons may not have administered anaesthetic appropriately but he no longer worked at the hospital, and as such could not be counselled.⁶⁶³ Ms Parsons suggested that Dr Patel should be held responsible as the consultant in charge but Dr Nydam did not respond.⁶⁶⁴ Instead, Dr Nydam introduced Ms Parsons to the Infection Control Nurse, Ms Aylmer, who had not been briefed on Ms Parsons' circumstances, nor provided with her file. Ms Parsons gave evidence that Dr Nydam's manner at the meeting was condescending and dismissive.⁶⁶⁵ She did, however, receive a letter from Dr Nydam, apologising for what he described as 'sub-optimal care'.⁶⁶⁶

P127 and P15

3.260 These patients were the subject of adverse incident forms on 20 August 2004 and 29 October 2004, respectively. Dr Keating said he understood the matters were to be reviewed at an Errormed meeting and that satisfied him.⁶⁶⁷ The first incident concerned a wound dehiscence. The second incident was remarkable in that the adverse incident form was completed by Di Jenkin, the Nurse Unit Manager of the Department of Surgery, and she put the risk rating as 'high'. The patient underwent a routine operation for removal of gallstones by keyhole surgery (a laparoscopic cholecystectomy) but then experienced a number of complications requiring a return to the Operating Theatre and a prolonged stay in the Intensive Care Unit. Ms Jenkin wrote in the adverse incident form 'surgical technique?' Dr Keating said that it did not require investigation by him in the first instance because that could be done by the Errormed Committee but, as he was aware, Dr Patel sat on the Committee.⁶⁶⁸

Marilyn Daisy

3.261 The next complaint was received in November 2004 from a senior vascular surgeon in Brisbane, Jason Jenkins. Dr Jenkins gave evidence that he had a confrontation with Dr Patel in the course of 2004. He became aware (from the transfer of patients from the Base to Brisbane) that Dr Patel was doing a measure of vascular surgery, and he came to the view, from observing and treating some of those patients, that Dr Patel was working beyond his level of competence. He said that he was particularly concerned for renal access patients because if the surgery is managed badly, they have reduced options for dialysis in the future. Dr Jenkins said that he approached Dr Miach to voice his

⁶⁶³ Exhibit 106 para 25. In fact, the junior doctor was merely on leave but it seems Dr Nydam made no inquiries into that issue.

⁶⁶⁴ Exhibit 106 para 25

⁶⁶⁵ In this evidence, Ms Parsons was supported by Ms Hall: T1730, T1787

⁶⁶⁶ Exhibit 106 para 27

⁶⁶⁷ Exhibit 448, paras 339 and 340.

⁶⁶⁸ T6961

concerns but was told – to his amazement - that Dr Patel was difficult to stop because he tended to ‘find’ patients in wards and operate without consulting Dr Miach.⁶⁶⁹ Dr Jenkins said that this amazed him because the practice of operating on a patient without first gaining the permission of the primary carer breached a clear protocol within hospitals.⁶⁷⁰

- 3.262 A particular incident caused Dr Jenkins to write a formal letter to Dr Miach on 2 November 2004, and copy the same to Dr Patel.⁶⁷¹ There was a patient who was a 43 year old lady with severe diabetes with renal problems. She was referred to Dr Jenkins for dialysis but he noticed that one of her legs had been amputated and the stump was still bandaged. The patient told Dr Jenkins that the operation had been performed 6 weeks earlier. On examination, he noticed that the stump was still healing. He was deeply concerned by a number of aspects of the lady’s treatment. His letter read in part:

I was astounded when I discussed with Marilyn about when did she have her left below knee amputation and I understand she was quite unwell and this was a life saving procedure...but she still has sutures in her amputation stump six weeks following the procedure. I find it mind boggling that someone could leave sutures in for this long. ...I think if procedures can't be performed appropriately within the Bundaberg Hospital then they should not be performed at all of if they are performed, then they should be followed up appropriately.

- 3.263 Dr Keating said that, on 8 November 2004, Dr Miach provided him with the letter without comment. He said that the patient had been reviewed once by the surgical team whilst she was in the Renal Dialysis Unit but he could not explain why she had not been reviewed again. It appears that Dr Keating did not take the matter any further.⁶⁷²

Desmond Bramich

- 3.264 Mr Bramich was admitted to the Base on 25 July 2004, suffering a crush injury after a caravan fell upon him. His condition stabilised and then improved so that he was talking freely and walking around. There was a sudden deterioration, however, at about 1pm on 27 July 2004, and Drs Gaffield and Patel provided treatment until Mr Bramich died ten minutes after midnight.
- 3.265 The death of Mr Bramich caused major controversy within the Base, and was the subject of considerable evidence before the Commission. In summary, there was a view that Mr Bramich should have been transferred to Brisbane early on the day of 27 July 2004, and that Dr Patel inappropriately declined to allow that transfer. There was also a view that Dr Patel had carried out a particular

⁶⁶⁹ Exhibit 254, para 9

⁶⁷⁰ It should be said that this complaint about Dr Patel was raised by Dr Miach, Dr Smalberger and Dr de Lacy and Dr Strahan.

⁶⁷¹ Exhibit 17

⁶⁷² Exhibit 448, para 199

procedure, known as a pericardiocentesis inappropriately and unnecessarily. Finally, there was a view that Dr Patel behaved unprofessionally towards Ms Bramich.

3.266 Dr Keating was apprised of the staff's concerns through a number of routes. He acknowledged that Dr Carter, the Director of Anaesthetics, approached him shortly after the death, and suggested that the patient's management be audited. He acknowledged that he also received, on about 2 August 2004, an Adverse Event form from a nurse called Karen Fox⁶⁷³ and a Sentinel Event form from Ms Hoffman. The latter included a very detailed two-page letter explaining problems the Intensive Care Unit was experiencing with Dr Patel. In particular, she wrote that:

- (a) Dr Patel had created a culture of fear and intimidation in the Unit;
- (b) On several occasions, Dr Patel has blocked the transfer of patients to Brisbane, even when they have stayed in the Base's Intensive Care Unit for more than 48 hours and a bed has been made available in Brisbane;
- (c) Dr Patel was doing operations which needed more post-operative support than the Unit was able to give;
- (d) All these problems had affected the care for Mr Bramich.⁶⁷⁴

3.267 Dr Keating testified that he carried out some preliminary investigations into the incident and decided there were clinical management problems as well as personality conflicts. He said he planned to meet with the relevant staff to discuss how the problems might be prevented. Those meetings had not occurred by 22 October 2004 (when a more wide ranging complaint was made by Ms Hoffman about Dr Patel), and Dr Keating said he was directed by Mr Leck not to take any further action on the Bramich review. He took that course.⁶⁷⁵

Gerardus Kemps

3.268 Mr Kemps was a 77 year old man who presented to the Base in December 2004 with a lump in his throat which was impeding him from eating. The evidence, in short, was that Dr Smalberger saw him in the Department of Medicine and took the view that he had a large cancerous mass in his oesophagus and that the cancer had spread to other parts of his body. He considered that the patient needed to be transferred to Brisbane where the staff might consider palliative care such as chemotherapy, and the laparoscopic introduction of a stent to assist with swallowing. Dr Smalberger understood that 'Brisbane' would not accept the transfer without the approval of the Bundaberg surgeons and he sent Mr Kemps

⁶⁷³ Exhibit 448, para 135, Exhibit 162, annexure LTR9

⁶⁷⁴ Exhibit 4, annexure TH16

⁶⁷⁵ Exhibit 448, paras 132 to 160

to the Department of Surgery for that purpose. Unfortunately, Dr Patel simply proceeded to carry out an oesophagectomy and by the time Dr Smalberger was aware of the development, Mr Kemps was dead.

- 3.269 Dr Keating says that he first heard about the operation when he received an email from Mr Leck on 21 December 2004⁶⁷⁶ which read:

Hi Darren,

The Oesophagectomy concerns me somewhat. Have any of these patients survived?

Peter

Mr Leck could not recall ever receiving any response to that email, nor pressing Dr Keating for such a response.⁶⁷⁷

- 3.270 The anaesthetist involved in the operation was Dieter Berens and, soon afterwards, he spoke to Dr Carter to say that he and others involved in the operation had some concerns about how it was conducted.⁶⁷⁸ The pair then met with Dr Keating and Dr Berens outlined the concerns of the theatre staff as to Dr Patel's conduct, and his own view that perhaps the matter should be referred to the Coroner. Dr Berens said that Dr Keating effectively said it was a matter for Dr Berens whether he chose to report the matter. Dr Keating, he said, showed no interest in investigating himself. Dr Berens and Dr Carter, for their part, learnt that Mr Kemps had already been buried and they decided against a referral to the Coroner on the basis that it would cause the family too much distress. In the event, they did not take the matter further.

- 3.271 On 14 January 2005, three nurses involved in Mr Kemps' care, namely Katrina Zwolak, Damien Gaddes, and Jenelle Law, lodged individual complaints with the Director of Nursing about the care that Dr Patel had provided to Mr Kemps. The Director of Nursing provided those complaints to Mr Leck but it seems no action was taken other than to provide them, in turn, to those who subsequently conducted a general clinical audit of the Department of Surgery at the Base.⁶⁷⁹

Patient P26

- 3.272 On 23 December 2004, that is two days after the death of Mr Kemps, a 15 year old boy, known before the Commission as P26, was flown to the Base. He had fallen from a motorbike and suffered an injury to his femoral vein, from which blood was being lost very rapidly. Dr Patel operated immediately to ligate the femoral vein. The blood loss was stemmed and the boy's life was saved. An

⁶⁷⁶ Exhibit 448, annexure DWK75; Exhibit 470

⁶⁷⁷ T7172

⁶⁷⁸ There were really two separate, but related, issues concerning Mr Kemps. In the first place, as Dr Smalberger and other testified (Exhibit 133), he seemed to be an entirely unsuitable candidate for an oesophagectomy. In the second place, the operation itself seemed to have been managed very badly.

⁶⁷⁹ Exhibit 448, para 300. Exhibit 281, attachment 4. The audit is discussed below.

issue arose, however, about the subsequent treatment given the boy. In the course of the next 12 hours, it was noted that he continued to suffer from ischaemia (that is, a lack of blood) to his left leg, and Dr Patel conducted two further operations. Further, it seems, when Dr Patel went on holidays on 26 December 2004, the boy remained at the Base and, indeed, was not transferred to Brisbane, and the care of a vascular surgeon, until 1 January 2005. When he was transferred, he was suffering an acute fever and a very bad infection. The vascular surgeons at the Royal Brisbane determined that the boy's life was at risk anew, and they amputated his left leg through the knee.⁶⁸⁰

- 3.273 The transfer of the patient from the Base to Bundaberg had been overseen by an experienced Emergency Medicine specialist in Brisbane, Stephen Rashford. He gave evidence that he was shocked that such a young patient with such a major vascular condition would remain at the Base, after three operations, for nine days. Dr Rashford testified that he went in person to see the boy upon his arrival in Brisbane and he was aghast at his condition. Dr Rashford said he slept on the issue for a night, but still found himself upset on the next day at the care the boy had received.
- 3.274 On 4 January 2005, Dr Rashford sent Dr Keating an email. He also sent the email to Mr Leck and to the zonal manager, Dan Bergin. The email ran for two pages. It gave the history of the case and explained that, on arrival in Brisbane, the boy had 'an ischaemic left leg – blue, cold and blistered. All the wounds were purulent. He had spiked fevers to 40C and had a HR of 140/min in flight'. Dr Rashford suggested that the 'role of earlier transfer needs to be assessed' and asked that his chart and management be examined.
- 3.275 Dr Keating gave evidence that the zonal manager requested a report on the incident and that Dr Keating provided one on the following day, 5 January 2005, concluding that 'ideally, patient should have been transferred to RBWH when stable on or about 25-26 December 2004' and that 'BHSD will institute a policy of transfer to tertiary facilities of patients with emergency vascular conditions when condition is stable (ie, life and limb are safe)'. Curiously, the report was prepared without speaking to Dr Patel (who was still on holidays) or the Brisbane vascular surgeons, and there was no evidence that Dr Keating ever formalised a new policy.⁶⁸¹
- 3.276 When Mr Leck provided the report to the zonal manager on 5 January 2005, he wrote that Dr Keating was 'not sure in the circumstances that an external review is warranted'. Mr Bergin responded on 7 January 2005:

Could there please be discussions between relevant staff of Bundaberg and RBWH HSD's to ensure in future the timely transfer of patients who require

⁶⁸⁰ Exhibit 254, Exhibit 208

⁶⁸¹ Exhibit 448, para 173

specialist vascular and other care not available in Bundaberg so as to improve patient outcomes. Please let me know of any unresolved difficulties in this regard.⁶⁸²

- 3.277 A complaint was also made about P26's care by one of the surgical ward nurses, Michelle Hunter,⁶⁸³ to the then Director of Nursing, Linda Mulligan. Her correspondence, also dated 4 January 2005 was directed more squarely to Dr Patel's role. It read in part:

My concerns are with the surgeon that performed his initial 3 operations whilst in the care of the Bundaberg Health Service. I am concerned that if the patient had been transferred to Brisbane initially he may not of lost his leg or be in such a grave condition (sic). I would like his treatment at this hospital investigated as I fear his health and well being has been compromised by inadequate, sub standard treatment by the medical team.

- 3.278 Ms Mulligan wrote back that she had referred the matter to Mr Leck, but Ms Hunter never heard anything further.⁶⁸⁴ It seems that no further action was taken on that complaint other than to provide it later to those conducting the clinical audit.⁶⁸⁵

Conclusion

- 3.279 It follows that staff or patients made over 20 complaints about Dr Patel in the course of his 24 month term at the Base.⁶⁸⁶ They vary, of course, with respect to the seriousness of the circumstances and the formality with which they were made. It was clearly unacceptable, however, that by January 2005 there had been no audit or inquiry into Dr Patel's skills by a doctor, let alone an independent general surgeon. One is struck by the sheer consistency of the complaints. They begin, as set out above, with an incident six weeks after Dr Patel commenced at the Base, when he performed a procedure to a patient for which he was not admitted, and they end with a failure to transfer the young patient, P26, in circumstances where his condition had required major vascular surgery.
- 3.280 The gravity of some of the complaints is immediately apparent. There was an approach by the most senior intensivist at a tertiary hospital in Brisbane; there was strident criticism from the Nurse Unit Manager of the Intensive Care Unit; there was a Director of Medicine who, on any view, was making novel arrangements to accommodate perceived incompetence by the Director of Surgery; there were approaches from doctors providing the anaesthetic services, namely Dr Joiner, Dr Carter and Dr Berens; and there were issues raised by a

⁶⁸² Exhibit 210, SJR4

⁶⁸³ Exhibit 141

⁶⁸⁴ Exhibit 141

⁶⁸⁵ Exhibit 281

⁶⁸⁶ In fact, the situation is slightly worse because Dr Patel took extended leave from April to August 2004: see the evidence of Ms Jenkin in Exhibit 494, para 53

senior vascular surgeon in Brisbane, a senior patient retrieval expert, and the Nurse Unit Manager of the Department of Surgery.

- 3.281 One is struck by two other matters when considering this history. The first is that the evidence of Dr Keating, and the evidence of the other witnesses, strongly supports a conclusion that management persistently downplayed complaints about Dr Patel. Where clinical problems were raised, the Base's Executive was quick to classify them as 'personality conflicts'. It was very reluctant to initiate any investigation into clinical decisions and, in some cases (eg, the challenge to the Renal Unit nurses to 'bring it on'), seems to have been quite obstructive.
- 3.282 The second feature is that the Commission heard much evidence from witnesses that problems that were not communicated to management because it was perceived as being unresponsive.⁶⁸⁷ That view is hardly surprising. Against that background, one can speculate with some confidence that, if the Executive at the Base had set out to ascertain the level of satisfaction with Dr Patel, they would have identified significantly more complaints.

The virtues of Dr Patel

- 3.283 It should not be thought that Dr Patel's time at the Base attracted only criticism. There were, as one might expect of a doctor who held a senior office for two years, many positive qualities that witnesses attributed to him.
- 3.284 In the first place, he was a prodigious worker. During his term, he saw over 1,450 patients in the course of 1,824 admissions.⁶⁸⁸ He operated on approximately 1,000 patients and he conducted some 400 endoscopic procedures.⁶⁸⁹ Staff attested to the fact that Dr Patel worked tirelessly.⁶⁹⁰ One principal house officer, Dr Kariyawasam, told how Dr Patel would book five patients per day for surgery and, if the surgical team fell behind schedule, they would work late rather than cancel operations.⁶⁹¹ He said that, from time to time, Dr Patel would organise 'blitzes' on particular procedures so that for instance, in one week, he performed 15 gallbladder operations.⁶⁹² He said that Dr Patel prided himself on the speed and the volume of his surgery,⁶⁹³ and on his ability to reduce surgical waiting lists.⁶⁹⁴ Dr Patel would actively liaise with theatre staff to ensure his patients received treatment as quickly as possible. Dr

⁶⁸⁷ See for example, Exhibit 59, para 42

⁶⁸⁸ Exhibit 102, page 26

⁶⁸⁹ Exhibit 102, page 26

⁶⁹⁰ See, for instance, the evidence of Dr Kariyawasam

⁶⁹¹ Exhibit 221, paras 12 to 18

⁶⁹² Exhibit 221, para 16

⁶⁹³ Insert references including the Gaffield stuff and the Berens stuff. See Exhibit 221, para 13

⁶⁹⁴ Exhibit 221, para 14

Kariyawasam said his time at the Base was the busiest of his surgical experience.⁶⁹⁵

3.285 Dr Patel implemented protocols to ensure that the Day Surgery Unit was operating at maximum capacity.⁶⁹⁶ He sat on a number of committees and he accepted an appointment as the accountable officer of Operating Theatres, which carries certain administrative responsibilities (and no extra remuneration).⁶⁹⁷ He would attend the Base each morning at 7.00 a.m. and he would conduct ward rounds well before most rostered staff had arrived.⁶⁹⁸ He arranged the theatre roster so that maximum operations could be conducted and he was happy to assume responsibility for operating lists where another surgeon was called away.

3.286 Further, it seems that Dr Patel was keenly aware of the means by which the Base was funded and he worked to maximise that funding. More will be said of the funding arrangements later in the Report, but it suffices to say a couple of things here. In the first place, Queensland Health sets down elective surgery targets for public hospitals and adopts a policy of reducing funding for those hospitals who do not reach their target. In the second place, where a hospital has treated a patient, the remuneration or credit allowed by Queensland Health for that treatment is determined by a system based on 'weighted separations'. That is, there are people who work out, by reference to a code, the complexity and expense involved in a given procedure and the hospital is given acknowledgment accordingly. Dr Berens gave evidence that Dr Patel could indicate the 'weighted separation' of a particular procedure, and numerous witnesses gave evidence that he constantly expressed to staff how valuable he was to the Executive in terms of reaching elective surgery targets. That view seems to be confirmed by a number of things. In the first place, even when the Executive were expressly informed of Dr Patel's comments about his value, it did not disabuse staff of their veracity.⁶⁹⁹ In the second place, when the District Manager eventually spoke to the Audit and Operational Review Branch of Queensland Health about involvement in an investigation, the Branch officer recorded that Mr Leck 'stated that the District needed to handle this carefully as Dr Partell (sic) was of great benefit to the District and they would hate to lose his services as a result of this complaint'.⁷⁰⁰ Thirdly, the contribution of Dr Patel to the Base was made clear by the statement tendered of Dr Keating:

When Dr Patel arrived at the hospital it was struggling to achieve its elective target. In the past, the Hospital had failed to achieve the elective surgery target resulting in a reduced funding allocation for the next financial year. There was

⁶⁹⁵ Exhibit 221, para 13

⁶⁹⁶ Exhibit 230

⁶⁹⁷ Exhibit 448, para 22

⁶⁹⁸ See the evidence of Dr Carter

⁶⁹⁹ See the cross-examination of Dr Keating about the letter of 22 October 2004, and see Exhibit 4, TH10

⁷⁰⁰ Exhibit 225, GF10

also significant pressure to reduce the size of elective surgery waiting lists. This pressure arose in the form of increasing overall time spent by patients on the waiting lists, increasing numbers of people on the waiting lists and numerous complaints by patients' relatives and local Members of Parliament.

Elective surgery encompasses virtually all surgery other than emergency surgery for acute surgical conditions (such as injuries sustained in motor vehicle accidents) or severe immediately life threatening conditions...

Dr Patel appeared to have an understanding of these multiple pressures and worked hard to reduce elective surgery waiting lists. In conjunction with ...Dr James Gaffield, he also assisted in the reduction of the outpatient waiting lists, being those patients waiting to be seen by a surgeon for an opinion as to future treatment. Many of these patients had been on the waiting list for 2 to 3 years. There was no financial benefit to the hospital in reducing these waiting lists...⁷⁰¹

- 3.287 The extent to which the matter of elective surgery targets influenced decision-making within the Base - and made Dr Patel particularly important - can perhaps best be gleaned by an email from Dr Keating to some of the theatre staff on 8 February 2005.⁷⁰² It read relevantly:

At the present time, BHSD is 92 wtd separations behind target. The target is achievable. BHSD must achieve target – for many reasons including financial (over \$750,000 per year), ability to undertake range of operations, new equipment for OT, repair of equipment in OT, education and training staff.

Should the target not be achieved, BHSD will not get another chance to upgrade the target and hence lose flexibility and significant dollars (with increased scrutiny of all dollars spent in OT). Therefore it is imperative that everyone continue to pull together and maximise elective surgery thruptut until Jun 30. All cancellations should be minimal with these cases pushed thru as much as possible.

To this end, as per draft policy, all elective surgery cancellations are to be discussed by Dr Patel, Dr Carter, Muddy and A/NUM OT. Should there be a problem, the final decision will be made by me...

- 3.288 Whilst, as will be seen later, those independent surgeons who evaluated Dr Patel's work considered he fell well below the standard of a reasonable surgeon, it will be seen also that he was not without skill, intelligence, and an aptitude for learning, and might well have thrived in a larger hospital where he was closely supervised.⁷⁰³ Dr Carter, the Director of Anaesthetics at the Base throughout Dr Patel's term, thought that Dr Patel was a reasonable surgeon.⁷⁰⁴ He said that when Dr Patel was doing routine work, his standard of surgery was 'as good as anybody who had been there previously'.⁷⁰⁵ Dr Carter indicated that it was not

⁷⁰¹ Exhibit 448, paras 24 to 26

⁷⁰² Exhibit 72. Dr Keating denied that the Base was wholly dependent on Dr Patel's surgery, and in particular, upon his complex surgery. 'I think he only did 20% of the elective surgery work and that in fact I think we did four oesophagectomies and a couple of Whipples and I think the number, the weighting for those is very small and we are talking about a large [elective surgery] target. ...If you are talking about weighting, joint replacements are far better value and in fact that's where we were concentrating our efforts.' T6869

⁷⁰³ See the summary of Dr Woodruff's evidence

⁷⁰⁴ T4004

⁷⁰⁵ T 3980

until December 2004 - when the fourth oesophagectomy resulted in Mr Kemps' death - that he lost confidence in Dr Patel.

3.289 There was also evidence from patients that Dr Patel could be an engaging force. One patient, Ian Fleming, testified that at their first meeting, Dr Patel was 'charming' and 'very confident' and that he was a 'powerful personality'.⁷⁰⁶ Mr Kemps widow testified to like effect. She said that the family had already been advised that Mr Kemps would be transferred to Brisbane when Dr Patel arrived in the ward, introduced himself as the 'Chief of Surgery', and indicated he would be performing keyhole surgery. Mrs Kemps said that they did not question Dr Patel because he seemed to know what he was talking about.⁷⁰⁷

3.290 Evidence of Dr Patel's ability to exude confidence and charm was also received from the nurses. Certainly, it seems, he could be impressive. It is noted that, in September 2003, the position of Academic Co-ordinator – Surgery at the University of Queensland's Central Queensland campus was advertised. There were two applicants for the position, Dr Patel and Dr de Lacy, and even though the latter was a fellow of the College with relevant Australian academic and surgical experience, the members of the selection panel apparently chose Dr Patel unanimously after the candidates gave addresses and answered questions.⁷⁰⁸

3.291 Perhaps the greatest of Dr Patel's attributes was his energy in working with younger doctors. A Dr Athanasiov, who was a Junior House Officer at the Base in 2004 gave evidence that, whereas the Base executive showed little interest in ensuring the professional development of junior doctors or listening to their concerns, Dr Patel was one of the doctors who was very supportive. He said that Dr Patel could be abrupt and abrasive but he would consider alternative viewpoints: it was just that 'you had to phrase your suggestion or your viewpoint in a certain way for Dr Patel to consider it'. Dr Athanasiov said he felt comfortable to ask questions and seek guidance from him.⁷⁰⁹ He testified:

[Dr Patel] put in a lot of effort with teaching, both informal teaching and formal teaching, and he always made himself available to provide assistance and advice. When he was on-call, you could call him at any time of day or night and he was always prepared to come in and help if you were out of your depth. And even if he wasn't on call and the other consultants felt like they needed help, then he would come in and help. So in that sense he was a good assistance to the junior staff just by being constantly present and providing us with assistance. ..He did informal teaching on ward rounds and on a case to case sort of basis where he would talk about what the problem with the patient was and management of the patient. He also took tutorials where he taught general surgical principles and he also had formal tutorials with the medical students as I understand.

⁷⁰⁶ Exhibit 114

⁷⁰⁷ Exhibit 126, para 7

⁷⁰⁸ See the evidence of Dr Keating in Exhibit 448, para 29, who was one of the three members of the selection panel:

⁷⁰⁹ Exhibit 142, paras 13 to 16

3.292 Dr Athanasiov's comments above were endorsed by Dr Kariyawasam. He said that Dr Patel would be available to junior staff whether it be on week days or weekends, working hours or the middle of the night.⁷¹⁰ Further, when Dr Patel's position came under some challenge in January 2005, Dr Kariyawasam signed an open letter prepared by Dr Athanasiov, drawing attention to the support and assistance' and the 'direction and advice' that Dr Patel had freely given.⁷¹¹ Dr Athanasiov and three other junior doctors also signed the letter.

'Splendid Isolation'

3.293 The expert evidence received by the Commission (and discussed later) showed that, in a number of respects, there were some serious shortcomings in Dr Patel's work. That begs the question, of course, as to how Dr Patel managed to maintain his position for so long. Part of the answer may lie in the fact that, whether by design or careful management, Dr Patel adopted a number of practices which reduced any scrutiny of his work.

3.294 In the first place, he dealt very severely with those around him who directly challenged his level of care. This was a constant theme in the evidence. Dr Berens, the anaesthetist, gave evidence, of course, about a vigorous discussion over a clinical issue, which ended with Dr Patel refusing to acknowledge Dr Berens. Dr Smalberger gave evidence, as canvassed earlier, about Dr Patel commenting, in front of nurses and the patient, that Dr Smalberger's opinion (which was later vindicated) was the 'stupidest thing he had ever heard'. A junior doctor, David Risson, gave evidence about sending a patient to Brisbane for treatment when unbeknownst to him, Dr Patel had intended that the patient be transferred for purely diagnostic purposes only. He said that when Dr Patel discovered what he had done, he became abusive and told Dr Risson to report to Dr Keating so that he could be re-assigned. Dr Joyner gave evidence that Dr Patel refused to speak with him after a difference of opinion and Dr Martin Strahan gave evidence that he arranged the transfer of a surgical patient to Brisbane in circumstances where he thought it might attract Dr Patel's ire and had some concern for his own safety.⁷¹² Nurses Hoffman, Aylmer, Druce and Pollock all described events in which they had raised issues with Dr Patel and he had subsequently refused to speak with them (sometimes for months and in the face of compelling clinical reasons for communication).

3.295 Dr Keating conceded that he was aware of a perception amongst staff that Dr Patel was 'arrogant, abrasive, rude and potentially abusive'.⁷¹³ He expressed that opinion on 4 January 2005 in a formal record but, of course, it was hardly

⁷¹⁰ Exhibit 221, para 29

⁷¹¹ Exhibit 142, ARA4

⁷¹² Exhibit 232

⁷¹³ T6874, T 6884

fresh. Ms Hoffman had complained as early as June 2003 not only that the Intensive Care Unit could not cope with the complexity and the complications that accompanied Dr Patel's surgery, but that he was regularly disparaging about the Unit and its staff. One of the theatre nurses, Jennifer White, gave evidence that Dr Patel was habitually rude to nursing staff and junior medical staff. She said that Dr Patel would talk constantly about himself, loudly and in self serving terms.⁷¹⁴ When Dr Gaffield was asked in cross examination to explain how he responded to a particular approach from Dr Patel, he testified:

Like I normally did to him, which was to try to get away from him as soon as I could because he just – he had – he was somebody who had lots of bad things to say about everybody around, including people standing right next to him, so I really didn't want to be any part in that sort of behaviour⁷¹⁵

3.296 There was also heard from a number of witnesses that Dr Patel would inform other staff that he was highly valued by the management. He would explain how vital he was in terms of reaching elective surgery targets, he would suggest that the Base was really a third world hospital and lucky to have him, and he would, on occasion, threaten to resign if his views on patient management were not adopted.⁷¹⁶ In short, it seems that Dr Patel communicated to people that, if they were to challenge him, he would visit retribution upon them and, in any case, the challenge was unlikely to receive serious consideration by management.

3.297 The second way by which Dr Patel avoided scrutiny was that he dismantled the surgical audit process, known as the Otago system. The Commission heard evidence that health care professionals might reasonably differ on the best auditing system to use, and the Otago system might properly have been replaced with an alternative. That, however, did not occur.

3.298 The third way was that Dr Patel tended to work with very junior staff. As will be remembered, there were no surgical registrars at the Base by the time Dr Patel came to work there. But, also, Dr Patel tended to work with doctors who did not have any consistent experience in surgery so that they would not have realised that the level of complications amongst Dr Patel's patients was abnormal. As Dr de Lacy later speculated in evidence:

There must have been somebody dying on the surgical ward all of the time and there must have been horrendous complications physically being managed on the surgical ward all of the time. If that's your first experience in surgery, then your conclusion that you draw is that that's what happens in surgery, in general surgery, and that is not true.⁷¹⁷

⁷¹⁴ Exhibit 71 para 9

⁷¹⁵ T 4593; Dr Carter said that Dr Patel was always 'brash and in your face' and it seems he was not inclined to seek him out.

⁷¹⁶ See, for example, the evidence of Ms Hoffman

⁷¹⁷ T4483

3.299 Fourthly, Dr Patel avoided the ‘general community of surgeons’⁷¹⁸ and any substantial contact with other specialists. He was not a fellow of the Royal Australasian College of Surgeons and, in consequence, he was not subject to the requirements the College places on fellows to maintain currency and transparency. Further, it meant that he was not drawn into contact with other surgeons who might ask questions about his work. That isolation was enhanced by Dr Patel’s conduct at the Base. Whereas, it seems, it is common for surgeons in regional centres to work and socialise closely,⁷¹⁹ and there were five or six surgeons in Bundaberg, Dr Patel did not seem to mix with them. Dr Thiele said he only passed him in the corridors; Dr de Lacy said that he seemed to keep to himself; and Dr Gaffield said that he was naturally inclined to avoid contact with Dr Patel in any case. There was no evidence of any close association between Dr Patel and any other surgeon.

3.300 As concerns other specialists, it is clear that, notwithstanding evidence that the practice of modern medicine unequivocally embraces a multi-disciplinary approach to many conditions (so that, for instance, oncologists and surgeons might confer about the best way to treat a cancer), Dr Patel rarely – if ever – sought the opinions of other specialists or referred patients or problems to them for opinions.⁷²⁰ Within the Base too, Dr Patel resisted any collaborative approach to treatment. Dr Carter gave evidence that there was frequent conflict between anaesthetists, on the one hand, and Dr Patel on the other.⁷²¹ It seems that, notwithstanding that Dr Patel’s medical knowledge was in some cases outdated, he would feel at liberty to countermand the orders of the anaesthetists.⁷²² He declined to adhere to the Australian principle that the anaesthetists and intensivists are the primary carers for a patient whilst that person is in the intensive care unit. Indeed, Dr Patel was aggressive in his bid for control.⁷²³ When Dr Carter was asked whether the Australian protocol was brought to Dr Patel’s attention, he responded:

Yes, and I brought it regularly to the attention of Dr Patel. We tried to make him sort of comply with the joint ward rounds but if we were there at half past seven, he would be there at seven. If we came in at seven, he would have been there at half past six. I think starting your ward rounds at midnight and laying in wait for the man would be a little stupid⁷²⁴

Dr Carter also made a comment that was entirely consonant with the evidence from a number of the nurses, namely that he was ‘not sure that Dr Patel had any

⁷¹⁸ T4428

⁷¹⁹ T3628

⁷²⁰ See the evidence below of Dr Woodruff and Dr O’Loughlin

⁷²¹ T 3989

⁷²² Refer to the transcripts for Carter and Berens

⁷²³ T 3989

⁷²⁴ T 3991

respect for nursing staff in general' and that Dr Patel was not keen to listen to anybody's advice.⁷²⁵

- 3.301 Fifthly, Dr Patel was much more reluctant than other doctors to transfer patients to tertiary hospitals.⁷²⁶ Perhaps this was because he had an over-inflated idea of his own capabilities but one of its consequences was the lessening of any scrutiny. Where a person is transferred, the tertiary hospital will have occasion not only to examine the patient and, perhaps, consider the quality of the surgical work, but it will study the patient records and be in a position to assess the decision-making. That opportunity was often not available for Dr Patel's patients.
- 3.302 Sixthly, he subverted Mortality and Morbidity meetings. More will be said of this aspect of hospitals later. Suffice it to say here that there is a practice in many surgical and other departments, of referring those cases the subject of a death or an adverse outcome to 'mortality and morbidity meetings'. The meeting will be attended by doctors within the department and often doctors from other departments, and doctors from outside the hospital.⁷²⁷ The referred cases will often be 'presented' by a junior doctor who was involved in the treatment and those present will be invited to comment on how the care might have been improved, with a view to ensuring a high standard of treatment is maintained. There was evidence that the meetings can sometimes be rather 'fraught', in that the discussion can be robust. All those who commented, however, said that the 'm & m' meetings are an important tool in maintaining clinical competence.⁷²⁸ That is borne out, in any case, by the fact that the Royal Australasian College of Surgeons requires its fellows to participate regularly in such meetings.⁷²⁹
- 3.303 In Bundaberg, Mortality and Morbidity meetings had been held effectively during Dr Thiele's administration.⁷³⁰ During Dr Patel's time, the meetings were held but, on several accounts, they were not true to their purpose. They appear to have been rarely attended by senior staff⁷³¹ so that any consultant-to-consultant interaction was absent. Instead, they tended to take the form of Dr Patel teaching younger staff about a given topic, rather than any open discussion.⁷³² The consequence was that the many complications that attended Dr Patel's surgery were not the subject of concerted attention from senior staff.
- 3.304 Seventhly, there was at least a repeated suggestion that Dr Patel wrote falsified and self serving notes. Ms Hoffman maintained that, when patients were handed

⁷²⁵ T 3991-2

⁷²⁶ See the evidence of Dr de Lacy Ms Hoffman and Ms Hunter

⁷²⁷ See the evidence of Dr Young and Dr Woodruff; The doctors will consultants, registrars and house officers

⁷²⁸ See the evidence of Dr Young, Dr Woodruff, Dr de Lacy

⁷²⁹ See Chapter 6

⁷³⁰ Indeed, so much so, as discussed earlier, that doctors from other hospitals would attend with their own cases to discuss

⁷³¹ Dr Gaffield was often in surgery and Dr de Lacy ceased attending because he considered that they were a farce: insert references

⁷³² See the evidence of Drs Nydam, de Lacy, and Kariyawasam, but note the contrasting evidence of Dr Boyd

over from the theatre staff to the Intensive Care staff, the latter would often be informed of some matter that did not appear in the notes.⁷³³ As will be seen later, this was given some support by the evidence gathered by the expert surgeons on review.

- 3.305 Eighthly, of course, Dr Patel was assisted by the circumstances in which he found himself. No inquiries of consequence had been made into his American history; he was not only the Director of the Department of Surgery, but clearly the more experienced surgeon; and he had not been the subject of any credentialing process. Moreover, as a doctor practising surgery in a public hospital, he was not subject to the 'market review' which affects a surgeon working privately.⁷³⁴ He was able to practise, as one counsel put it, in splendid isolation.⁷³⁵

Complicity in the Executive

- 3.306 As will be seen in due course, Dr Patel wreaked extensive havoc in Bundaberg. It was suggested by Dr de Lacy that two things needed to come together for that situation to arise. The first was that there was a surgeon who was prepared to actively mislead people and to shield himself from any scrutiny. The second factor - which in Dr de Lacy's view was no less important - was that there was 'complacency at best by the supervising body'.⁷³⁶ In my view, there is considerable force in that opinion. Despite what appear now to be concerted efforts by Dr Patel to shield himself from any real scrutiny, there were at least 20 complaints to management over the 24 months of his term. The failure to act on those complaints can, in part, be attributed to a lack of adequate systems. There was no adverse events policy at the Base until September 2004; there was no risk policy until June 2003; there was no integrated complaints policy that required that all complaints concerning any given practitioner (whether they emanated from staff, patients, adverse event forms, risk incident forms etc.) be centrally available; there were no functional mortality and morbidity meetings, and there was no Credentialing and Privileging Committee (let alone one with a surgeon amongst its members) that could assess Dr Patel initially and on an ad hoc basis as significant complaints emerged. Dr Gaffield, in the course of his testimony, gave some insight into the particular problem that Dr Patel presented:

He definitely craved professional acknowledgment of his good work. He wanted people to think he was really, you know, better than average whether that be through the complexity of the operations he could do, the volume of them, the speed at which he could do them. He wanted – he was not content with being average, he wanted to stand out. Bundaberg Hospital wasn't a place that that was appropriate – for that kind of person, I mean, there's lots of surgeons like

⁷³³ Exhibit 4, para 44

⁷³⁴ T3622

⁷³⁵ Counsel for the Medical Board: T4336

⁷³⁶ T4471

that but I don't think they'd seen one like him there for a long time, if ever, and the place wasn't set up to keep pace with him or to police him either way.

- 3.307 In my view, however, a lack of good systems can not account for the failure to act on complaints of the type described. It was a small hospital, the complaints were emanating from a number of senior people, and one is left to wonder at the fact that it was not until April 2005 that Queensland Health or Base staff ever asked an independent surgeon to review the work or the decision-making processes of Dr Patel. At the very best, Dr Keating and Mr Leck demonstrated a woeful ignorance of clinical outcomes in the Base, and a disconnection from staff. That may have come about because Dr Patel was such an intimidating and impressive figure. Perhaps it was because he held himself out as an accomplished general surgeon and those in management did not feel qualified to challenge him. Maybe it was because the Base was much more fiscally driven under the Leck/Keating administration and Dr Patel seemed much more adept at meeting surgery targets. Perhaps it was because management had come to realise how difficult it was to recruit surgeons prepared to work in the conditions operating at the Base. I think it was a little of each of these factors. The conduct is, nevertheless, inexcusable.

Renewal of registration

- 3.308 It will be recalled that Dr Nydam had offered Dr Patel the position of Senior Medical Officer, Department of Surgery at the Base on a 'temporary full time' basis. The appointment was expressed to run from February/March 2003 for a period of twelve months. By January 2003, Dr Nydam and Wavelength seem to have agreed that Dr Patel would commence his employment on 1 April 2003⁷³⁷ and, in the event, the Board granted registration for that period. The letter notifying Dr Patel of his registration read in part:

Registration is contingent upon you practicing as a Senior Medical Officer in surgery at Bundaberg Base Hospital or any other public hospital authorised by the Medical Superintendent during the period of your registration. You should also note that the approval is for a specific purpose, to be undertaken in the defined period after which your registration will cease. Any further period will require a fresh application for registration and further consideration by the Medical Board.

- 3.309 On 25 November 2003, Dr Keating wrote to Dr Patel offering him an 'extension of [his] current contract' from 1 April 2004 to 31 March 2005, with an option of renewal for a further twelve months. Although the offer was phrased in terms of an extension, it provided that the appointment was as the Director of the Department of Surgery, rather than the Senior Medical Officer position envisaged by the initial contract.

⁷³⁷ Exhibit 51 KN10

- 3.310 Dr Keating gave evidence that the reason the offer was made some four months before the expiry of the initial contract was that there were the three administrative hurdles – namely the area of need declaration, Medical Board registration and issue of temporary working visa - which needed to be surmounted.⁷³⁸ On 21 November 2003, Dr Huxley at the Workforce Reform Branch of Queensland Health (and in her capacity as the Minister's delegate) considered the application for an area of need certification.⁷³⁹ Dr Huxley's evidence was that, to her knowledge, 'assuming the documentation has been completed correctly, no Area of Need application for a position within the public health system has ever been refused'.⁷⁴⁰ This application was not refused.
- 3.311 Dr Nydam wrote to Department of Immigration with a view to extending the sub class 422 temporary working visa. On 27 January 2004, the Department of Immigration wrote to Dr Keating to indicate that the Base's sponsorship of Dr Patel had been approved.⁷⁴¹
- 3.312 Dr Nydam also approached the Medical Board. By a letter dated 1 December 2003, Dr Keating advised the Medical Board that the Base had extended Dr Patel's contract to 31 March 2005 and enclosed an application for further registration.⁷⁴² Dr Keating was required to provide the Medical Board with the area of need position description (Form 1). He did so by explaining that Dr Patel was to be the Director of Surgery and would provide surgical services to outpatients and inpatients at the Base, amongst other things.⁷⁴³ He was also required to provide the Board with a completed Assessment Form (this form being peculiar to area of need registrants), setting out Dr Patel's skills by marking boxes across eleven categories. He did so by indicating that Dr Patel's performance was 'better than expected' across nine categories and 'consistent with level of experience' for the balance. Where Dr Keating was required to list Dr Patel's strengths, he wrote that he 'effectively utilises his broad knowledge, skills and experience in general surgery to provide high quality patient care. He is a willing and enthusiastic leader. He also brings understanding and clinical management subjects to appropriate forums'. Where Dr Keating was asked to list Dr Patel's areas for improvement, he wrote that he 'should continue to develop his understanding of the Australian/Queensland health care systems and work towards implementing a formal approach to evaluation of the quality of surgical services provided at BHSD'. Dr Keating left blank the section where employers were invited to comment on those areas 'requiring substantial

⁷³⁸ Exhibit 448 para 36

⁷³⁹ Exhibit 58 para 10(xvi)

⁷⁴⁰ Exhibit 58, para 10(xvi)

⁷⁴¹ Exhibit 448 DWK10

⁷⁴² Exhibit 448 attachment DWK4

⁷⁴³ Exhibit 448 DWK 5

assistance' or 'further development' and setting out an 'improving performance action plan'.

- 3.313 On 9 March 2004, the Medical Board wrote to Dr Patel, indicating that he had been granted special purpose registration and that no conditions were imposed. The letter read in part:

Special purpose registration enables you to fill an area of need at Bundaberg Base Hospital, or any other public hospital authorised by the Medical Superintendent on a temporary basis. It is advised that you are **not registered as a specialist**. Any variation to your practice would require further approval by the Board. You should also note that the above approval is for a specific purpose to be undertaken in the defined period of time.

- 3.314 I have already made comments about the process of Dr Patel's initial registration. Many of them apply with more force to the renewal of his registration. In particular, I am disturbed by the following features:

- (a) Whilst the Minister was empowered by s135(3) to declare an area of need where there was a scarcity of medical practitioners, his delegate made no inquiry to ascertain whether such a situation existed in relation to the Director of Surgery position at the Base;
- (b) Such an inquiry in my view was clearly warranted given that a practitioner with general registration was being proposed for a position as a Director of Surgery;
- (c) If inquiries had been made, the Minister or his delegate would have ascertained, at the very least, that there was a fellow of the Royal Australasian College of Surgeons who had extensive rural experience, had worked as the Director of Surgery in a major tertiary hospital and, had extensive experience in general surgery who had already approached the Base in July 2003 seeking a Visiting Medical Officer position, being of course Dr de Lacy.⁷⁴⁴ It may well be that there were other people who might have accepted the position;
- (d) Dr Nydam indicated that, in his view, Dr Patel was only the acting Director of Surgery. He envisaged, it seems, not so much that a more suitable candidate might be found but that Dr Patel might take steps towards gaining a fellowship in the College. Some small steps had been taken along this path. Dr Keating and Dr Patel had completed in January 2005 a Queensland Health form entitled 'performance appraisal and development agreement',⁷⁴⁵ and the agreement envisaged that Dr Patel will lodge an application for recognition as a specialist with the College.⁷⁴⁶ There is no evidence, however, that either Dr Patel or the Base ever

⁷⁴⁴ See the evidence of Dr de Lacy

⁷⁴⁵ Exhibit 448, para 45, DWK12

⁷⁴⁶ Exhibit 448, DWK13

approached the College with a view to ascertaining what program Dr Patel might meet in order to gain fellowship;

- (e) Further, the application to the Medical Board did not seek deemed specialist registration so that the Board was not strictly required to invoke the national guidelines⁷⁴⁷ and take counsel from the AMC and the College as to the appropriate path for Dr Patel;
- (f) The Board was now squarely apprised of the fact that Dr Patel was to work as the Director of Surgery. It granted registration for that position whilst explicitly noting that Dr Patel was 'not registered as a specialist'. That conduct was entirely unacceptable. The Board was required to refrain from registering applicants unless they had a 'medical qualification and experience ... suitable for practicing the profession in the area'. It is difficult to see how a person who the Board has declined to register as a specialist could nevertheless be considered suitable for heading the Department of Surgery in a major regional hospital;
- (g) One can well understand there will be situations where, for reasons of timing, for example, an overseas trained doctor filling a legitimate area of need, cannot gain a fellowship. The national guidelines, however, allow for that possibility. They provide that the State Boards might register overseas trained doctors as 'deemed specialists' on the proviso that they introduce appropriate safeguards in consultation with the Australian Medical Council and/or the relevant College. There was no such consultation here. There were no conditions attached. There was absolutely no scrutiny of Dr Patel's performance and suitability, and this occurred in circumstances where he had no real reporting mechanisms in his first year;
- (h) Given that the application referred to Dr Patel's contract being 'extended', the Medical Board might have asked itself when Dr Patel had become the Director of Surgery and how it came about that he was no longer a Senior Medical Officer reporting to the Director of Surgery (as the first application envisaged). It seems that the issue was never considered;
- (i) The Board continued its practice of giving a generic approval. The comment from the Medical Board in its correspondence that 'special purpose registration enables you to fill an area of need at Bundaberg Hospital, or any other public hospital authorised by the Medical Superintendent on a temporary basis' has no legislative basis. If it was intended to indicate that special purpose registrants are entitled to work at any public hospital ex officio, that is simply unsupported in the Act. If it

⁷⁴⁷ See Exhibit 36

was suggested that the terms of Dr Patel's particular registration meant that he could work wherever directed by Dr Keating, that is also unsupported. The registration envisages that the registrant will practise in an area of need. Such an area exists where the Minister has certified it to be so. Dr Huxley expressly disavowed the suggestion that all of Queensland is an area of need⁷⁴⁸ and Dr Keating could not direct Dr Patel to work at a public hospital other than the Base because the mere direction would not make that other hospital an area of need.

- 3.315 In all the circumstances set out above, it was especially important for the Board to enquire as to whether or not there had been any complaints about the applicant or at the very least, whether there had been any assessment of Dr Patel by a surgeon. That simply did not happen.
- 3.316 In the absence of invoking the College process, it was particularly incumbent upon the Board to impose conditions requiring supervision for Dr Patel but it failed to take even this rudimentary step.
- 3.317 The Medical Board specifically advised Dr Patel that he need not re-submit the documents which accompanied his original application⁷⁴⁹ and this included the verification of licensure. That omission not only denied the Board an opportunity to revisit documents apparently perused hurriedly in the past; it also meant that the Board was not making any enquiries to ascertain whether the Board of Examiners in Oregon had heard disciplinary proceedings against Dr Patel in the year just past.

The demise of Dr Patel

- 3.318 It will be recalled that the Nurse Unit Manager of Intensive Care, Ms Hoffman, raised concerns in June 2003 that Dr Patel was performing operations so complex that her Unit could not provide adequate support. It will also be recalled that Dr Keating spoke with a number of doctors and decided that the operations might proceed, but he did not return to Ms Hoffman. Her concerns did not abate. Ms Hoffman gave evidence that, in the months that followed, her apprehension was heightened by her awareness of further events, set out below, concerning Dr Patel.
- 3.319 On 3 July 2003, there was notice given by Ms Aylmer of an increasing incidence of wound dehiscence.

⁷⁴⁸ Exhibit 58 para 11

⁷⁴⁹ Statement of Demy-Geroe, para 48

- 3.320 In September 2003, there was a patient who had been in the intensive care unit for some twelve days, and was likely to require further lengthy ventilation. Ms Hoffman understood that Dr Patel was resisting any move to transfer the patient and she approached Dr Keating and the Director of Nursing, Linda Mulligan about her concerns.⁷⁵⁰
- 3.321 By the end of 2003, Ms Hoffman testified, she had personally witnessed, or otherwise been informed by Intensive Care staff, of occasions where theatre staff would tell her staff, at the point of handover, of errors which had occurred during the operation and were not set out in Dr Patel's notes.⁷⁵¹
- 3.322 On 25 February 2004 she was concerned about a patient known as P49 who was the subject of an operation on a Friday, leading to there being three ventilated patients in the ICU on a Sunday morning.⁷⁵² (There was evidence that there were usually only three nurses on duty in ICU and three ventilated patients would occupy the entire time of those nurses when there were ten beds in the ward).
- 3.323 By early 2004, Ms Hoffman had become aware that Dr Miach had directed that Dr Patel not operate on his patients.⁷⁵³
- 3.324 In early February 2004 and whilst Ms Hoffman was the Acting Director of Nursing, she met with Mr Leck, the District Manager, and set out in some detail her concerns with the increased use of Intensive Care for ventilated patients and, in particular, for Dr Patel's patients. Ms Hoffman gave evidence that, in the course of that meeting, she provided Mr Leck with a document entitled 'ICU Issues with Ventilated Patients' which summarised those concerns. That document is in evidence⁷⁵⁴ and was very direct. Ms Hoffman maintains there that:
- (a) The Intensive Care Unit was only capable of ventilating patients for short periods of 24 to 48 hours;
 - (b) The Intensive Care Unit was constantly exceeding this timeframe and whilst that could be done for short periods it could not be sustained;
 - (c) The staff had explained the situation to the surgeons, particularly Dr Patel, but he has not heeded that advice and had said he would 'not practise medicine like this';
 - (d) In response to Intensive Care's claims that the level of surgery was too complex for their resources, Dr Patel had repeatedly threatened to

⁷⁵⁰ Exhibit 4 para 34

⁷⁵¹ Exhibit 4 para 44

⁷⁵² Exhibit 4 para 45

⁷⁵³ Exhibit 4 para 48

⁷⁵⁴ Exhibit 4 para 50, TH10, Mr Leck gave evidence that he then made inquiries of Dr Keating and Ms Mulligan about the issues raised by Ms Hoffman: T7217

resign, to withdraw elective surgery patients from the Intensive Care Unit, to complain to the Medical Director or go 'straight to Peter Leck' as 'I have earned him half a million dollars this year';

(e) Dr Patel had in fact refused to transfer his patients on several occasions despite them having deteriorated;

(f) There was a feeling of 'disunity' amongst Intensive Care staff and the nurses were refusing to care for Dr Patel's patients.

3.325 Ms Hoffman says that she indicated to Mr Leck that she did not wish him to act upon her complaints at that time because she would attempt to broach them directly with Dr Patel. Ms Hoffman testified, however, that the complications and the complex operations continued. She mentioned four such patients, in particular, in the months following this conversation (mostly concerned with serious complications following Patel operations).⁷⁵⁵ She made reference to a number of patients for whom the clinical conditions appeared to mandate transfer to Brisbane, but Dr Patel declined.⁷⁵⁶ She also testified that she had been reliably informed that Dr Patel had instructed his junior doctors to avoid certain words such as 'wound dehiscence' in the medical charts.⁷⁵⁷

3.326 In or about February 2004, a new Director of Nursing was appointed, namely Linda Mulligan. Ms Hoffman said that, at this time, she was speaking widely and freely within the Hospital with a view to preventing more of the larger operations.⁷⁵⁸ She said that she met with Ms Mulligan, on several occasions to discuss her concerns but Ms Mulligan took the position that the problems were borne of some 'personality conflict'.⁷⁵⁹

3.327 On 27 July 2004, the patient called Desmond Bramich, referred to earlier in this report, died. He was the man who was admitted to the Base after suffering crush injuries when a caravan fell upon him. He was treated by Dr Gaffield and whilst, initially, he seemed to have recovered well he became seriously ill on the afternoon of 26 July 2004 and died three hours later. His death caused enormous distress amongst the nursing staff involved in his care. They were concerned, in particular, that Dr Patel had obstructed a transfer of the patient, that he had performed, very crudely, a procedure known as a pericardiocentesis, and that he had treated Mr Bramich's wife abruptly.

3.328 Ms Hoffman consulted the Queensland Nurses Union about what she should do. A Union representative raised the concern with Ms Mulligan but, on the representative returning to Ms Hoffman, the latter became concerned that the

⁷⁵⁵ Exhibit 4 paras 58 - 61

⁷⁵⁶ Exhibit 4 paras 67 - 70

⁷⁵⁷ Exhibit 4 para 64

⁷⁵⁸ Exhibit 4 para 117

⁷⁵⁹ Exhibit 4 para 84

matter was still being portrayed as some kind of personality conflict.⁷⁶⁰ In the event, she received, and provided to Ms Mulligan, statements from some six nurses who all expressed in various ways their concerns about the care received by Mr Bramich.⁷⁶¹ On 28 September 2004, she emailed Ms Mulligan in relation to her concerns about the over use of the Intensive Care Unit. She received a reply but she was not convinced that it squarely addressed her concerns.⁷⁶² Ms Hoffman said that she then made an appointment to see Ms Mulligan. This would have been on about 20 October 2004. She said that she was more forceful in that meeting than she had been previously. She said that she raised squarely six concerns, namely that:

- (a) There was a high level of complications coming to the Intensive Care Unit from people who had been the subject of Dr Patel's surgery;
- (b) There was a high number of deaths;
- (c) Dr Patel's behaviour in the Intensive Care Unit was inappropriate;
- (d) The Bramich incident had caused considerable distress amongst the staff;
- (e) The Hospital was not providing support to the staff;
- (f) Dr Patel had suggested to the nurses that he was untouchable because he made so much money for the Base.

3.329 Ms Hoffman testified that Ms Mulligan told her to put her concerns in writing. She did so and she returned to meet with Ms Mulligan and Mr Leck on the same day. Ms Hoffman said that, when she was ushered into Mr Leck's office, she repeated all of her concerns. She explained that her Union had advised that she should make a complaint to the Crime and Misconduct Commission or write to the Director-General but she was eager first to attempt an internal resolution of the matter. She told Mr Leck, she said, that unless there was an independent chart audit of Dr Patel's patients, she would be forced to take some other action.

3.330 Ms Hoffman said that Mr Leck listened carefully to her, took notes, and asked that she make a formal written complaint.⁷⁶³ In the event, she sent Mr Leck a copy of her document 'ICU Issues with Ventilated Patients' (with annotations to include the Bramich case). Soon after the meeting, she also sent Mr Leck a formal letter setting out information she had collected which formed the basis for her concerns about Dr Patel's fitness. A file note ran for two pages and recorded that Ms Hoffman had made the following points:

⁷⁶⁰ Exhibit 4 para 111

⁷⁶¹ Exhibit 4 para 114

⁷⁶² Exhibit 4, attachment TH35

⁷⁶³ Exhibit 4 para 125

- (a) Dr Patel seemed to be operating outside his scope of practice when looking at the transfer of a patient;
- (b) Staff would book hospital beds in Brisbane but the patient would not be transferred;
- (c) Dr Patel was wont to use funding as a threat – he would say that he made \$500,000.00 for the hospital and if the staff couldn't guarantee to provide care, he would resign;
- (d) Dr Patel was very old-fashioned in the type of drugs he used and, when arguments erupted between him and the anaesthetists, the nurses were caught in the middle;
- (e) Ms Hoffman had raised her concerns with Dr Strahan who said that the local doctors had concerns but did not 'have enough to stick their necks out with';
- (f) Dr Miach would not let Dr Patel operate on his patients;
- (g) Ms Hoffman had already raised her concerns, in the company of Dr Joiner, with Dr Keating. People were refraining from making complaints because they could not see any point to doing so;
- (h) Dr Patel was pushing the intensive care unit so hard that it was working outside its scope of practice;
- (i) Dr Miach was openly questioning Dr Patel's qualification.

3.331 That letter was dated 22 October 2004 and, as will be seen, it marked a significant development in the unrest about Dr Patel.⁷⁶⁴ Here was a complaint that could not be dismissed as some personality clash or a passing clinical difference. Ms Hoffman set out a history dating back to the Phillips oesophagectomy on 19 May 2003 and ending with the Bramich case. She identified the poor care which had allegedly been given to certain patients and she provided the Universal Record numbers for those patients. She recorded that Dr Miach refused to allow Dr Patel to operate on his patients; she attached statements from five other nurses, and she named doctors who might corroborate her concerns. The letter (to which I shall refer as 'the Hoffman letter') is set out in full below.

Dear Peter,

I am writing to officially inform you, of the concerns I have for the patients in ICU in relation to the behaviour and clinical competence of one of the surgeons, Dr Patel.

Dr Patel first voiced his displeasure with the ICU around the 19TH May 2003. A patient UR number 034546 came to the ICU post oesophagectomy. This patient

⁷⁶⁴ The letter is Exhibit 4, TH37

had multiple comorbidities and for the last 45 minutes of surgery, had no obtainable Blood pressure. The anaesthetist who accompanied him into the ICU, stated 'It was a very expensive way to die.' He required 25 ug of Adrenaline and 100% O2. Dr Patel stated the patient was stable. The Nursing staff who were communicating with the patients family told the patients mother that he was extremely ill. Indeed he progressed to brain death. Dr Patel continued to say the patient was stable. The course of treatment for this patient was very difficult, he required dialysis and there was constant conflict between the anaesthetists, Dr Patel and the Physicians about his care. The Direct of Anaesthetics and ICU was away and Dr Younis was left in charge, he was reluctant to question whether or not we should be doing such large operations here at BBH. Dr Jon Joiner and I went to see Dr Keating to voice our concerns. We both believed we could not offer adequate post op care for oesophagectomies. The literature stated a hospital should be doing at least 30 per year to maximise outcomes. At this time I first stated my concern that Dr Patel could describe a patient on maximum Inotropes and ventilation as stable. I voiced these concerns to Dr Keating. After this incident Dr Patel and I had a conversation where I told him that the ICU wished to have a good professional working relationship with him. I tried to tell him that we were a level one ICU and that our staffing levels and scope of practice meant that we could only keep ventilated patients for 24 – 48 hours, before transferring them to Brisbane. Dr Patel stated that he would not practise medicine like this and he would go to 'Peter Leck and Darren Keating and care for his own patients'. This incident was repeated relatively soon after the first. Dr Patel would threaten the staff with his resignation when it was suggested it was time to transfer out a ventilated patient. He continually stated he was working in the 'third world' here. He would use 'Peter Lecks' and 'Darren Keatings' names as a type of intimidation and threat to the staff. He stated on several occasions he would go straight to Peter Leck as he had made him 'half a million dollars this year'. Every time we had a ventilated patient in the ICU that required inotropes he would argue with the anaesthetists about which inotrope to use. His choice of inotropes did not reflect best practice guidelines in Australia. He refused to speak to the writer, (myself). All requests for a bed would go through either another nurse or doctor. He would yell and speak in a very loud voice, denigrating the ICU and myself and at time the anaesthetists. The nursing staff felt they were often the 'meat in the sandwich'. He would harass them and ask them 'whose side they were on'. At times he would actively try to denigrate my ability as a NUM to the nursing staff and other doctors. (See attached documentation).

Soon after Dr Patel started operating here the nursing staff observed a high complication rate amongst the patients. Several patients had wound dehiscence and several experienced perforations. This is a list of patients I believe require formal investigation. This is taken from our ICU stats and are not a full and comprehensive review as there are no stats from OT or Surgical Ward.

UR 1302324 6/6/03 post op oesophagectomy
 12/6/03 wound dehiscence
 15/6/02 2nd wound dehiscence

suffered a third wound dehiscence was transferred to Brisbane on 20/6, had a J tube leak and peritonitis. A bed had been obtained earlier for this man, but Dr Patel went up to Dr Keating who advised our anaesthetist to keep him for a few more days, in which time the bed was taken, and he stayed several more days whilst another bed was sourced. The Doctors at RBH questioned why we were doing such surgery here when we were unable to care for these patients.

UR 009028 post op oesophagectomy ventilated for 302 hours

UR 001430 ventilated for many days: transferred to Brisbane after many arguments in the ICU with Dr Patel who refused initially to transfer this patient.

UR 880266 issue with transferring patient to Brisbane

UR 083866 Bowel Obstruction Resection and Anastomosis on 7/2/04 T/F to Brisbane on 11/2/04 on the 12/2/04 laparotomy showed perforation and peritoneal soiling

UR 134442 Wound Dehiscence and complete evisceration 8/4/04. Booked for sigmoid colectomy and found to have ovarian ca.

UR 020609 27/4 Wound dehiscence

UR 29/6 Insertion of Vascath perforated @ IJ

UR 086644 Delay in Transfer to Brisbane, See attached report, Pt died.

UR 017794 10/7 laparotomy for Ventral Hernia, developed haematoma in ward and attempted evacuation done without any analgesia. Drs notes consistently say patient well when Pt was experiencing large amounts of pain and wound ooze.

UR 057809 pt had Whipples, death cert stated he died of Klebsiella pneumonia and inactivity

UR 063164 death cert state pt died of malnutrition. Had been operated on 31/7/04

Several conversations were had with other doctors, Acting Directors of Nursing and NUMs. Dr Miach refused to allow Dr Patel to care for his patients as he stated he had 100% complication rate with Peritoneal Dialysis insertion. This was stated in a Medical Services forum as well as in a private conversation with myself. This data was shown to the Acting Director of Nursing Mr Patrick Martin.

On the 27th July 2004, Pt UR number 086644 returned to ICU in Extremis with a chest injury. The events of these 13 hours is well documented. Dr Patel interfered in the arranged transfer of this patient to Brisbane and the patient died after it was thought the retrieval team were on their way to retrieve this patient. The subsequent events of this intervention and the traumatic pericardial tap (described by the nurse caring for the patient as repeated stabbing motions) resulted in the ICU staff requesting advice from the nurses union. The staff involved in this situation described it as the worst they had ever seen. They were acutely distressed. An attempt was made to seek EAS support, but they were unable to assist due to their workload. One staff member accessed Psychological support privately. I was requested to fill in a sentinel event form, by the then QI Manager Dr Jane Truscott. The events of this incident were discussed at length with the union, who offered support to the staff. They also offered me several ways I could report the long standing concerns I had with the current situation in ICU. The day after the patient's death, when I thought he had safely been transferred to Brisbane, Dr Strahan came to talk to me in the office and found me very distressed. He offered to talk to some of the other doctors and get back to me as the representative of the AMA in Bundaberg. He did this state 'here is widespread concern, but at the moment no one is willing to stick their neck out'. He urged me to keep quiet on my concerns. I spoke with Dr Dieter Berens and informed him the nursing staff were going to report their concerns with Dr Patel to an official source. He stated he would support us, by telling the truth, but he was concerned he would lose his job and Dr Patel would be the one left behind. It is widely believed amongst the medical and nursing staff that Dr Patel was very powerful, that he was wholeheartedly supported by Peter Leck and Darren Keating and was untouchable. Anyone who tried to alert the authorities about their concerns would lose their jobs. This perception was indeed perpetrated by Dr Patel on a daily basis. Many of the residents and PHO's have expressed their concerns, Dr Alex Davis and Dr David Risson, But

were unsure of what to do because of the widespread belief Dr Patel was protected by executive.

The Nurses union have offered advice in that there are several ways these concerns can be reported if not dealt with internally, after my conversation with Peter Leck and Linda Mulligan on Wed, I believe they were not in receipt of the full concerns, but now that they are they will deal with them.

Dr Miach has reiterated he has dealt with the issue by not letting Dr Patel near his patients. These concerns were openly discussed at the medical services forum.

A peripheral concern is the reports the junior doctors have voiced about forms not being filled out correctly, of being told not to use certain words in discharge summaries, and various other chart irregularities.

Toni Hoffman.

Documentation from Karen Stumer, Karen Fox, Kay Boisen x 2, Karen Jenner, Vivienne Tapiolas included.

- 3.332 In spite the meeting with the District Manager and the Director of Nursing, and despite the level of detail contained within the letter, Ms Hoffman heard nothing by way of response for many months. In the meantime, her concerns only escalated. On 20 December 2004, there was an incident concerning a patient known before the Commission at P44. In essence, that patient was being maintained by a ventilator in Intensive Care. There was a perception amongst the nursing staff in the Unit that Dr Patel placed pressure on staff for the ventilator to be switched off so that the bed was made available for another operation (in fact, the oesophagectomy for Mr Kemps). They were concerned because it is the practice in hospitals to have two independent doctors conduct brain death tests before such a drastic step is taken (notwithstanding that, it seems, there are other reliable indicators of brain death) and Dr Patel was apparently eager to avoid the formalities of that step.⁷⁶⁵ The staff were concerned both at the lack of formality and the intimidatory approach adopted by Dr Patel.
- 3.333 Ms Hoffman said that, at some point early in 2005, she made a list of all those operations which had gone badly since the Bramich incident. She sets out that list in her statement and they number eight.⁷⁶⁶ They include people with complications such as a wound dehiscence or a haematoma, Mr Kemps who died, and the boy, P26, whose leg was ultimately amputated.

Action taken by Dr Keating and Mr Leck

- 3.334 In the meantime, there were developments in the Executive Office. By a coincidence, Dr Miach had also attended those offices on 22 October 2004. He

⁷⁶⁵ Exhibit 4 para 139 TH42

⁷⁶⁶ Exhibit 4, para 142

had a heated exchange with Dr Keating on 21 October 2004 in which Dr Miach maintained that he had previously provided Dr Keating with the data concerning the catheter report and Dr Keating denied that this was so.⁷⁶⁷ After the meeting, Dr Keating emailed Dr Miach and requested that he forward the document they had discussed. On 22 October 2004, Dr Miach provided the report (which measured two sheets). It seems that Dr Keating had difficulty understanding the ramifications of the report but, nevertheless, he refrained from approaching Dr Miach.⁷⁶⁸

3.335 On 22 October 2004, Mr Leck provided Dr Keating with a copy of the Hoffman letter. He said he asked Dr Keating to arrange meetings with some of the doctors mentioned in the letter, because Dr Keating maintained that it was 'all personality-based conflict' and Mr Leck wanted him to hear what other doctors had to say.⁷⁶⁹ In consequence, Dr Keating approached Dieter Berens, David Risson and Martin Strahan. Meetings with those doctors were held on 29 October 2004, 2 November 2004 and 5 November 2004 respectively. The doctor, in each case, was interviewed by Mr Leck and Dr Keating and the latter made notes of the meetings.⁷⁷⁰ The note concerning Dr Berens read that:

- (a) Dr Beren said that he could only talk about those areas where he 'crossed over' with Dr Patel and that was, primarily, the intensive care unit;
- (b) His critical care knowledge was not up to date in relation to the 'choice of some drugs and fluids plus application of some physiology principles to care of critically ill patients';
- (c) He could remember two cases of concern and he was also aware that Dr Patel had a difficult working relationship with the intensive care unit nurses;
- (d) Dr Berens said that Dr Patel's manual skills were very good and that the patients being admitted to the base were, as a group, older and sicker than several years ago;
- (e) He questioned Dr Patel's judgment in undertaking some procedures in relation to his currency and made particular mention of vascular surgery and the Whipple's operation;
- (f) Dr Berens said that Dr Patel's attitude to other professionals made him hard to work with on occasions and that he 'made categorical statements, didn't appear flexible and wouldn't discuss alternative clinical options';

⁷⁶⁷ Exhibit 448, para 218-9

⁷⁶⁸ Exhibit 448, para 219 and attachments DWK62-4, T7001

⁷⁶⁹ T7195, T7223

⁷⁷⁰ Exhibit 448, DWK 61.

- (g) Dr Berens said that Dr Patel was reluctant to admit his own mistakes and 'didn't appear to be completely accountable and honest about his surgical actions';
- (h) He did acknowledge, however, that he could continue to work with Dr Patel.

3.336 The notes of the meeting with Dr Risson record that:

- (a) Dr Risson had concerns as to the transparency of the current surgical audit process which, in his view, lacked structure. He was concerned that no reasons were given for the termination of the Otago database nor was it replaced adequately;
- (b) He had a concern which was shared by nursing staff about the apparent number of post-operative complications including infection;
- (c) He said that his relationship with Dr Patel was amicable but he appreciated that he could be flighty and unpredictable and that resident staff considered that he could be severe in his reprimands;
- (d) Dr Risson had never been told to refrain from writing or mentioning anything on a discharge summary.

3.337 The notes of the meeting with Dr Strahan record that:

- (a) Dr Strahan was concerned by a case in which he was performing a gastroscopy but he could not advance the scope further after multiple attempts;
- (b) The woman experienced ongoing pain and she was referred to the Base;
- (c) Dr Patel operated and found a carcinoma of the pancreas;
- (d) She was sent home and later re-admitted for a Whipple's operation but she died;⁷⁷¹
- (e) Dr Strahan questioned whether Dr Patel should be conducting Whipple's operations in Bundaberg. He also said that he believed Dr Patel could be rigid in his thinking and inflexible when new evidence came to hand;
- (f) Dr Strahan said that Dr Patel appeared to operate without some form of peer review.

3.338 It seems that Mr Leck had assumed responsibility for dealing with the letter. He did not, however, deal with it quickly. He and Dr Keating had interviewed the three doctors named above within two weeks but they did not make any enquiries of Dr Miach, despite the unambiguous assertion that the Director of

⁷⁷¹ In fact, subsequent evidence revealed that Dr Patel had refrained from carrying out the Whipple's operation. He performed a palliative procedure instead but the patient died some weeks later.

Medicine was 'not letting Dr Patel near his patients', nor of Dr Joiner, Dr Patel, or Doctor Carter.⁷⁷² Notwithstanding the very specific information contained in the Hoffman letter, they did not call for the files, nor arrange for an independent surgeon to assess the allegations and, indeed, it seems that Dr Keating continued to maintain that the complaints were 'personality based'.⁷⁷³

- 3.339 On 16 November 2004, the tilt train disaster occurred in Bundaberg and it can be appreciated that this would have consumed management to some extent. It is notable, however, that no formal steps were taken towards an independent review until 16 December 2004, being some six weeks after the provision of the letter of 22 October 2004. In the meantime, and notwithstanding the very serious allegations being made by Ms Hoffman and the real corroboration provided by the three doctors, Dr Patel continued to operate without restriction or supervision.
- 3.340 On 16 December 2004, Mr Leck made a telephone call to the Audit and Operational Review Unit of Queensland Health. The call was taken by an officer called Rebecca McMahon and a copy of her file note, dated 17 December 2004, has been the subject of comment earlier in this report. According to the note, Mr Leck indicated he had received a formal written complaint from the Nurse Unit Manager of the Intensive Care Unit. Ms McMahon records that Mr Leck said that the complaint concerned the Director of Surgery, "Dr Partell" (sic). He indicated that the doctor had poor outcomes from surgery, including deaths, and was keeping patients in the Intensive Care Unit when they should be transferred. Mr Leck, moreover, had made preliminary enquiries and 'staff had supported this complaint with vague statements and concerns'. He noted, however that there was no clear evidence at this stage of inappropriate surgical practices. He said that there was some personality conflict between the Director of Surgery and the Nurse Unit Manager, and that the complaint needed to be handled carefully because 'Dr Partell was of great benefit to the district'.⁷⁷⁴ He said he was proposing to deal with the complaint by 'doing a clinical review of the procedure in the ICU generally' and he proposed to use Mark Mattiussi or a certain intensivist from Redcliffe-Caboolture. He was contacting Audit to see if they had an interest.
- 3.341 The note records that the officer advised Mr Leck that the matter appeared to concern clinical practices rather than official misconduct and that it should be reviewed by a clinician. The officer said that, in the past, such reviews had been conducted by the Chief Health Officer. The note records that the officer made

⁷⁷² Nor had Mr Leck done so when Ms Hoffman made detailed complaints about Dr Patel in March 2004: T7218

⁷⁷³ T7227

⁷⁷⁴ Mr Leck said in evidence that he was conscious that, whilst Dr Patel was at the Base, the elective surgery targets had been met. He conceded this was part of the reason for underlining the importance of Dr Patel: T7190

further enquiries which confirmed her view that the Chief Health Officer, Dr Gerry FitzGerald, might be the appropriate person to conduct the review.

- 3.342 Soon after the telephone call, it seems. Mr Leck sent Ms McMahon a copy of the Hoffman letter by facsimile.⁷⁷⁵ On the same day Ms McMahon sent an email to Mr Leck and to Dr FitzGerald confirming her view that the complaint involved 'issues of clinical practice and competence rather than allegations of official misconduct' and would thus be the subject of review by 'a suitably qualified team of medical practitioners.' The officer said that Dr FitzGerald would be 'able to provide advice as to the manner in which this review should be conducted.'⁷⁷⁶ Dr FitzGerald has confirmed that he received this email. He notes, however, that he did not receive a copy of the Hoffman letter at this time. It seems that he did nothing other than to print out the email and await an approach from Mr Leck.⁷⁷⁷ For his part, Mr Leck telephoned Dr FitzGerald's office on 17 December 2004 and, although he did not speak to Dr FitzGerald himself, he was told that the doctor was going on leave and any attention to the issue would need be delayed.⁷⁷⁸
- 3.343 Dr FitzGerald was scheduled to take leave over the Christmas-New Year period. On 26 December 2004, however, the tsunami struck in the Indian Ocean. He was involved in the Queensland Health response⁷⁷⁹ and this delayed his holiday. In the event, he did not return to his position until 17 January 2005.⁷⁸⁰
- 3.344 In the meantime, Mr Leck made some efforts to further the matter. He had already been corresponding with the Deputy Director-General of Queensland Health, Dr John Scott, in relation to concerns about the care given to P26. He wrote to him by email on 13 January 2005,⁷⁸¹ and the correspondence read as follows:

Sorry we have missed each other over the last week.

I was really trying to catch up about Dr Patel, our Director of Surgery, who undertook the procedure on the 15yo male who had initial surgery in Bundaberg and subsequently transferred to Brisbane where he had a leg amputation. You will recall that Steve Rashford raised some concerns.

I was just wanting to flag that I actually do have some concerns about the outcomes of some of Dr Patel's surgery. Late last year I received some correspondence from a member of the nursing staff outlining a number of concerns about outcomes for patients (including some deaths). This is coloured by interpersonal conflict between Dr Patel and nursing staff – particularly in ICU.

⁷⁷⁵ T4251, Exhibit 225, GF8

⁷⁷⁶ Exhibit 225, GF8

⁷⁷⁷ T3200

⁷⁷⁸ T4252

⁷⁷⁹ Exhibit 225 para. 56

⁷⁸⁰ Exhibit 225, para 54

⁷⁸¹ Exhibit 225, GF9

Until the last week, my medical superintendent did not believe the complaints were justified and were completely driven by the personality conflict – however, he has now expressed some concern although he still believes most of the issues are personality driven.

Late last year I made contact with Mark Mattiussi for advice about who could conduct a review of the concerns – and particularly of elective surgical ICU cases. My med super is keen not to have a professional ‘boffin’ from a tertiary hospital undertake such a review for fear that they might not relate to ‘real’ world demands of surgery in regional areas.

Mark suggested Alan Mahoney from Redcliffe. I flagged this also with Audit and Operational Review seeking some assistance for the review. They have referred me to Gerry FitzGerald.

Unfortunately, Gerry has been away (back next week) – I was really ringing to flag this with you as I am becoming increasingly anxious about the need for a swift review process and wasn’t sure I could wait until next week to get something going (now I think that this is OK – sorry!).

A few of the nursing staff have advised that they reported the matter to the QNU before coming to management (thankfully the QNU advised them to report to us).

3.345 Dr Scott responded on 20 January 2005 by suggesting that Mr Leck contact Mark Waters or John Wakefield (both of Queensland Health) if Dr FitzGerald could not be contacted. It seems, however, that Mr Leck telephoned Dr FitzGerald on 17 January 2005. He explained that the issue was becoming increasingly important to him and that, against the background of conflicting opinions within the Base on Dr Patel, he needed to know whether there was a clinical issue at the heart of the complaints.⁷⁸² On 19 January 2005, Mr Leck provided Dr FitzGerald with certain material going to concerns about Dr Patel,⁷⁸³ under cover of a memorandum of the same date. The memorandum explained that Ms Hoffman had raised concerns about ‘the outcomes of surgery for some patients’ being treated by Dr Patel, that Ms Hoffman suggested there was conflict between Dr Patel and a number of staff including herself, and that she had put her concerns in writing, giving some detail about patients, their treatment and outcomes. The memorandum explained that interviews had been held with some staff (ie Drs Risson, Strahan, and Berens), that the concerns had been raised with Dr Patel following his return from leave on 13 January 2005, and that he had indicated that he did not intend to renew his contract when it expired on 31 March 2005.⁷⁸⁴ There were several attachments to the memorandum, namely:

- (a) The Hoffman letter;
- (b) The notes of the interviews with Drs Berens, Risson, and Strahan, and Ms Hoffman;

⁷⁸² T3202, T4253, T4204

⁷⁸³ The material is set out in Exhibit 281

⁷⁸⁴ Exhibit 281, T3203

- (c) An Adverse Event Report form signed by Ms Hoffman going to the Bramich incident (in which the assessor rated the risk as 'very high');
- (d) A copy of the email from Ms McMahon dated 17 December 2004;
- (e) A letter of complaint from a registered nurse on the surgical ward, Michelle Hunter, dated 4 January 2005 about the care given by Dr Patel to P26;
- (f) Letters of complaint from three registered nurses, Jenelle Law, Damien Gaddes, and Katrina Zwolak, all dated 14 January 2005, concerning Dr Patel's conduct in relation to the P44 incident, and the care given to Mr Kemps;
- (g) Ms Hoffman's revised version of 'ICU Issues with Ventilated Patients';
- (h) Letters of complaint from a registered nurses, Karen Stumer, dated 22 October 2004, concerning allegedly poor care provided to patients by Dr Patel;
- (i) Two statements from a registered nurse, Karen Fox, concerning poor care allegedly given by Dr Patel to Mr Bramich and another;
- (j) Letters of complaint from other nurses, namely Vivian Tapiolas, Kay Boisen (two), Karen Jenner concerning various poor care allegedly provided by Dr Patel;
- (k) A Sentinel Event form concerning Mr Bramich signed by Ms Hoffman; and
- (l) The catheter report.

3.346 There was various email correspondence between the Dr FitzGerald's office (mostly from Susan Jenkins, the Manager of Clinical Quality Unit for the Chief Health Officer) and the Base in the course of February 2005.⁷⁸⁵ The result was that Mrs Jenkins arranged that she would attend the Base on 14 February 2005 with Dr FitzGerald and the Base would make available certain medical records for perusal, together with certain people (numbering over 20) for interviews. Further, Dr FitzGerald indicated to Mr Leck that his visit would not take the form of an investigation into Dr Patel concerning particular charges. Instead, it would be a general clinical audit of the Base. He wrote that:

I have reviewed all the material to date and while it is appropriate to proceed with the clinical audit, it is too early to be able to document any particular concerns regarding any individual...it would be too early and inappropriate to raise any particular concerns with Dr Patel which he may feel he has to respond to in particular...⁷⁸⁶

⁷⁸⁵ Exhibit 225, GF11

⁷⁸⁶ Email of 8 February 2005, Exhibit 225, GF12

Dr FitzGerald says that prior to his visit, he met with officials of the Queensland Nurses Union and reassured them that those who attended meetings with him would be treated with respect, dignity and confidentially.⁷⁸⁷

- 3.347 I should say that there was evidence from Dr Keating that, during the meeting with Dr Patel on 13 January 2005, he was told that he was not to conduct any more oesophagectomies at the Base.⁷⁸⁸ It is startling to note, at this stage, how little had otherwise occurred. The Nurse Unit Manager had made a formal complaint on 22 October 2004 containing extremely serious allegations about the Director of Surgery. The complaint named particular files which might be studied and named particular doctors who might corroborate the concerns. The preliminary enquiries by management had, in fact, corroborated the concerns. They had also been supported by a barrage of complaints from a number of nurses, concerning a number of patients, some of them involving the deaths of patients. Further, some of the most serious complaints concerned incidents that had occurred after the Hoffman letter was delivered (notably the Kemps death and the P26 amputation). Notwithstanding those circumstances, it was the case by February 2005, that Dr Patel had been operating for some four months, without any investigation, since the delivery of the Hoffman letter. Further, now that some enquiry was being made, it was not being conducted by a surgeon but, rather, by the Chief Health Officer who, whilst he had qualifications as an emergency medicine specialist, had not practised clinically for some fifteen years.⁷⁸⁹ The investigation, if it can be called that, moreover, was not focused on considering the veracity of the charges against Dr Patel. Instead, it was to take the form of a clinical audit which, by definition, is 'non-judgmental or non-threatening,' which does not adopt 'processes which would seek guilt' and which, instead, seeks to 'identify issues of concerns so that those issues can be addressed in the interests of quality improvement.'⁷⁹⁰ One can well imagine circumstances where such a tool is useful, but this situation – where so many questions had been raised about a very senior, un-credentialed doctor conducting surgery in a regional hospital – is not one of them.

Dr Patel's contract is extended

- 3.348 Dr Keating maintained that, in December 2004, when Dr Patel was due to take leave (and was aware, of course, that his contract ended on 31 March 2005) he

⁷⁸⁷ Exhibit 225, para.62, T4205

⁷⁸⁸ T6822, T6828: Dr Keating says that this restriction was followed up later with another: that Dr Patel would not perform elective surgery requiring the support of the Base's Intensive Care Unit.

⁷⁸⁹ T6094. Some inquiries were apparently made in the course of November 2004 but the person identified was not considered suitable to perform the audit: T7229 Mr Leck testified that he spoke with Dr Mark Mattiussi in the course of his search for a suitable person to conduct an audit, and that conversation gave him some comfort that perhaps oesophagectomies were appropriate for the Base: T7238

⁷⁹⁰ T3214, Exhibit 225, para 63, T6113

put pressure on Dr Keating, to agree in writing on the terms of any extension.⁷⁹¹ The result was that Dr Keating wrote to Dr Patel by a letter dated 24 December 2004, offering an extension of his contract from 1 April 2005 to 31 March 2009.⁷⁹²

- 3.349 Dr Patel never accepted the four year contract proposal from Dr Keating. He went on holidays, and whilst he was away, there were further complaints about him, particularly from Dr Berens, Dr Carter and the registered nurses Ms Jenner, Ms Zwolak and Mr Gaddes, about the Kemps matter, and from Dr Rashford and the registered nurse, Ms Hunter, about the P26 matter. By the time Dr Patel had returned from holidays, Dr Keating had prepared two detailed briefing papers for Mr Leck. The papers spoke of Dr Patel's enthusiasm, his commitment to teaching and his efficiency innovations in the operating theatres. They also, however, acknowledged that Dr Patel had a number of serious flaws. They spoke of 'poor patient selection', a refusal to make appropriate transfers, carrying out operations when appropriate post-operative support was not available, unprofessional conduct with junior staff, poor judgment at times, outdated medical knowledge, and a lack of support from much of the staff. They also made reference to a number of allegations, including those of poor personal infection control measures, Dr Miach's concerns about the peritoneal catheters, Dr Jenkins concerns about P52, the increased wound dehiscence, the complaints surrounding the Bramich matter, and Dr Cook's approach.
- 3.350 Those notes were the subject of discussion between Dr Keating and Mr Leck.⁷⁹³
- 3.351 On 13 January 2005 and soon after Dr Patel's return, he and Mr Leck met with Dr Patel to discuss complaints that had arisen. At that meeting, they secured an undertaking that Dr Patel would not carry out any further oesophagectomies at the Base. Dr Patel then indicated he would not be renewing his contract.⁷⁹⁴ He wrote a letter to Dr Keating (with a copy going to Mr Leck) on 14 January 2005, indicating that he considered his decision was in everyone's best interest.
- 3.352 As might be expected, by this time, the issue of Dr Patel's competence, and the pending investigation were pressing on Mr Leck's mind. When he received an email from one of the Intensive Care nursing staff, Karen Smith, on 13 January 2005, reading simply, 'Dear All, Treacherous Day, regards, 'Muddy' [Ms Smith's nickname],⁷⁹⁵ he responded by emailing Ms Mulligan, 'Linda, please explore

⁷⁹¹ Exhibit 448, para 258, T6868

⁷⁹² Exhibit 448, para 259, DWK65; T6867 the offer was made notwithstanding Queensland Health guidelines requiring that appointments for more than one year be the subject of a formal appointment process. Dr Keating said he reasoned that, if the investigation into Dr Patel found that the complaints were well founded, the Base could escape the contract

⁷⁹³ Exhibit 448, para 261

⁷⁹⁴ Exhibit 448, DWK68

⁷⁹⁵ Exhibit 471

what is meant by 'treacherous day' – I assume it relates to Jay - so we need to quieten this down.'⁷⁹⁶

- 3.353 The employment situation changed quickly. By a letter dated 2 February 2005, Dr Keating offered Dr Patel a three month locum to 31 July 2005 (at a rate of \$1,150.00 per day) and Dr Patel accepted that locum position on 7 February 2005.⁷⁹⁷ At the same time, Dr Keating began navigating, for a third time on Dr Patel's behalf, the three obstacles for overseas doctors practising in Queensland, namely area of need certification, Medical Board registration, and obtaining a visa.
- 3.354 Dr Keating sought area of need certification for Dr Patel. That application recorded that registration was sought for the period from 1 April 2005 to 31 March 2006, and that a visa was sought from 1 April 2005 to 31 March 2009. The application was approved by Dr Huxley on 1 February 2005.⁷⁹⁸
- 3.355 On 31 January 2005, Dr Keating sent an application for registration to the Medical Board in respect of Dr Patel.⁷⁹⁹ Oddly, notwithstanding the correspondence that had already passed between Dr Keating and Dr Patel, the covering letter for the application (signed by Dr Keating) maintained that Dr Patel's contract had been extended to 31 March 2009.
- 3.356 There are a number of aspects of the application which warrant mention, namely:
- (a) Renewal was sought for a period of 12 months;
 - (b) No explanation was offered for how – given the terms of s141 of the *Medical Practitioners Registration Act*, an area of need doctor could be offered a contract for four years;
 - (c) Dr Patel for the third time maintained, falsely, that his registration in another country had not been affected by a condition;
 - (d) In the assessment form, Dr Keating again gave a glowing reference. Of the eleven categories, he marked Dr Patel's performance as 'exceptional' in two; 'better than expected' in six; and 'consistent with level of experience' in three. When asked to list Dr Patel's strengths, he recorded that 'Dr Patel is a very committed and enthusiastic clinician who has continued to be a very effective member of staff and Director of Surgery. He has a very strong work ethic which is a model for others. Dr Patel is a willing and effective teacher who has continued to make strong contributions.' When asked to list areas for improvement in Dr Patel, Dr Keating wrote simply 'nil significant'.

⁷⁹⁶ Exhibit 479. In fact, the initial email related to an entirely separate issue.

⁷⁹⁷ T6826, T6873-7, Exhibit 448, DWK 69, DWK70

⁷⁹⁸ Exhibit 448, DWK71

⁷⁹⁹ Exhibit 448, DWK70

- (e) In the area of need position description, Dr Keating wrote, amongst other things, 'Dr Patel has been in this role for the past 12 months and his performance ...rates as excellent'.

3.357 Also, on 1 February 2005, Dr Keating wrote to the Department of Immigration⁸⁰⁰ seeking an extension of Dr Patel's visa for four years. On behalf of the sponsor, the Bundaberg Health Service District, Dr Keating recorded that the proposed period of employment was four years.

3.358 Given the environment of complaint and pending investigation, one is driven to wonder, of course, how management at the Base could possibly contemplate engaging Dr Patel for another three months, let alone another four years. Dr Keating answered these queries in his testimony, albeit to my mind unsatisfactorily. He said that Dr Patel had been keen to secure a four year working visa in Australia, that he was very insistent and that the four year contract had been proposed to assist with the visa. He said that he was always conscious that any contract could be terminated if the investigation found against Dr Patel. He said that he was more effusive about Dr Patel than was warranted because he was concerned that Dr Patel would read the documents.⁸⁰¹ He said that he wanted to allow for the possibility that Dr Patel might leave the Base but agree to work there again at some later time.⁸⁰² He said he had overlooked the fact that some aspects of the documentation had not been altered after the parties began to look at a three month, rather than four year, extension.⁸⁰³ He inferred that the three month extension was necessary to allow the Base time to recruit a new surgeon.

3.359 I will deal with these matters more fully in my findings. Suffice to say, here, that I find it completely unacceptable that, faced with many staff complaints, and accepting as they did, that many of the complaints were well founded or warranted investigation, the executive should proceed to extend Dr Patel's contract.

Dr FitzGerald visits the Base

3.360 Dr FitzGerald and Mrs Jenkins visited the Base on 14 and 15 February 2005. Dr FitzGerald testified as to his involvement that:

Ordinarily I would arrange for somebody else to undertake these sorts of investigations and reviews and reports through me, but in this case, because I think, of the concerns raised by Peter Leck in our discussions over phone, and also the information presented, I thought this was probably a complex situation that may need perhaps – not so much technical judgment, but perhaps more – if I say political, the policy and interaction of people, and judgment about those

⁸⁰⁰ Exhibit 448DWK71

⁸⁰¹ T6886

⁸⁰² T6911

⁸⁰³ T6913

issues as well as the management of evidence, shall we call it, but certainly data about outcomes et cetera...

He also testified, however, that the visit effectively lasted only one day because on 15 February 2005, he and Mrs Jenkins visited Hervey Bay Hospital on unrelated business.⁸⁰⁴ He said that, when they first arrived at the Base, they met with Mr Leck and Dr Keating, and were informed that the Base had received no patient complaints or adverse events about Dr Patel (but a folder of complaints was located by the Central Zone Manager on 15 April 2005).⁸⁰⁵ Dr Keating gave evidence that, to his recollection, Dr FitzGerald's question was restricted to complaints that were the subject of litigation (of which there was only one relating to Mr Bramich).⁸⁰⁶ I prefer the evidence of Dr FitzGerald and, in any case, I can see no good reason for Dr Keating refraining from volunteering those complaints which had not, as yet, resulted in litigation.

- 3.361 Dr Keating did not communicate the issues set out in the briefing papers to Dr FitzGerald when he visited (let alone provide him with a copy). He took the attitude, he said, that he would answer such questions as were asked, and he said (as Dr FitzGerald acknowledged) that their discussions were very general.⁸⁰⁷
- 3.362 Dr FitzGerald testified that he did not seek to gain evidence on any particular matters during the Bundaberg interviews but, rather, he sought to 'collect [the] personal impressions of issues of concern' to those who chose to meet with him. He said that the principal issues of concern raised with him were that Dr Patel was conducting operations outside his scope of practice and that patients were not being transferred promptly.⁸⁰⁸ He conceded, however, that he gathered a wide range of information. He accepted, for instance, that Dr Miach spoke to him about the catheter placement issue and indicated, after consistent failures by Dr Patel, Dr Miach refused to send more patients to him.⁸⁰⁹ Dr FitzGerald said that, although he did not raise the issue with Dr Keating, he understood that the procedure of inserting the catheters should not have been complicated and, in any case, he questioned Dr Patel's judgment in doing six when he was incompetent.⁸¹⁰ He met a number of nurses and, presumably, they spoke to the wide ranging issues the subject of their complaints. He also gave evidence that most of the surgery was carried out by Dr Patel because Dr Gaffield reported to him. He said that he was surprised that oesophagectomies would be carried out, and concerned about the judgment of a surgeon who would do them.⁸¹¹ He was

⁸⁰⁴ T3226

⁸⁰⁵ Exhibit 225, para 75, T4239

⁸⁰⁶ T6966, Exhibit 448, paras 349 and 350

⁸⁰⁷ T6820

⁸⁰⁸ Exhibit 225, para. 65.

⁸⁰⁹ T3226

⁸¹⁰ T3226, T4249-50

⁸¹¹ T4230

also concerned by the judgment of a surgeon who would conduct the six peritoneal catheter placements.

- 3.363 Dr FitzGerald said he discovered a strange thing about Dr Patel's notes, either in the course of the visit or soon afterwards. He said it is not uncommon to come across medical records that are incomplete or inadequate. With Dr Patel, however, something quite different was evident. The notes were very well written: they just did not seem to reflect the information being received from other people.⁸¹² He gave the example of consents to operations and said that, if the notes were correct, then Dr Patel followed 'an exquisite process' in obtaining consent.
- 3.364 Ms Hoffman was one of the nurses who met with Dr FitzGerald. She said that the meeting lasted for 1½ to 2 hours. Dr FitzGerald explained that he was not conducting an investigation but rather a fact finding mission to decide whether an investigation should ensue. Ms Hoffman recalled that she spoke of all her general concerns about Dr Patel. She gave Dr FitzGerald specific examples of allegedly poor care and, where asked, she elaborated upon them.
- 3.365 The meeting did not fill Ms Hoffman with confidence. In the first place, she noted that Dr FitzGerald had not obtained a copy of her letter dated 22 October 2004 setting out in detail her concerns, let alone the various statements attached to that letter. (Dr FitzGerald testified, and I accept, that he had received the letter but did not take it to the meeting – or even, perhaps, to Bundaberg – because he was not there to test allegations.⁸¹³) Further, she recalls that, when Dr FitzGerald asked Ms Hoffman what she thought should happen and she said that she thought Dr Patel should be stood down pending an investigation,⁸¹⁴ he responded that it was 'better to have a surgeon rather than no surgeon at all'.⁸¹⁵ Counsel for the Nurses Union put this contention to Dr FitzGerald, and I note that he did not dispute it.⁸¹⁶ Dr FitzGerald said that he found Ms Hoffman to be very impressive, and so too a number of other staff members articulating similar views. He said, however, that there were some staff who believed that – whilst Dr Patel was doing operations which were inappropriate, and delaying transfers too long – his 'basic surgery was probably all right'.⁸¹⁷
- 3.366 Dr FitzGerald said that, at the conclusion of the interviews at the Base, he met with Dr Keating. He testified that he explained the outcome of the interviews generally and said that he would provide a draft report to the executive at the Base in due course (so that they could check it for factual accuracy) with a view

⁸¹² T4206

⁸¹³ T4209

⁸¹⁴ Dr FitzGerald himself agreed that Ms Hoffman specifically raised concerns about Dr Patel continuing to perform surgery: T4209

⁸¹⁵ T4208

⁸¹⁶ T4208-9

⁸¹⁷ T4213

to providing the final report in four to six weeks.⁸¹⁸ He said that, by the time he left, he had received undertakings from Dr Keating and Dr Patel that the latter would cease performing complicated operations at the Base and that he would ensure that patients were transferred appropriately. When Dr FitzGerald returned to Brisbane, he set about preparing a report but its completion was delayed by the need to obtain benchmarking data as to what was normal in comparable surgical practices.

- 3.367 Both Dr Keating and Mr Leck gave evidence⁸¹⁹ – consistent with Dr FitzGerald's evidence⁸²⁰ – that at the time of Dr FitzGerald's departure from the Base, he had reached no firm view on Dr Patel's competence.

The end game

- 3.368 Whilst Dr FitzGerald was drafting his report in Brisbane, Ms Hoffman was becoming increasingly concerned in Bundaberg that no action was being taken upon her letter of 22 October 2004. Dr FitzGerald did not return to her (or, for that matter, to the Base management) to indicate how the draft was developing. She was aware that, since delivery of her letter on 22 October 2004, a number of very serious incidents had occurred (attracting complaints about Dr Patel), including the death of Mr Kemps and the amputation of P26's leg. She was aware that, notwithstanding her letter, the Executive had named Dr Patel in November 2004 as the Employee of the Month.⁸²¹ She was aware, of course, that Dr Patel continued to operate. Further, whereas she had sought a chart audit, she was disappointed to be informed by Dr FitzGerald that he was undertaking something much more general, and to find him imbued with an attitude that 'a bad surgeon is better than no surgeon'. Ms Hoffman was particularly dismayed when Dr Patel came to the intensive care unit in about February 2005 to tell everybody 'the good news' that his contract was to be extended to July 2005 to help the Base achieve its elective surgery target.⁸²² She testified that, given the nature and number of the complaints against Dr Patel, this apparent development felt like a 'big huge slap in the face'.⁸²³

- 3.369 Ms Hoffman decided that she must take further action and she determined to approach the local member of Parliament, Mr Messenger MP.

- 3.370 Something should be said of Mr Messenger. He gave evidence before the Commission. He had been a member of the Royal Australian Air Force for some twenty years and an ABC radio journalist in 2002 and 2003. He said that in the

⁸¹⁸ T4237

⁸¹⁹ T6900, T7204

⁸²⁰ T4234-7

⁸²¹ T184

⁸²² Exhibit 4 para 154

⁸²³ T184

course of his work with the ABC, especially, he became keenly aware that health was a pressing issue in the Bundaberg area. State elections were held in Queensland on 7 February 2004. Mr Messenger gained pre-selection for the National Party and he campaigned very heavily around a theme of Bundaberg needing better health services, and of a halt being brought to bullying of health providers. In the event, Mr Messenger was elected as the Member of the Legislative Assembly for the seat of Burnett. It seems that, from that time, he became something of a lightning rod for health complaints. This may be because, whereas Mr Messenger was a member of the Opposition, the other seats in the area, Bundaberg and Hervey Bay, were held by members of the Government so that people were uncertain as to whether complaints would be fully explored. Alternatively, or additionally, it may be because of the terms of his campaign. In any case, in the course of his evidence, Mr Messenger was able to set out a busy history of receiving complaints from various constituents about problems with the Base Hospital. In particular, he related concerns communicated to him about the Mental Health Unit within the hospital.

- 3.371 On 18 March 2005, Ms Hoffman visited the offices of Mr Messenger and provided him with a copy of her letter dated 22 October 2004. She also spoke for some two hours to Mr Messenger about her concerns and Mr Messenger recorded that conversation.
- 3.372 In the days that followed, Mr Messenger sought advice from his political colleagues and on that basis decided that, before progressing Ms Hoffman's complaints, he should seek some corroboration. He made a telephone call to Dr Strahan who was, of course, named in the letter as somebody who was a leader in the local medical community. Mr Messenger's evidence was that Dr Strahan told him that the local medical community was well aware of concerns about Dr Patel but they were hoping that he would go away at the end of his contract.
- 3.373 Mr Messenger considered this to be sufficient corroboration for Ms Hoffman's complaints which, one can readily see, would have been cogent and compelling in themselves. On 22 March 2005, Mr Messenger tabled the Hoffman letter in Parliament, and the Shadow Health Minister, Stuart Copeland, MP, asked a question without notice of the Minister for Health, Gordon Nuttall MP.⁸²⁴ He referred to 'the fact finding process conducted by Dr FitzGerald' and the serious allegations raised about Dr Patel's competence, and asked if the Dr FitzGerald's findings would be released. Mr Nuttall responded that he was not aware of the issue but would make enquiries.
- 3.374 On the same day, Dr FitzGerald was asked to provide notes to, and orally brief, the Minister about Dr Patel. Dr FitzGerald emailed the Minister's office with

⁸²⁴ Hansard, 22 March 2005, page 611

background information and suggested answers to Parliamentary questions. He met with the Director-General and, later in the day, he met with the Minister (when, it seems, he spoke to the emailed material).⁸²⁵ He indicated to the Minister – as was the case – that his draft report was nearly complete but he was awaiting benchmarking data from similar hospitals. He also indicated that Dr Patel had been performing surgery outside his scope of practice but that Dr FitzGerald had advised the Base that he should cease doing so.⁸²⁶ On 23 March 2005, Mr Nuttall made a statement to Parliament, explaining amongst other things that Dr FitzGerald's clinical audit was incomplete but it would be provided, when finalised, to the Director-General.⁸²⁷

3.375 Still, it seems, nothing was done to stop Dr Patel practising surgery on the people of Bundaberg. On the contrary, a number of nurses gave very consistent evidence that they were reprimanded *en masse*.⁸²⁸ Ms Hoffman said that, on the day after Mr Messenger spoke in Parliament, the Acting Director of Nursing called a meeting of ICU staff. She said that, when all the nurses were assembled, Mr Leck arrived. He was visibly furious, lectured those present about the Code of Conduct, that the conduct in naming Dr Patel was appalling and that it would erode confidence in the Base. Then he left.⁸²⁹

3.376 On the same day, and with the apparent approval of head office,⁸³⁰ Mr Leck responded to urgings from Dr Patel by writing a letter of support in the Bundaberg News-Mail which read:

I refer to the article of March 23 concerning allegations made against surgeon Dr Jay Patel. The fact that a number of allegations have been made public without completion of a review process designed to ensure that the application of natural justice, is reprehensible. At this time, I have received no advice indicating that the allegations have been substantiated. A range of systems are in place to monitor patient safety and the community can be assured that we constantly work to improve our service delivery. Dr Patel is an industrious surgeon who has spent many years working to improve the lives of ordinary people in both the United States and Australia. He deserves a fair go.⁸³¹

3.377 On the following day, Dr Patel resigned.⁸³² He wavered, subsequently, it seems in his position, and Mr Leck testified that, as far as he was concerned, the three month contract to July 2005 was still available to Dr Patel.⁸³³ In the event, of course, he resigned.

⁸²⁵ Exhibit 391, T6134, T6154

⁸²⁶ T5311-2: Dr FitzGerald gave evidence that he gave advice in the terms of his subsequent report, which was effectively complete but for the benchmarking detail: T6134

⁸²⁷ Hansard, 23 March 2005, page 691

⁸²⁸ Nurses Hoffman, Aylmer, Jenner

⁸²⁹ Exhibit 4, paras 167-9

⁸³⁰ T7207, Exhibit 474

⁸³¹ Exhibit 473

⁸³² Exhibit 475, T7245

⁸³³ T7246. Mr Leck said that this was because any immediate departure would cause problems in maintaining a service: T7244

3.378 Also on 24 March 2005, Dr FitzGerald finalised his report and provided it to the Director-General (but not the Minister).⁸³⁴ The report, which was tendered in evidence:⁸³⁵

- (a) was entitled 'Clinical Audit of General Surgical Services, Bundaberg Base Hospital, Confidential Audit Report';
- (b) explained that a clinical audit is a 'systematic review and critical analysis of recognised measures of the quality of clinical care, which enables benchmarking and identified areas for improvement...';
- (c) says that the catalyst for the audit was a 'level of concern raised by a number of staff at the hospital in regard to some patient outcomes [and] ...a number of staff interactions';
- (d) summarises staff opinion under the 'nine quality dimensions of the National Health Performance Framework';
- (e) suggested a number of systemic changes including the implementation of a credentialing system and an audit system;
- (f) compared some rates of complications for Bundaberg with those recorded nationally;
- (g) maintained that staff concerns fell into two main groups, namely procedures being conducted beyond the scope of the Base and the lack of good working relationships between staff;
- (h) noted that there was also concern about increased rates of unplanned admission, complication and wound dehiscence;
- (i) suggested a number of systemic changes.

3.379 I should say that there are a number of aspects of the report that concern me. First, notwithstanding the events which precipitated the report, it makes no reference to Dr Patel by name, and infrequent reference to him by office, i.e., 'the Director of Surgery'.⁸³⁶ Second, no comment is made on startling statistics contained within the report. A table contained in Appendix A-1 suggested that the rate of surgical complications in Bundaberg was, in a number of categories, more than double that for the peer group.⁸³⁷ Further, a table at page 9 of the report shows that, whereas the national rate of bile duct injury had been steadily decreasing so that it was at .29% in 2003, the Bundaberg rate had steadily increased from July 2003 so that, for the semester ended December 2004, it was at 8.06% some 28 times higher than the national figure. Dr FitzGerald gave

⁸³⁴ T6096

⁸³⁵ One version appears as Exhibit 230 (T3214) and the final version appears as Exhibit 225, GF30

⁸³⁶ Exhibit 225, T4221

⁸³⁷ T3216

evidence that most of those injuries would be associated with the procedure known as a laparoscopic cholecystectomy, and that this was a relatively routine operation for a general surgeon. Those factors, in my view, would rather excite one to question the competence of the operating surgeon, Dr Patel. I note that I asked Dr FitzGerald, in the course of his evidence, to explain why he did not mention in the report that there was a prima facie case that Dr Patel was incompetently performing routine surgery. He said he could not answer that question.⁸³⁸

- 3.380 In the third place, where references are made to the Director of Surgery, they are almost all positive⁸³⁹. It is noted that the Director was 'accessible...and easy to contact', had 'a good work ethic and a heavy workload,' and had 'created efficiencies in OT by changing some outmoded work practices'. Further, where negative comments are made, they are juxtaposed with positive comments or downplayed. The report speaks very generally about concerns being raised and then continues: 'However, as well as raising concerns, some staff made complimentary comments about the divisional director's commitment to teaching and mentoring of junior medical staff. In addition, there has been significant improvement in efficiency, especially in the operating theatre and in meeting elective surgery targets'. Where the report talks of a lack of good working relationships between staff, it acknowledged that the director had a confronting personality, but it also read 'the director of surgery has high standards and this has led to some degree of conflict with staff.' Dr FitzGerald said that it is part of the philosophy behind clinical audits that, whilst they might include positive comments about an individual, they omit negative ones. As he was forced to agree, that necessarily gives the reader a skewed picture of the individual.⁸⁴⁰
- 3.381 Fourthly, where changes were recommended, it was suggested that the problems were generic rather than confined to Dr Patel.⁸⁴¹ The report spoke of the need for 'team building' but Dr FitzGerald could not identify problems in communication independent of Dr Patel; it spoke of the need to complete the implementation of credentialing but Dr FitzGerald was not aware of anyone who had not been credentialed other than Dr Patel (and, by inference, perhaps, Dr Gaffield).⁸⁴² He did not highlight, moreover, the very disturbing fact that Dr Patel had not been the subject of this process in a term lasting almost two years.⁸⁴³
- 3.382 Fifthly, there was no attempt to address the very serious allegations raised by a number of senior doctors and nurses, and no suggestion that those allegations might be dealt with by a more detailed enquiry.

⁸³⁸ T6111

⁸³⁹ T4221-4

⁸⁴⁰ T6121

⁸⁴¹ T6123

⁸⁴² T4221-4

⁸⁴³ T6125

- 3.383 Sixthly, there was no critique of important systemic failings such as the failure to credential and privilege Dr Patel, to have a strong audit system in place, or to conduct frank mortality and morbidity meetings.
- 3.384 Seventhly, the report contained many recommendations but none of them proposed that Dr Patel should be directed to cease operating⁸⁴⁴ or that his contract should not be renewed.⁸⁴⁵
- 3.385 Dr FitzGerald has responded to these points. He said that the practice in clinical audits is to praise individuals, where appropriate, but to confine criticisms to systems rather than people. He said that he was not performing a management audit and that was why he did not look at managerial failings. He said that he did not address concerns about Dr Patel's registration because, even though clinical audits are confidential, they often reach the public domain. He also points out that he did take steps to confine any damage from Dr Patel. In the first place, he obtained an undertaking from Dr Keating that Dr Patel would not carry out oesophagectomies or complex surgery.⁸⁴⁶ In the second place, he contacted the Medical Board on 16 February 2005 and arranged that the determination of Dr Patel's pending application for renewal would be deferred.⁸⁴⁷ In the third place, he wrote to the Medical Board when he completed his report on 24 March 2005, suggesting that they consider investigating the competency of Dr Patel.⁸⁴⁸ In the fourth place, he notes, he sent a memorandum to the Director-General on 24 March 2005, dealing more directly with concerns about Dr Patel.
- 3.386 The latter memorandum (which was not sent to anyone other than the Director-General) was certainly in dramatically different terms to the report. It read relevantly:⁸⁴⁹

The report of the clinical audit is now complete and I have attached a copy to this memorandum...

There is evidence that the Director of Surgery at Bundaberg Hospital has a significantly higher surgical complication rate than the peer group rate (Appendix 1). In addition, he appears to have undertaken types of surgery which in my view are beyond the capability of Bundaberg Hospital and possibly beyond his own skills and experience, although his surgical competence has not been examined in detail. I believe his judgment, both in undertaking these procedures and also delaying the transfer of patients to a higher level facility, is below that which is expected by Queensland Health. I would recommend that these matters should be examined by the Medical Board and have written to the Executive Officer – Mr Jim O'Dempsey, bringing the matter to his attention.

The audit report also identifies that there has been a failure of systems at the hospital which has led to a delay in the resolution of these matters. The

⁸⁴⁴ Dr FitzGerald acknowledged that this was an option available to Queensland Health (as, of course, is clear from the credentialing policy): T6097

⁸⁴⁵ T4226, T42328

⁸⁴⁶ T4234

⁸⁴⁷ T3228, T6146

⁸⁴⁸ T3248

⁸⁴⁹ Exhibit 225, GF14

Credentials and Clinical Privileges Committee has not appropriately considered or credentialed the doctor concerned. The Executive Management Team at the hospital does not appear to have responded in a timely or effective manner to the concerns raised by staff, some of which were raised over twelve months ago. While the report makes a number of recommendations for system improvements, I would recommend that some discussions should occur with hospital management, reminding them of their responsibilities to put such systems in place and ensure they respond appropriately for reasonable clinical quality concerns.

3.387 In the end, I remain critical of Dr FitzGerald's conduct. The reason for his involvement was that Mr Leck was anxious to ascertain whether there was any substance to the serious allegations he was receiving. He should have received an answer in the affirmative. Instead, and despite the very serious allegations with which he was briefed before he even visited Bundaberg, Dr FitzGerald chose to adopt a style of investigation which, necessarily, would 'accent the positives.' That point, in any case was, for a long time, academic because Dr FitzGerald testified that, although he sent the completed report to the Director-General on 24 March 2005, he did not send it (or a draft) to the executive at the Base until 7 April 2005 (and only then because the Director-General asked him to do so).⁸⁵⁰ Dr FitzGerald could not explain why this was so.⁸⁵¹ The political considerations in Brisbane seem to have taken priority over the clinical interests of patients in Bundaberg. In that regard, it is little comfort that Dr Patel should give an undertaking not to conduct complex operations. Given that he had no effective supervisor and there was no written protocol, he was to be the arbiter of complexity - and that in circumstances where his judgment was extremely questionable.⁸⁵² Further, the statistics (both in the report's tables and in the catheter results) demonstrated that Dr Patel could show incompetence even in routine procedures.

3.388 The issue of supervision leads me to a further failing in Dr FitzGerald's work. He was not only the Chief Health Officer but, by virtue of that position, a member of the Medical Board. He was informed, of course, during his visit to Bundaberg that Dr Patel had not been credentialed at the Base. He said that he was told that this was because the College's co-operation could not be secured so he recommended that the Base nominate its own surgeon.⁸⁵³ Given the failings he had noted in management and the complaints he had heard in relation to Dr Patel, he should have taken steps to see that happened immediately but he did not do so.⁸⁵⁴ There is a bigger issue. Dr FitzGerald commenced his review on

⁸⁵⁰ T6015-6, T6819. The fact that the Base did not learn of the audit findings until 7 April 2005 is all the more remarkable because the Director-General was in telephone and email contact with Mr Leck on 24 March 2005: T5500

⁸⁵¹ T6133. The delay is hard to reconcile with Dr FitzGerald's knowledge that Mr Leck was relying upon the report: T6145

⁸⁵² T4236, T6108

⁸⁵³ T4236, T3222, T3224, T3225, T6929

⁸⁵⁴ T6112

about 20 January 2005, when he received Mr Leck's memorandum with a bundle of attachments.⁸⁵⁵ Dr FitzGerald should have checked the circumstances of Dr Patel's registration (and he could have done so very quickly as a member of the Medical Board). He would have noted a striking anomaly, namely that Dr Patel was not recognised as a specialist in Queensland, and yet he was practising in an unsupervised position, without any peer review, as the Director of Surgery. That, and the bundle of complaints, should have prompted him to see that there was urgent assessment of Dr Patel's work by a surgeon and to seek a review by the Medical Board. He never took the first step. The second was only taken on 24 March 2005 - seven days before Dr Patel's registration was due to expire - when Dr FitzGerald asked the Medical Board for an 'assessment of [his] performance'.⁸⁵⁶

- 3.389 Dr FitzGerald gave evidence that his understanding in February 2005 was that the Base and Dr Patel were negotiating about a possible extension to the contract for three months.⁸⁵⁷ That fact should have made action on Dr FitzGerald's part particularly urgent – both to ensure that any incompetency be curtailed over that three month period and because the Base would have wished to know of any such issues before negotiations concluded.
- 3.390 The necessary result of Dr FitzGerald's approach was that Dr Patel was able to continue to practise, and that any investigation would, at best, be substantially impaired because he had departed. Dr FitzGerald said that Mr Leck's memorandum of 19 January 2005 made him turn his mind to finishing the investigation before Dr Patel left because 'it worries me at times where we don't progress investigations because people depart, that there is unfinished business, and as a result, when these people come back there is no evidence to avoid or manage the issues that were of concern before'.⁸⁵⁸ I share that concern and would add that there should be some sense of responsibility within Queensland to ensure that incompetent and dangerous doctors are not able to simply move to a different state or country and set up practice anew with a clean record because Queensland has failed to respond promptly to complaints.
- 3.391 On 29 March 2005, Mr Leck informed Dr FitzGerald that Dr Patel was on 'stress leave' and was intending to depart the country.⁸⁵⁹ In fact, two days later, Dr Patel departed Australia for America, with a ticket paid for by Queensland Health.

⁸⁵⁵ T6110

⁸⁵⁶ Exhibit 225, GF13; Dr FitzGerald acknowledged that he was aware any investigation by the Medical Board could take weeks or months: T6117

⁸⁵⁷ T6159, and see T6145-6 and Exhibit 392, Copy 1

⁸⁵⁸ T3203

⁸⁵⁹ T6107

- 3.392 On 7 April 2005, the Minister, Gordon Nuttall MP, and the Director-General of Queensland Health, Dr Stephen Buckland, visited the Base. Staff were notified by email that there was to be a 'staff forum' concerning the Patel matter⁸⁶⁰ and, in the event, about 100 to 150 staff attended the forum. One of those attending was Margaret Mears and she said that, from the outset, she 'felt under attack.' She said the Minister noted that he had just been to Springsure, which was a 'wonderful town' and 'now here we are in Bundaberg'.⁸⁶¹ She recalls that Mr Nuttall and Dr Buckland told the staff that the outcome of the clinical audit would not be published because of the release of the Hoffman letter, and Dr Patel's departure. Dr Buckland said that, in the circumstances, no decent doctor would want to work in Bundaberg.⁸⁶² Her recollection was that Mr Nuttall said that the only way they could stop the 'rubbish' was by voting out Mr Messenger.⁸⁶³
- 3.393 Another nurse who attended the meeting, Karen Jenner, gave evidence that the meeting was told that the report compiled by Dr FitzGerald would not be made public now because Dr Patel had been denied natural justice and had returned to America.⁸⁶⁴ She said Dr Buckland said that he 'supported his staff one hundred per cent and would not tolerate them being denied natural justice'.⁸⁶⁵
- 3.394 Ms Aylmer also attended the forum. She said that the speakers took an aggressive tone, particularly Dr Buckland, and that the staff were told that, 'due to the leak to the media' the clinical audit could not be released.⁸⁶⁶ She recalled Ms Jenner querying the contention that the audit results could not be published because Dr Patel was overseas, and Dr Buckland responding with words to the effect, 'The report will not be released: what part of that don't you understand'.⁸⁶⁷
- 3.395 Dr Buckland addressed this issue in evidence and in his statement. He said that he and the Minister were visiting Springsure and they decided to divert the plane back because of the negative media coverage concerning the Base. He said that neither he nor the Minister said there would be no further action taken on the clinical audit: rather, Dr Buckland maintained, he said that it would be hard to take any action against Dr Patel in view of his departure but the review process would otherwise continue.⁸⁶⁸ He acknowledged that he did say that, now that Dr Patel had left the country, the 'audit process would be difficult to finalise'.⁸⁶⁹ Dr Buckland accepted that the tone and effect of his comments at the meeting were probably critical of the way that matters had been ventilated in the media.⁸⁷⁰ He

⁸⁶⁰ Exhibit 507, para 12

⁸⁶¹ Exhibit 507

⁸⁶² Exhibit 507

⁸⁶³ T7375

⁸⁶⁴ Exhibit 508

⁸⁶⁵ Exhibit 508

⁸⁶⁶ Exhibit 59, para 47

⁸⁶⁷ T1009-1010

⁸⁶⁸ Exhibit 335, para 34

⁸⁶⁹ Exhibit 335, para 33, T5505

⁸⁷⁰ T5567

also conceded that he may have said words to the effect that 'no decent doctor would want to come to Bundaberg to work in such circumstances'.⁸⁷¹ Dr Buckland testified that the intent of the visit was not to 'engage in a major confrontation' but rather to 'reassure the staff that they had our support'.⁸⁷² One can understand how that might not have been readily apparent to the staff.

- 3.396 The comment that the audit process would be difficult to finalise, is particularly hard to understand given that Dr FitzGerald had specifically indicated by his memorandum of 24 March 2005, that his attached audit was complete. Dr Buckland testified that the audit process is much more than the report, that after the report is written there is a period of consultation with those considered therein, and this was the part that would be difficult to complete. He denied that what he was really communicating was that, since Dr Patel was not coming back and could not be afforded natural justice, the audit would not be completed, but he conceded that his language was poorly chosen.⁸⁷³
- 3.397 In the end, I accept the evidence of the nurses. It is corroborated, in any case, by much of the other testimony, including the evidence of Dr Keating who was present at the meeting. He said that the Minister and the Director-General announced that there would be no further investigation, and that the investigation had been stopped. He said that Dr Buckland told the meeting that this was because Dr Patel 'could not put his side of the story' from America.⁸⁷⁴ He said that some recommendations going to systemic matters would be provided to the executive. He said that Mr Nuttall had said he was there to support the staff and that it was going to take a lot of work to regain the trust of the local community. He recalls the Minister saying that he had just come from Springsure where he opened a multipurpose health service, and that there was a contrast in what he had done that day.⁸⁷⁵
- 3.398 The evidence from the nurses spoke consistently about aggression or belittling or angry tone on the part of the speakers. I do not believe that the Minister and the Director-General would have allowed this impression to be communicated inadvertently. Dr Buckland agreed that there was clearly a 'level of frustration and anger' on the part of staff regarding the issue, and he could hardly have thought that his comments would be construed as supportive. I am strongly inclined to the view that the main purpose of the meeting for the Minister and Dr Buckland was to tell staff that the audit report would not be released and to admonish them to 'move on.' I do not accept Dr Buckland's explanation of his comments. In particular, I believe he was less than honest in telling staff that the

⁸⁷¹ T5567

⁸⁷² T5567

⁸⁷³ T5506, Exhibit 335, para 34

⁸⁷⁴ T6817

⁸⁷⁵ T6818

audit process had not been finalised, that it could not be released in Dr Patel's absence, and that - somehow - natural justice could only be afforded to people who are present in the country. The position taken by Dr Buckland was particularly unsavoury because, as he well knew, Dr FitzGerald – by his memorandum of 24 March 2005 - had reached firm views on Dr Patel's competence, had recommended that the matter be referred to the Medical Board, and had not suggested that Queensland Health needed to take up any issues with the practitioner.

3.399 The effect of the comments made by Mr Nuttall, and especially Dr Buckland, at the forum was to discourage staff from raising complaints about clinical issues,⁸⁷⁶ and I find that the two men were well aware that the comments would have that effect.

3.400 Some time later on 7 April 2005, Mr Leck was communicating with the zonal manager, Mr Bergin, about the leak of information.⁸⁷⁷ Where Mr Bergin had asked whether Internal Audit had been 'involved' to investigate the matter, Mr Leck responded relevantly:

No, not at present...In the meeting today the DG advised that we would not have a witch hunt and that we needed to move on from this incident. The Minister said that leaking confidential information including patient details such as UR numbers was unacceptable and that whilst he supports freedom of speech in terms of raising matters with MP's, he would not tolerate the leaking of such information...Perhaps we have the Audit team come up and deliver some training sessions around the Code of Conduct and deliver some firm and scary message?

...

3.401 Dr Keating gave evidence that, immediately following the meeting at the Base attended by the Minister and the Director-General, he spoke privately with Dr Buckland. He explained, as was the case,⁸⁷⁸ that he had conducted a "Google" search on the previous evening and it had revealed Dr Patel's disciplinary history in the United States.⁸⁷⁹ Dr Buckland recalls receiving that information and gave evidence that, as they returned by aeroplane to Brisbane, he said to the Minister words to the effect of 'There is more to this guy than we know. I will have a look at it', but no more⁸⁸⁰. The Minister, for his part, could not remember such a conversation. Dr FitzGerald gave evidence that, within a day or so of Dr Buckland's visit to Bundaberg, Dr Buckland told him that he had been informed by Dr Keating that a "Google" search revealed problems with Dr Patel's registration.⁸⁸¹

⁸⁷⁶ T6821

⁸⁷⁷ Exhibit 477; T7211

⁸⁷⁸ T6812

⁸⁷⁹ T6815

⁸⁸⁰ T5507, Exhibit 391, para 36

⁸⁸¹ T4211

- 3.402 Certainly, it is the case, that although Queensland Health and the Medical Board were alerted to the possibility of registration anomalies by about 8 April 2005,⁸⁸² the existence of those anomalies was only made known to the public through an article in *the Courier-Mail* on Wednesday 13 April 2005.⁸⁸³ There appear to have been no plans at that time to disclose the registration anomaly with the public.⁸⁸⁴ The article by Mr Thomas created huge interest because it revealed that Dr Patel had been restricted from certain types of surgery in Oregon and that he had been required to surrender his licence in New York.
- 3.403 It remained the case that still a surgeon had not reviewed Dr Patel's work.
- 3.404 On 9 April 2005, however, the Minister announced that a Queensland Health team, headed by Dr Mark Mattiussi, the District Manager for the Logan and Beaudesert District Health Service), and including Dr John Wakefield (Executive Director Patient Safety Centre) and Associate Professor, Leonie Hobbs (Acting Executive Director Women's & Newborn Services, Royal Brisbane and Women's Hospital) and Dr Peter Woodruff (vascular surgeon) would conduct a review.
- 3.405 On 26 April 2005, the Government announced a Commission of Inquiry.

Conclusion

- 3.406 It is impossible to consider the history of complaints against Dr Patel without one matter impressing itself forcefully. Within eight weeks of the commencement of Dr Patel's employment, there was a very serious complaint, relating to an oesophagectomy for Mr Phillips and another for Mr Grave. From that time, there was a long, long history of patients who received terrible outcomes, and people, whether they be patients, relatives or for that matter medical staff, who were deeply affected by experiences. Notwithstanding that first complaint in May 2003, Queensland Health did not obtain a surgeon's review of Dr Patel's work until June 2005, when Dr Woodruff provided his section of the review team's report. It was painfully obvious to Dr Woodruff and indeed the other two surgeons who subsequently reviewed Dr Patel's work, that he was not a competent surgeon. One must ask then how the system failed Bundaberg so badly.

⁸⁸² T4261

⁸⁸³ T4229-4230: The story of Dr Patel and Mr Messenger's speech had been reported by the *Bundaberg News-Mail* and *The Courier-Mail* but it received fresh impetus with the publication of Mr Thomas' article about Dr Patel's disciplinary history.

⁸⁸⁴ T4264

THE COMPETENCE OF DR PATEL

3.407 Dr Patel held himself out as a general surgeon - both by his initial approach to Wavelength Consulting Pty Ltd⁸⁸⁵ and by the subsequent provision of his *curriculum vitae* - and he engaged in the practice of a general surgeon whilst employed at the Base. Accordingly, when I consider his competence below, I do so by reference to the standard expected of a general surgeon in Australia.

What is a General Surgeon?

3.408 The *Medical Practitioners Registration Act* 2001 provides, in effect, that a person may only use the title of 'surgeon' in Queensland if he or she is a fellow of the Royal Australasian College of Surgeons, and is registered by the Medical Board in one of nine subspecialties.⁸⁸⁶ The College, for its part, recognises the same nine subspecialties of surgery, namely general, cardiothoracic, orthopedic, pediatric, vascular, urology, plastic and reconstructive, otolaryngology head and neck, and neurosurgery.⁸⁸⁷ In practice, a trainee surgeon must choose from those nine areas and, if the trainee gains a fellowship, it will be specific to that sub-specialty. It follows, of course, that a surgeon may gain a fellowship in an area such as orthopaedics or neurosurgery, without ever understanding those issues peculiar to general surgery.

3.409 The subspecialty of general surgery is predominantly concerned with the abdominal organs, including the liver, the pancreas, the bowel, and the gallbladder. It is also concerned with breast, extracranial and endocrine surgery (particularly where the latter concerns the thyroid).⁸⁸⁸ The surgery to be conducted will include hernia repair (where a hole in the abdominal wall is patched or stitched), appendectomies, colorectal procedures, splenectomies breast reconstruction, mastectomies, and procedures to the liver, gallbladder, pancreas, bowel and the thyroid.⁸⁸⁹ The College points out that the scope of general surgery is difficult to define⁸⁹⁰ and I infer that general surgeons may also practise in those areas not covered more specifically by one of the other subspecialties.

3.410 As might be expected, the training required to become a Fellow in General Surgery is rigorous. The usual path is as follows. Candidates complete a primary medical degree and they then work for one year as interns in hospitals;⁸⁹¹ they

⁸⁸⁵ T675

⁸⁸⁶ see section 161, and Schedule 3 to the Regulations

⁸⁸⁷ www.surgeons.org

⁸⁸⁸ T4421

⁸⁸⁹ T3598, T 4421; Wilson RE, 'Multispecialty Surgical Conditions in General Practice', *MJA* 2005; 182 (7): 337-339; and see 'Logbook, General Surgery' at www.surgeons.org

⁸⁹⁰ www.surgeons.org

⁸⁹¹ T555, www.surgeons.org

will work for a further one to three years as a house officer as they wait to gain selection for an accredited training position,⁸⁹² then they will complete two to four years of basic surgical training.⁸⁹³ At the end of that training, the doctor – now a registrar - may compete for a position on an advanced surgical training program in general surgery (or such other subspecialty as the doctor chooses).⁸⁹⁴ This program will be completed over four years⁸⁹⁵ and the College stipulates, amongst other things, that the registrar must perform a certain number of procedures unassisted in the course of the program.⁸⁹⁶ Throughout the basic and specialist surgical programs, the trainees are subject to checks by the College in terms of logbooks, reports and examinations.⁸⁹⁷ There are also minimum requirements for training posts to ensure quality, including a minimum number of specialists to supervise trainees and a minimum amount of work flowing through those posts.⁸⁹⁸

- 3.411 Following successful completion of these requirements, the doctor is awarded a fellowship in general surgery from the Royal Australasian College of Surgeons. By that time, the doctor is likely to be aged in his or her mid 30's and will have considerable experience as a junior doctor, as a registrar, and in performing various operations both supervised and unassisted. Even after gaining fellowship, surgeons are required to meet certain standards set by the College. They must engage in continuing medical education programs, reaccreditation courses (usually on a three to five year basis), and other educational and quality assurance activities.⁸⁹⁹ The College runs panels of review for its members and, where necessary, requires them to attend certain courses, have their work mentored, or cease certain activities pending skills assessment.⁹⁰⁰
- 3.412 One of the key quality assurance activities the College requires of its members is regular participation in morbidity and mortality meetings. In essence these meetings are attended by surgeons and junior doctors. Recent cases which have involved a death or an adverse outcome are presented, usually by junior doctors, and then discussed by all present, with a view to considering how similar outcomes might be avoided in the future and improving generally the level of clinical care.⁹⁰¹

⁸⁹² T555, Exhibit 34 para [4]

⁸⁹³ RACS: *Review of the Assessment of Overseas Trained Doctors*, April 2005, page 9 viewed 2 November 2005, <http://www.surgeons.org> Selection into basic surgical training is a two part process, requiring selection into the College program and appointment to an accredited hospital.

⁸⁹⁴ RACS: *Review of the Assessment of Overseas Trained Doctors*, April 2005, page 9 viewed 2 November 2005, <<http://www.surgeons.org>>

⁸⁹⁵ T555, www.surgeons.org

⁸⁹⁶ www.surgeons.org

⁸⁹⁷ T770 and T771

⁸⁹⁸ T776

⁸⁹⁹ T771

⁹⁰⁰ T771

⁹⁰¹ T3620

- 3.413 Doctors who have been trained overseas may, of course, gain a fellowship in the College. Indeed, the changes to the *Medical Practitioner's Registration Act 2001* made by s143A, if implemented appropriately, should ensure that doctors who are registered as 'deemed specialists' are moving towards full fellowship if they stay for any length of time. For each overseas trained applicant, the College will usually assess the doctor's qualifications and experience, and then determine the further training required to gain fellowship. It will usually require that the applicant undergo a period of at least twelve months supervision before being considered for fellowship.⁹⁰² Where overseas trained doctors have been awarded a fellowship they have met precisely the same standards as are required of an Australian-trained surgeon.⁹⁰³
- 3.414 In short, a person will only attain the position of general surgeon in Australia if he or she has demonstrated discipline, aptitude, experience and knowledge, and complied with the professional obligations set by the College. Citizens are entitled to expect (as, in my experience, they do) that doctors who hold this standing will act in a learned and professional way.
- 3.415 Evidence going to the competency of Dr Patel was received from three surgeons, namely Geoffrey de Lacy, Barry O'Loughlin, and Peter Woodruff. Each of those doctors considered a sample of Dr Patel's patients, and whilst the range of patients differed markedly, the doctors' conclusions did not. Each of them found, amongst other things, that the care given by Dr Patel fell well below the standard expected of a reasonably competent surgeon.

Dr de Lacy

- 3.416 Dr de Lacy gave evidence that:

- (a) He was awarded a fellowship of the Royal Australasian College of Surgeons in 1997 and has practised since that time as a general surgeon. During 1998 and 1999, he was the Director of Surgery at the QEII Hospital in Brisbane, and he has also held appointments as a senior lecturer in surgery at the University of Queensland, and as an examiner for the Australian Medical Council;⁹⁰⁴
- (b) He has worked previously in regional hospitals at Maryborough, Hervey Bay, Broken Hill, Gosford and Griffith;
- (c) He moved to Bundaberg in July 2003 and has maintained a private practice from the Mater in Bundaberg as a general surgeon since that

⁹⁰² RACS: *Review of the Assessment of Overseas Trained Doctors*, April 2005, page 28 viewed 2 November 2005, <http://www.surgeons.org>; see T1985 and 1986 for an explanation of the rigorous process applied by one of the Australian Colleges.

⁹⁰³ eg, Dr Jayasakera in surgery, and Dr Smalberger and Dr Berens in the Royal Australian College of Physicians

⁹⁰⁴ T 3594

time. He has also worked for approximately two years as a Visiting Medical Officer at the Base;⁹⁰⁵

- (d) Queensland Health had implemented an arrangement whereby former Patel patients might see one of a panel of surgeons at Queensland Health's expense, for a second opinion or follow up surgery. Dr de Lacy participated in that arrangement. In consequence, he saw over 150 patients and he has carried out more than 100 procedures, whether they be diagnostic or remedial.⁹⁰⁶ For all the patients, Dr de Lacy prepared individual reports and provided the same (which go into considerable technical detail and have been tendered in evidence) to the relevant general practitioners;⁹⁰⁷
- (e) In providing information and opinions in those reports, Dr de Lacy availed himself of the following sources, namely the history taken from the patient, the x-rays and pathology reports (all of which were made available by the Base)⁹⁰⁸, and the data gleaned through an examination of the patient and, in some case, subsequent surgery;⁹⁰⁹
- (f) Dr de Lacy had his reports to hand when giving evidence;
- (g) In his opinion, Dr Patel fell well below the standard of a competent surgeon in the vast majority of cases.⁹¹⁰ Although he had not compiled a list, Dr de Lacy believed that the number of patients who received appropriate care may have been as few as ten;⁹¹¹
- (h) Dr de Lacy said there were four main areas in which Dr Patel performed poorly namely:
 - Inadequate assessment of the presenting patient;
 - Defective surgical techniques;
 - Poor post operative management;
 - Inadequate follow up.

In the course of his testimony, he gave details of care provided to particular patients to illustrate these shortcomings;

- (i) In relation to the *assessment of presenting patients*, Dr de Lacy said Dr Patel failed to make use of all appropriate tests and, perhaps in

⁹⁰⁵ Exhibit 252, para 3

⁹⁰⁶ Exhibit 252, para 5 T3598, T3639

⁹⁰⁷ Exhibit 252A T3598

⁹⁰⁸ T 3599, T3596

⁹⁰⁹ Exhibit 252 paras 5 and 6, T 3597

⁹¹⁰ T 3605, T3639

⁹¹¹ T 3639. Dr de Lacy made the point, it should be noted, that poor care would not necessarily result in a poor outcome: T3607

consequence, he regularly misdiagnosed patients. The pre-operative investigations (going to such matters as the patient's suitability for anaesthetic⁹¹²) were regularly omitted and this led to more frequent incidents of post operative heart attack and post operative respiratory compromise.⁹¹³ Further, whereas good surgeons tend to be reticent to operate (because, surgery, by its nature, is an intrusive procedure), Dr Patel seemed reluctant to consider other treatment paths;⁹¹⁴

- (j) Dr de Lacy said that the *poor surgical techniques* were evidenced by high infection and leak rate, poor wound closure technique, injuries to contiguous anatomical structures, removing the wrong organ, missing cancers on diagnostic procedures, and failing to remove cancers at the time of operation.⁹¹⁵ He said that Dr Patel seemed to be out of date in his techniques and gave the example of Dr Patel's failure to make use of a procedure called a cholangiogram in the course of a procedure to remove the gallbladder called a laparoscopic cholecystectomy;
- (k) Dr de Lacy spoke about anastomotic leaks. He said that when a surgeon joins two ends of a hollow tube, the procedure is called 'anastomosis.' It commonly occurs when a general surgeon removes a cancerous segment of bowel and then re-unites what remains. Dr de Lacy said that an anastomotic leak is a recognised indicator of poor care and that the number of leaks suffered by Dr Patel's patients was 'grossly excessive';⁹¹⁶
- (l) Dr de Lacy spoke at some length about incisional hernias and their relationship with wound dehiscence. He explained that the abdominal wall may be damaged inadvertently in the course of surgery. Where it fails to repair itself, an incisional hernia develops. In consequence, the intestines can make their way through the abdominal wall and, sometimes, through the outer layer of the skin. Either of those phenomena is called a wound dehiscence (or, more colloquially, a 'burst abdomen');⁹¹⁷
- (m) Dr de Lacy said that incisional hernias can be caused by poor wound closure technique, by infection, or by poor suturing material. Some patients will suffer problems because, by reason of medication or other illnesses, they do not heal swiftly.⁹¹⁸ He said that good surgeons could

⁹¹² T 3655

⁹¹³ T 3636, Exhibit 252, para 7

⁹¹⁴ T 3635 – T3636

⁹¹⁵ Exhibit 252 para 7(b)

⁹¹⁶ T 3616, line 50

⁹¹⁷ T 3611. Dr de Lacy said that there are also cases where the abdominal wall remains intact but the superficial skin opens up. This is a relatively common and unremarkable phenomenon.

⁹¹⁸ T 3608

expect that the incidence of wound dehiscence and incisional hernias would be rare. On the other hand, in the course of treating the former Dr Patel patients, Dr de Lacy had already carried out more than twenty incisional hernia repairs;⁹¹⁹

- (n) Dr de Lacy said that it was possible to infer from these findings, with confidence, that Dr Patel had poor wound closure technique and that he would often select inappropriate people for surgery;⁹²⁰
- (o) Dr de Lacy said he could also infer that Dr Patel must have been rough in his technique because Dr de Lacy had observed injuries to the liver, the spleen, the rectum, the bladder, the ureter and other abdominal organs;⁹²¹
- (p) Dr de Lacy said that he had looked after complications in the last four months that he had never seen before.⁹²² Dr de Lacy recalled his first former Patel patient. She had presented to Dr Patel for repair of an incisional hernia. She presented to Dr de Lacy with a bowel obstruction and he discovered, upon operating, that the stitches for the hernia repair had passed through twenty loops of the small bowel.⁹²³ He said that it was very hard to envisage how a surgeon could make such a mistake but that he has subsequently seen in Dr Patel's former patients many other errors of a similar magnitude;⁹²⁴
- (q) As to the issue of *post operative management*, Dr de Lacy said that Dr Patel would fail to recognise, or treat, major post operative complications such as a haemorrhage following bowel resection, bile leak following cholecystectomy, dehiscence after abdominal incision, and cardio respiratory failure;
- (r) In relation to *inadequate follow up*, Dr de Lacy said there was a notable failure by Dr Patel to refer patients to appropriate specialists or to recognise failings in his own operations. He would also fail to follow up on inadequate resection margins;⁹²⁵
- (s) One of the major problems in Dr de Lacy's view was that Dr Patel seemed to consider operations an end in themselves rather than a means of improving the patient's condition. He did not appear concerned to ensure that procedures reduced patients' suffering. He

⁹¹⁹ T 3611

⁹²⁰ T 3608

⁹²¹ T 3601

⁹²² T 3605, line 30

⁹²³ T 3597

⁹²⁴ T 3601.

⁹²⁵ This refers to the practice amongst good surgeons of marking out a cancer and providing some margin on either side to ensure that the entire cancer is excised: Exhibit 252 para 7(d)

gave as an example a man known to the Commission as P16. Dr Patel performed an oesophagectomy on P16 and he survived.⁹²⁶ Dr de Lacy noted that the primary purpose of the procedure is to lessen the patient's discomfort by allowing them to swallow.⁹²⁷ When Dr Patel performed the oesophagectomy however, he omitted that part of the operation which prevents reflux. The result was that the man still could not swallow, received little benefit from the operation, and was very unhappy with his quality of life;⁹²⁸

- (t) Dr de Lacy said that the magnitude of Dr Patel's errors can only properly be understood when you compare his results to those you would expect of a normal general surgeon. He said that Dr Patel's results were not 'ten times what you might expect. They're more like 100 times what you might expect'.⁹²⁹ He said that one should bear in mind, in particular, that most of Dr Patel's surgery was elective (as opposed to being an emergency situation) so that there was ample time to assess the patient, arrive at a treatment path, and decide whether the local hospital had adequate supporting structures for the path envisaged.⁹³⁰ Dr de Lacy said that a death in those circumstances is a disaster and should be very rare. Although, by the nature of his involvement, Dr de Lacy had not studied those cases where patients had died, he believed that the results of Dr Woodruff's audit (which showed 13 deaths over the two years, mostly concerned with elective patients) was very telling.⁹³¹
- (u) In Dr de Lacy's opinion, Dr Patel failed to appreciate his own limitations or those of the Base. Dr de Lacy made the point that the regional setting has different ramifications for emergency and elective surgery. Where an emergency situation develops in a rural area, a general surgeon may, of necessity, move beyond his or her normal scope of practice. On the other hand, in relation to elective surgery, the regional setting will tend to restrict that scope. The surgeon will be keenly aware that there are better places for certain procedures.⁹³² Oesophagectomies were a good case in point. Dr Patel should not have attempted them at the Base. They are always complicated because they interfere with lung function, there is a danger of leaks,

⁹²⁶ He, in fact, performed 4 oesophagectomies during his time at the Base: two patients died within hours of surgery, one died within months, and P16 was a survivor.

⁹²⁷ He said that the procedure does not extend the patient's life expectancy.

⁹²⁸ T 3605

⁹²⁹ T3602, line 15

⁹³⁰ T 3602

⁹³¹ T 3602

⁹³² T 3613

and they are always elective because the cancer moves slowly.⁹³³ Good surgeons understand that you do them regularly to maintain competence or you do not do them at all.⁹³⁴ They also understand that, even if you have maintained competence, you do not do them at a hospital with insufficient support facilities;⁹³⁵

- (v) What Dr de Lacy found particularly striking when he compared Dr Patel's notes with the objective evidence and the patients' histories was that, in his view, Dr Patel clearly set out to mislead the reader. There would be instances of wound dehiscence, incisional hernias or anastomotic leaks, but no reference to the same in the notes. Dr de Lacy said that, on the other hand, the notes would be sprinkled with stock phrases such as 'risks and complications of the operation explained',⁹³⁶ but patients regularly told Dr de Lacy that Dr Patel had only seen them for one minute in the pre-operative consultation⁹³⁷ and that he had not examined them.⁹³⁸ The notes would often contain text book descriptions of operations but when Dr de Lacy subsequently operated on the same patients, he found that the descriptions were wholly inaccurate.⁹³⁹ Dr de Lacy reached the view that the notes were dishonest rather than merely slipshod, and that they showed a surgeon trying to cover himself.⁹⁴⁰

Dr O'Loughlin

3.417 O'Loughlin testified that:

- (a) He has been a fellow of the Royal Australian College of Surgeons since 1984 and the Director of Surgery at the Royal Brisbane Hospital since about 1995. He was a senior lecturer in surgery at the University of Queensland between 1985 and 1987;
- (b) In the course of 2005, he has seen approximately 42 former Patel patients. As for Dr de Lacy, this occurred pursuant to an arrangement made by Queensland Health. Dr O'Loughlin said that he saw the patients at the Base and that there were two other surgeons from the Royal Brisbane, namely Michael Rudd and George Hopkins, who also saw patients there;⁹⁴¹

⁹³³ T 4423

⁹³⁴ T 4423

⁹³⁵ T3603, T 4423

⁹³⁶ T4428, line 40

⁹³⁷ T4428

⁹³⁸ T 4425

⁹³⁹ T 4426

⁹⁴⁰ T 4428

⁹⁴¹ Dr O'Loughlin said that Dr Rudd and Dr Hopkins saw about 25 to 30 former Patel patients between them.

- (c) The 42 patients fell into three categories. There were 14 patients who had received reasonable care and who simply required re-assurance,⁹⁴² there were seven patients who required remedial surgery,⁹⁴³ and there was the balance - some 20 patients - who had a range of symptoms and complaints, and required further investigation such as an endoscopy or an ultrasound;⁹⁴⁴
- (d) Dr O'Loughlin emphasised that one needed to be careful in drawing conclusions from his findings because he saw a small number of patients whereas Dr Patel operated on a very large number of people.⁹⁴⁵ He also wished to emphasise that surgery is not a benign undertaking so that, even in the best hands, there will be complications. Dr O'Loughlin said that good surgical practice involves seeking to minimise the risk of complications and dealing with them well by availing oneself of the best techniques, being trained well, keeping up to date, and enlisting the support of more competent and experienced people;⁹⁴⁶
- (e) In reaching opinions, Dr O'Loughlin, like Dr de Lacy, had recourse to the clinical records, together with his own observations from examining patients, taking a history and performing surgery;
- (f) In Dr O'Loughlin's view, about half the patients he saw received a standard of care which was less than he would expect from a competent surgeon.⁹⁴⁷ In general, he observed shortcomings in judgment, knowledge and technical abilities. Asked whether he would have allowed Dr Patel to operate on him, Dr O'Loughlin said simply 'no;'
- (g) Dr O'Loughlin said he had formed the view from examining records and talking with patients that Dr Patel did not perform satisfactory examinations of the patients. Where, for instance, a patient presented with rectal bleeding, Dr Patel would send the patient for a colonoscopy without first carrying out a rectal examination, and Dr O'Loughlin regarded this as a serious omission;⁹⁴⁸
- (h) Further, whereas good practice required that Dr Patel consider non-invasive treatment, there was little evidence that that happened. Instead, Dr Patel generally recommended an operation. Dr Patel did not seem to

⁹⁴² T 3956

⁹⁴³ Exhibit 173A para 5 – T 3958

⁹⁴⁴ T 3958

⁹⁴⁵ T 3957, line 45

⁹⁴⁶ Exhibit 173A para 11

⁹⁴⁷ T 3966 line 30

⁹⁴⁸ T 3959

exercise appropriate clinical judgment in terms of recognising that, on occasions it is better to refrain from operating;⁹⁴⁹

- (i) The practice of medicine is a multi disciplinary exercise and it is mandatory that surgeons consult with other specialist groups such as gastroenterologists, gynaecologists and urologists. Dr Patel, on the other hand, seemed to practise in isolation.⁹⁵⁰ Consistent with this multi-disciplinary view of medicine, Dr O'Loughlin, as the Director of Surgery at the RBH, was regularly contacted by his previous counterparts at the Base (Doctors Nankivill and Anderson) who consulted with him on a range of matters. Not once during his tenure as Director of Surgery at the Base did Dr Patel ever make contact with Dr O'Loughlin;⁹⁵¹
- (j) Dr O'Loughlin said that complications are not uncommon in emergency surgery, particularly when the patients, as was common in Bundaberg, had a range of 'co-morbidities', but he was concerned that particular Patel patients had several complications even though they were treated in an elective context;⁹⁵²
- (k) Dr O'Loughlin discussed five patients to illustrate his point. The first patient was a man with a polyp in his bowel.⁹⁵³ Dr Patel conducted a biopsy and it did not show any malignancy. In those circumstances, Dr Patel should have recommended that the entire polyp be removed by an experienced colonoscopist⁹⁵⁴ and analysed comprehensively. Instead, he proceeded to remove the entire bowel. There is no evidence that Dr Patel ever advised the patient of the biopsy results, and this raised questions about Dr Patel's professional integrity.⁹⁵⁵ Further, when Dr Patel attempted to replace the bowel with an ileostomy⁹⁵⁶ and a stoma collection bag, the attempt was made poorly, unsuccessfully and over the course of two operations;
- (l) There was another patient who presented to Dr Patel with a painful gallstone condition. Dr Patel recommended that the gall bladder be removed by a laparoscopic (that is, keyhole) procedure known as a cholecystectomy, mentioned earlier. A number of complications followed. Whereas the procedure is normally straight forward (if technically demanding) and the patient is discharged within 24 hours, this patient was the subject of four operations. The gall bladder was inadvertently

⁹⁴⁹ T 3959

⁹⁵⁰ Exhibit 173A para 8

⁹⁵¹ Exhibit 173A para 8

⁹⁵² T3962

⁹⁵³ A polyp is a fleshy growth that arises in the lining of the bowel and will, in some cases, develop into cancer – See Exhibit 173, para 7

⁹⁵⁴ Exhibit 173, para 8

⁹⁵⁵ Exhibit 173A, para 10

⁹⁵⁶ Being the section which protrudes from the skin

opened causing gallstones and bile to spill; a haematoma developed where an instrument had been used; there was a collection of fluid under the liver; and the patient commenced bleeding internally and draining bile, but Dr Patel neither identified the sources of those fluids nor investigated them further. Moreover, the patient developed a hernia at the site of the wound from the third operation, and the alignment of the hernia suggested it was caused by a technical failure in sewing the wound together.⁹⁵⁷ Dr O'Loughlin agreed that if a registrar showed him such a history, Dr O'Loughlin would be questioning whether the registrar was suited to a career in surgery.⁹⁵⁸

- (m) The third case study concerned a lady who had a laparoscopic cholecystectomy for painful gallstones. Again, however there were a number of complications. The small bowel was inadvertently opened, causing a leak of bowel contents; a second operation was conducted to repair the laceration but this resulted in a further inadvertent laceration to a different part of the bowel. Following the second operation, moreover, the patient developed a complete wound dehiscence which required packing for some months, and there was an incisional hernia which eventually required further repair. Dr O'Loughlin said that the main problem was a failure to access the abdominal cavity in an optimal way. He said that it is possible that this complication could occur in a competent surgeon. He tended to suspect, however, that Dr Patel was not proficient in laparoscopic surgery. Dr O'Loughlin said that, whilst they were only two cases, they demonstrated significant and serious complications and, further, he was aware of a further laparoscopic cholecystectomy patient who suffered complications and was transferred to the Royal Brisbane. Dr O'Loughlin said that this is no small failing because cholecystectomies are a routine part of a general surgeon's work. He said that they are a good litmus test of a surgeon's competence.⁹⁵⁹ He said, further, that laparoscopic surgery is a very important part of a general surgeon's practice.⁹⁶⁰
- (n) The next example was a patient who had a mass which might have emanated from the bowel or an ovary. Dr O'Loughlin said that the appropriate course to take was further investigation. Dr Patel, however, removed part of the bowel as well as the left ovary. The patient suffered a complete wound dehiscence and this required a return to the operating theatre. Moreover, she suffered a post operative heart attack so that her

⁹⁵⁷ Exhibit 173A para 23, T3965

⁹⁵⁸ T3963, line 10

⁹⁵⁹ T 3964

⁹⁶⁰ T 3964

recovery was 'stormy and prolonged.' The patient eventually saw a gynaecologist at the RBH. It emerged then that the cancer had been emanating from the ovary. The optimal treatment was to provide clearance surgically around the ovarian area and then provide chemotherapy. Surgery was not, however, an option because of the heart attack following the first operation. Dr O'Loughlin believed that the patient was not given appropriate care in that she was inadequately assessed pre-operatively, the wound closure technique may have been defective and the conduct of the first operation effectively denied the patient the opportunity for a better directed operation;⁹⁶¹

- (o) Dr O'Loughlin gave a further example. It concerned a man who had a perianal fistula. He had a worrying cardiac history but Dr Patel appears not to have reviewed him pre-operatively and he proceeded to surgery. The operation proceeded badly in that a good part of the anal sphincter was divided (which is not a mistake that an experienced surgeon would make). Given the dual complexities of the presenting problem and the cardiac history, the patient should have been referred to a tertiary hospital.⁹⁶²

Dr Woodruff

3.418 Dr Woodruff testified that:

- (a) He was admitted as a Fellow of the Royal College of Surgeons in 1971 and as a Fellow of the Royal Australasian College of Surgeons in 1984. He is a former Vice-President of the Royal Australasian College of Surgeons and the President elect of the Australian and New Zealand Society of Vascular Surgeons;⁹⁶³
- (b) Dr Woodruff has qualifications in general surgery and vascular surgery but he has practised as a vascular surgeon since at least 1977. He has worked in several rural locations including Mr Isa, Orkney, Shetland and Bougainville;⁹⁶⁴
- (c) Dr Woodruff was one of a team of four medical professionals ('the Review Team') appointed by the Director-General of Queensland Health on 18 April 2005 to 'review the clinical cases of Dr Patel where there has been an identified adverse outcome or where issues related to his clinical practice have been raised,'⁹⁶⁵ amongst other things;

⁹⁶¹ T3965-3966, Ex 173A paras 31-39

⁹⁶² Exhibit 173A paras 40 - 46

⁹⁶³ Exhibit 283 paras 1-9

⁹⁶⁴ Exhibit 283 paras 1-9

⁹⁶⁵ Exhibit 102 page 20

- (d) The Review Team's work was completed on 30 June 2005⁹⁶⁶ and Dr Woodruff was primarily responsible for reviewing Dr Patel's surgical performance.⁹⁶⁷ The Team ascertained that Dr Patel saw some 1,450 patients during his time at Bundaberg and the Team made a decision to carry out the task described in the subparagraph immediately above by confining its investigations to those patients who had died, who were the subject of a complaint or who had been transferred to another institution;⁹⁶⁸
- (e) Dr Woodruff and the Review Team identified 221 cases (including 88 deaths) which met the criteria set out above.⁹⁶⁹ Dr Woodruff accepted, however, that there would undoubtedly be patients who suffered adverse outcomes but were not caught by the Review Team's methodology;⁹⁷⁰
- (f) In considering the treatment provided to those patients, Dr Woodruff had the benefit of all the files relevant to the 221 patients. He said that those documents ran to some 47,500 pages and that he was able to organise them with the benefit of scanning and a specialised computer software.⁹⁷¹ Dr Woodruff did not have the benefit enjoyed by Dr de Lacy and Dr O'Loughlin of speaking to the patients, much less examining them or performing surgery;⁹⁷²
- (g) Dr Woodruff said that there were 16 patients who were considered by both Dr de Lacy and himself. He said that of those patients, in relation to 14, he and Dr de Lacy had reached the same conclusion, and in relation to the balance, their conclusions were similar;
- (h) Dr Woodruff noted that:
- There were thirteen deaths in which an unacceptable level of care on the part of Dr Patel contributed to the adverse outcome;⁹⁷³
 - There were a further four deaths in which an unacceptable level of care on the part of Dr Patel may have contributed to the outcome;⁹⁷⁴

⁹⁶⁶ Exhibit 102

⁹⁶⁷ T 4270 It should be noted that there were no other surgeons or indeed treating doctors, on the team

⁹⁶⁸ T 4270

⁹⁶⁹ T 4270; Exhibit 283, para 12

⁹⁷⁰ T 4271

⁹⁷¹ Exhibit 283 para 16

⁹⁷² T 4361

⁹⁷³ Exhibit 283, table D3

⁹⁷⁴ Exhibit 203, table F

- There were, in addition, 31 surviving patients where Dr Patel's poor level of care contributed to, or may have contributed, to an adverse outcome;⁹⁷⁵
 - Of the 31 patients identified, there were 23 patients who suffered major technical complications;⁹⁷⁶
 - In all, there were 48 patients where Dr Patel contributed, or may have contributed, to an adverse outcome;⁹⁷⁷
- (i) Dr Woodruff concluded:
- I have no hesitation in saying that [Dr Patel's] performance was incompetent and that his performance is far worse than average or what one might expect by chance.⁹⁷⁸
- (j) Dr Woodruff spoke in detail about particular cases, starting with the deaths. He said that, although he had identified some 88 deaths (34 occurring within one month of surgery) with which Dr Patel was associated, in many cases his association was incidental;⁹⁷⁹
- (k) When the figures are considered carefully, however, it leads to a harsher judgment of Dr Patel. Many patients were *in extremis*⁹⁸⁰ or suffering terminal pathology. Those deaths (which are not attributable to Dr Patel) 'spuriously' show Dr Patel in a better light. Dr Woodruff believed that they should not be considered when arriving at a 'denominator'.⁹⁸¹ When one reduces the sample accordingly, one finds there is a high proportion of operations that went wrong. Dr Woodruff said, in particular, that of the 13 deaths, there were seven or eight where the treatment was just 'outlandish' and involved 'absolutely non defensible processes'.⁹⁸²
- (l) Dr Woodruff referred to a patient known before the Commission as P238 as an example of incomprehensible treatment. In December 2002, she required partial removal of the pancreas and stomach and she presented to the Base. Dr Baker (who, Dr Woodruff opined, was a very competent surgeon)⁹⁸³ referred the patient to the experts at the Royal Brisbane Hospital for treatment. She nevertheless had a 'very stormy' admission and almost died. She presented with a recurrence

⁹⁷⁵ Exhibit 283, table G

⁹⁷⁶ Exhibit 283, table H – 1 patient appeared under two headings

⁹⁷⁷ Exhibit 283, Table E

⁹⁷⁸ T 4327

⁹⁷⁹ T 4282

⁹⁸⁰ T 4273

⁹⁸¹ T 4283

⁹⁸² T 4282

⁹⁸³ T 4281

of the problem at the Base during Dr Patel's time and, despite the history, Dr Patel elected to operate. The patient died;

- (m) There was a patient known as P161 who died after Doctor Patel carried out a very complicated operation known as a 'Whipple's procedure.' Whipples procedures are outside the scope of the Base's practice.⁹⁸⁴ Dr Patel attempted a number of these operations at the Base and that showed an error of judgment.⁹⁸⁵ Dr Woodruff said that there was a lack of judgment in even putting this patient forward for the operation because a CT scan disclosed 'more than a suspicion of metastatic disease.'⁹⁸⁶
- (n) Similarly there was a patient known to the Commission as P224. A CT scan showed that he was suffering from a non-resectable tumour but Dr Patel attempted a thyroidectomy. The patient died. Dr Woodruff could not understand why Dr Patel would recommend surgery, let alone attempt that surgery at the Base,⁹⁸⁷
- (o) Another example was a patient known before the Commission as P98. Dr Patel elected to proceed with surgery notwithstanding that the patient was suffering from obstructed jaundice on that day, which is a clear error of judgment. Dr Woodruff said that the patient appears to have died from fatal hepatorenal syndrome which is a risk of taking that course;
- (p) Dr Woodruff considered, of course, the three oesophagectomies (out of a total of four conducted by Dr Patel), for which the patient died, namely Kemps, Phillips and Grave. He said that, given the history of Mr Kemps, you could 'almost guarantee' that the tumour was not curable⁹⁸⁸ and that the procedure would lead to aortic bleeding. He said he could not understand how anybody could even contemplate surgery.⁹⁸⁹ In relation to Mr Phillips, he said that surgery was a legitimate consideration but, given the renal problems, the procedure was going to be very difficult and the patient should have been transferred to a tertiary hospital.⁹⁹⁰ In relation to Mr Grave, he said that there was evidence of metastases. He said that the operation demonstrated 'a litany of surgical ineptitude,'⁹⁹¹ including vocal chord

⁹⁸⁴ T 4289

⁹⁸⁵ T 4290

⁹⁸⁶ T 4286

⁹⁸⁷ T 4287

⁹⁸⁸ It was the evidence of Dr Smalberger, who had referred Mr Kemps to the Department of Surgery at the Base for transfer to Brisbane, that the pathology strongly suggested, at that time, that Mr Kemps cancer was widespread or 'metastatic' (so that the removal of the oesophagus would not halt the progress of the disease).

⁹⁸⁹ T 4291

⁹⁹⁰ T 4293

⁹⁹¹ T 4295

paralysis, myocardial infarction, peritonitis, two wound dehiscences and a leak from the jejunostomy site. He said that, although Mr Grave eventually died from the underlying cancer, the complications would have reduced his ability to resist the disease;

- (q) Dr Woodruff said that it had occurred to him that, of the 13 deaths, eight related to procedures from which Dr Patel had been prohibited in Oregon. He speculated:

And I wonder whether this is not the missing piece of the mosaic... I wonder if his motivation for doing these quite outlandish operations is not to try and re-assert in his own mind that what he's been precluded from doing in Oregon he is in fact capable of doing, and that he is, in effect re-credentialing himself if only in his own mind.⁹⁹²

- (r) Dr Woodruff turned to the other adverse outcomes. He said Dr Patel had a frightening complication rate.⁹⁹³ His audit revealed, amongst those patients of the 221 who survived, 7 cases of major wound dehiscence, 12 cases of infection or haematoma, and 5 cases of anastomotic leaks, and that these are all recognised indicators of poor care.⁹⁹⁴
- (s) Dr Woodruff said that his review showed instances to support the thesis that Dr Patel engaged in rough handling in the course of his surgery;⁹⁹⁵
- (t) He said that, although he had distinguished between those patients where Dr Patel's poor care had contributed and 'maybe' contributed to an adverse outcome, the large number of technical problems which he had encountered suggested that one could be more confident about the latter category;⁹⁹⁶
- (u) Dr Woodruff said that certain forms of surgery necessitated that the surgeon has recourse to other colleagues. This would be a little more difficult in Bundaberg but Dr Woodruff said that it was remarkable that having considered over 47,000 pages of case notes for Dr Patel's patients 'there is not one letter from Patel to any other doctor, not one'.⁹⁹⁷
- (v) Dr Woodruff considered, despite the foregoing, that Dr Patel was an intelligent and extremely industrious man⁹⁹⁸ who had a potential in a different environment to be a 'productive contributor.' Dr Woodruff said

⁹⁹² T 4307

⁹⁹³ T 4328

⁹⁹⁴ Exhibit 283, Table H; He agreed, further, that incisional hernias were another good indicator. Since they usually develop some time after surgery, information on the same was available to Dr de Lacy but not Dr Woodruff

⁹⁹⁵ T 4361

⁹⁹⁶ T 4310

⁹⁹⁷ T 4290

⁹⁹⁸ T 4336

that Dr Patel's surgical performances were not the worst that Dr Woodruff had seen.⁹⁹⁹ He said that if Dr Patel had spent time in a skills laboratory (such as the one run by Queensland Health) and had been supervised appropriately (as envisaged by the Medical Board of Oregon), the outcomes of his surgery might well have been different;

- (w) He said that the situation in Bundaberg was not unique and there had been aberrant surgical practices in other parts of Queensland. They have often been picked up, however, by credentialing, or through morbidity and mortality meetings.¹⁰⁰⁰ He said that, if Dr Patel had been working in a major tertiary hospital, any sub-standard performance would have been 'very evident'.¹⁰⁰¹ He said he was aware of practitioners who are now well regarded Fellows of the College whose performance had improved remarkably when their environment was changed, particularly from one of isolation;¹⁰⁰²
- (x) Dr Woodruff said there were some notes that seemed to have been made retrospectively but otherwise they seemed to demonstrate Dr Patel's 'rose-tinted view' of his own care, rather than any dishonesty;¹⁰⁰³
- (y) Dr Woodruff said that there are nine characteristics¹⁰⁰⁴ that the College considers necessary in a competent surgeon. Dr Patel clearly lacked judgment. Dr Woodruff said it was also clear from the records that Dr Patel did not always work well with other staff and did not always have the support of the nurses. Dr Woodruff concluded that Dr Patel also lacked collaboration, management and leadership attributes.¹⁰⁰⁵

Conclusion

3.419 In short, three respected surgeons working independently of each other found very similar patterns amongst those cases they considered. There was evidence from witnesses of fact before the Commission that corroborated those findings. Witnesses gave evidence that Dr Patel's knowledge was out of date, that he was rough in his surgical handling, that he was rigid in his views and did not work well with other medical staff, that he was too quick to operate rather than consider other treatment paths, and that his operations seemed to be visited by an abnormal number of complications. In the end, some of the procedures were so

⁹⁹⁹ T 4337

¹⁰⁰⁰ T 4328

¹⁰⁰¹ T 4336

¹⁰⁰² T 4337

¹⁰⁰³ T 4342

¹⁰⁰⁴ Medical Expertise, Technical Expertise, Judgment, Communication, Collaboration, Management and Leadership, Health advocacy, Scholar/Teacher, Professionalism.

¹⁰⁰⁵ Exhibit 283, paras 22 and 23

bizarre that Dr Woodruff could not even attribute Dr Patel's decision-making to hubris.¹⁰⁰⁶ There was some other motivation being played out and it may well have been that he was trying to show that the restrictions placed in Oregon were unjust.

- 3.420 It will be recalled that, in the previous section of this report, I outlined some 20 complaints made to management, many on behalf of specific patients, in the course of Dr Patel's term. It is interesting that, when one considers the experts' finding, it is clear that almost all of those patient complaints were the subject of findings that the care provided was inadequate. That fact underlines something which should have been self-evident, namely that a health system which responds frankly to internal and external complaints will be much better placed to identify and improve shortcomings in clinical care and communication.

Adverse findings and recommendations

- 3.421 I should also address one point that has been the subject of some speculation, namely that the executive at the Base received performance bonuses. The Commission explored this issue thoroughly and there was no basis for it. It seems that, to the extent management at the Base failed to act to a proper standard, they were motivated by an unhealthy culture or a desire to retain their jobs, rather than any more immediate pecuniary incentive.
- 3.422 One cannot help but have some sympathy for the conditions in which management at the Base worked. The evidence made clear that they had budgets that were effectively fixed, that fiscal considerations were a 'major focus' with Queensland Health and that there was, at the very least, a perception that a number of managers around Queensland had lost their jobs for failing to work within budget.¹⁰⁰⁷ They were faced with a scenario where, despite the legitimate claims of senior doctors like Dr Nankivell and Dr Baker for more resources, they could do little because corporate office, they believed, was unresponsive. The situation was more exacting still. Against the background of gross under-resourcing, many good doctors elected to leave or they became disenchanted so that our public hospitals lost much of the goodwill which was once, according to Dr Thiele, 'the oil in the cogs.' The managers were also required to work within a culture that was, as will be discussed later, seriously averse to public discussion, at least to the extent it might lead to negative publicity. As Mr Leck testified, they were required to make decisions by reference to a risk matrix which rated 'significant and sustained statewide adverse publicity' on the same level as 'loss

¹⁰⁰⁶ T4281, T4287

¹⁰⁰⁷ T7129, Exhibit 468. In fact, the zonal manager, Mr Bergin, had informed Mr Leck that his job would be in peril if he did not bring the district in under budget. T6051, line 40

of life' (i.e. major) and 'sustained national publicity; QH reputation significantly damaged' on the same level as 'multiple deaths' (i.e. extreme)¹⁰⁰⁸

3.423 There was, nevertheless, in my view, conduct which was unacceptable. I make adverse findings immediately below and also in Chapter 6. I make recommendations here based on those findings.

Dr Patel

3.424 I find that:

- (a) Dr Patel knowingly misled the Medical Board of Queensland and Queensland Health by failing to disclose disciplinary action brought against him in the United States of America, and by falsifying his work history for the two years prior to December 2002.
- (b) Dr Patel repeatedly performed surgical procedures at the Base that he had been restricted from performing in the United States of America.
- (c) Dr Patel performed surgical procedures at the Base that were beyond his competence, skill and expertise, beyond the capacity of the Hospital and its staff to provide adequate post-operative care, and unnecessary.
- (d) As a result of negligence on the part of Dr Patel (and in accordance with Dr Woodruff's findings), 13 patients at the Base died and many others suffered adverse outcomes.
- (e) Dr Patel unreasonably failed to transfer patients to a tertiary referral hospital within an appropriate timeframe, causing adverse outcomes for many of those patients.
- (f) On many occasions, Dr Patel failed to adequately record in patient files the true details concerning material facts including the surgical procedures undertaken, complications arising from surgery, wound dehiscence, infections, the course of post-operative care, reasons for post-operative return to surgery.
- (g) As the Director of Surgery at the Base between 1 April 2003 and 1 April 2005, Dr Patel failed to ensure that the Department of Surgery conducted appropriate surgical auditing including the holding of effective morbidity and mortality meetings.
- (h) Dr Patel failed to refer 13 reportable deaths to the Coroner.
- (i) Dr Patel held himself out as a general surgeon when he lacked any specialist registration in Queensland.

¹⁰⁰⁸ T7174, Exhibit 162, LTR4

3.425 I recommend that:

- (a) The conduct of Dr Patel in relation to securing registration with the Medical Board of Queensland and a position at the Base be referred to the Queensland Police Service for further investigation in relation to fraud (s408C *Criminal Code*) and attempts to procure unauthorised status (s502 *Criminal Code*).
- (b) With respect to the matters found by Dr Woodruff, Dr O'Loughlin and Dr de Lacy, Dr Patel's conduct be referred to the Queensland Police Service for further investigation in relation to the offences of assault (s335 of the *Criminal Code*), assault occasioning bodily harm (s339 of the *Criminal Code*), grievous bodily harm (s320 of the *Criminal Code*), negligent acts causing harm (s328 of the *Criminal Code*) and manslaughter (s303 of the *Criminal Code*).
- (c) The conduct of Dr Patel in holding himself out as a general surgeon be referred to the Medical Board of Queensland for further investigation in relation to s158 *Medical Practitioners Registration Act 2001*

Dr Nydam

3.426 I find that:

- (d) Dr Nydam sought the appointment of Dr Patel under an area of need declaration when, in fact, there was an Australian qualified general surgeon willing to accept the position of Director of Surgery at the relevant time.
- (e) As the Acting Director of Medical Services at the Base immediately prior to, and at the time of, Dr Patel's appointment, Dr Nydam failed to check Dr Patel's references prior to his appointment at the Bundaberg Base Hospital.
- (f) Despite intending at all relevant times that Dr Patel fill the role of Director of Surgery at the Base, Dr Nydam represented to the Medical Board in January 2003 that Dr Patel would work as a Senior Medical Officer accountable to the Director of Surgery.
- (g) In completing a Form 55 *Sponsorship for Temporary Residence in Australia (non business)* on or about 8 January 2003 in relation to the proposed employment of Dr Jayant Patel as a Senior Medical Officer, Surgery, at the Base, Dr Nydam falsely represented that the position had been advertised a number of times over the past 6 months. There have been no Australian applicants.'
- (h) In applying for an area of need decision in relation to Dr Patel's employment as a Senior Medical Officer, Dr Nydam had no basis for

considering that the position fell within an area of need as that term is used in s135 of the *Medical Practitioners Registration Act 2001*.

- (i) Dr Nydam failed to maintain, or to encourage others to maintain, a credentialing and clinical privileging process in accordance with either Queensland Health policy or the practice established under previous Directors of Medical Services at the Base;
- (j) Dr Nydam failed to take steps to ensure, prior to, or immediately after the commencement of, Dr Patel's employment at the Base, he was subject to a process of credentialing and clinical privileging.

I make no recommendations in relation to Dr Nydam.

Dr Keating

3.427 I make the following adverse findings with respect to Dr Keating:

- (a) He failed, from or about 14 April 2003 (when his employment at the Base commenced), to ensure compliance with good practice by ascertaining the terms of Dr Patel's registration and ensuring that he was an appropriate person to continue as the Director of Surgery.
- (b) He failed to comply with good practice from or about 14 April 2003 by ensuring that Dr Patel was the subject of a credentialing and privileging process, either in accordance with Queensland Health policy or on an ad hoc basis.
- (c) Dr Keating failed to take steps to ensure, prior to, or immediately after the commencement of, Dr Patel's employment at the Base, he was subject to a process of credentialing and clinical privileging.
- (d) From April 2003, Dr Keating was made aware of numerous complaints about the clinical practices and procedures of Dr Patel and his behaviour, including but not limited to, the following:
 - In May and June 2003, a complaint by Ms Toni Hoffmann and Dr Jon Joiner about the performance of oesophagectomies at the Base;
 - In May 2003, a complaint about incorrect topical treatment to a patient;
 - In June 2003, a complaint about Dr Patel operating on the wrong part of a patient's ear;
 - In July 2003, a complaint from a Dr Peter Cook about the performance of oesophagectomies at the Base;
 - In July 2003, a complaint from Ms Aylmer about a rise in the incidence of wound dehiscence;

- In October 2003, a complaint from Mr Ian Fleming about Dr Patel's treatment of him for diverticulitis;
 - In November 2003, a complaint about Dr Patel's personal infection control measures;
 - In late 2003, a complaint from Dr David Smalberger about the clinical and professional conduct of Dr Patel;
 - In the course of 2004, an audit of peritoneal catheter placements demonstrating that Dr Patel had a one-hundred per cent complication rate;
 - In March 2004, a complaint from Ms Toni Hoffman concerning Dr Patel's clinical conduct and professional behaviour and a complaint by Mr Geoffrey Smith about treatment provided by Dr Patel;
 - In April 2004, a complaint from Ms Vicki Lester about the treatment that she had received from Dr Patel;
 - In July 2004, complaints from staff about Dr Patel's involvement in the treatment of Mr Desmond Bramich;
 - In October 2004, a complaint from Ms Hoffman about Dr Patel's clinical conduct in relation to a number of patients;
 - On 2 November 2004, a complaint from Dr Jason Jenkins in relation to the treatment of P52;
 - In December 2004/January 2005, complaints from doctors and nurses at the Base about a further oesophagectomy;
 - In January 2005, concerns raised by Dr Stephen Rashford and Ms Michelle Hunter about the care provided to P26.
- (e) Dr Keating failed to take appropriate action to investigate these complaints, particularly having regard to their combined significance.
- (f) Notwithstanding Dr Keating's knowledge that Dr Patel had not been subject to the credentialing and privileging process, and that he had been the subject of various complaints, Dr Keating:
- Offered to extend Dr Patel's contract from 1 April 2004 to 31 March 2005, from 1 April 2005 to 31 July 2005 and, at one point, from 1 April 2005 to 31 March 2009;
 - Repeatedly advised the Medical Board (when renewal of registration was being sought) that Dr Patel's performance at the Base was competent, or better.

- (g) Between 29 October and 5 November 2004, the concerns raised by Ms Hoffman were given considerable support by Drs Berens, Risson and Strahan.
- (h) From 5 November 2004, Dr Keating failed to give any, or any adequate, consideration to revoking, or appropriately restricting, Dr Patel's right to conduct surgery in the Base.
- (i) Until early January 2005, Dr Keating repeatedly advised Mr Leck that Ms Hoffman's complaints were unjustified and largely personality driven when he should have appreciated (particularly in the context of other complaints) that they raised genuine and concerning medical issues.
- (j) On or about 5 January 2005, Dr Keating prepared a briefing note which acknowledged the veracity of many of the allegations made by staff at the Base about Dr Patel.
- (k) By a letter dated 2 February 2005, and in the circumstances set out above, Dr Keating offered Dr Patel a temporary full time position of locum general surgeon for the period from 1 April 2005 to 31 July 2005.
- (l) When, in early February 2005, Dr Keating wrote to the Medical Board seeking renewal of Dr Patel's registration, he provided an assessment of Dr Patel's performance completed which was knowingly false, failed to inform the Medical Board of any of the matters set out in the briefing note of January 2005, and failed to inform the Medical Board that a clinical audit was being conducted by the Chief Health Officer into complaints about Dr Patel.
- (m) On 1 February 2005, Dr Keating signed a Form 55 'application for sponsorship of visa' for Dr Patel and sent that form to the Department of Immigration and Multicultural Affairs wherein he stated that Dr Patel was to be employed as Director of Surgery at the Hospital for a further four years, in circumstances where that information was, to Dr Keating's knowledge, false.
- (n) On 14 February 2005, Dr Keating met with the Chief Health Officer and discussed Dr Patel with him but failed to mention any of the adverse matters canvassed in the briefing note, or otherwise to volunteer concerns that had been raised about Dr Patel's performance.

3.428 I recommend that:

- (a) Dr Keating's conduct with respect to the application for a four year visa be referred to the Australian Federal Police for investigation into whether he has committed an offence against s. 137 of the *Criminal Code* (Cth), on the basis that he may have knowingly or recklessly given false or misleading information to the Department of Immigration and Multicultural Affairs.

- (b) Dr Keating's conduct in relation to the renewal of Dr Patel's registration be referred to the Queensland Police Service for investigation and prosecution for a breach of s. 273 of the *Medical Practitioners Registration Act 2001*, as he may have given false or misleading information or documents to the Medical Board.
- (c) The Crime and Misconduct Commission prosecute Dr Keating for official misconduct.
- (d) Alternatively, or subsequently, the Director - General of Queensland Health consider taking action against Dr Keating under s.87 of the *Public Service Act 1996*, on the basis that he has performed his duties carelessly or incompetently, or has been guilty of misconduct.

Mr Leck

3.429 I find that:

- (a) Mr Leck failed to ensure between October and December 2002 that Dr Jayasekera was appointed to the position of Director of Surgery at the Base in circumstances where he had applied for the position, he satisfied all the selection criteria, he was prepared to accept such position and the only other candidate who satisfied those criteria had declined the position.
- (b) Mr Leck permitted recruitment and registration of a medical practitioner as a Senior Medical Officer accountable to the Director of Surgery when he knew, or should have known, that immediately after the commencement of his employment it was intended to promote him to the Director of Surgery position.
- (c) Mr Leck failed to prevent Dr Nydam from misrepresenting to the Medical Board, details of the position Dr Patel would occupy and the level of supervision to which he would be subject.
- (d) Mr Leck failed to prevent Dr Nydam from misrepresenting to the Department of Immigration in the Form 55 Sponsorship for Temporary Residence in Australia the extent to which the position for which Dr Patel was sought had been advertised within Australia.
- (e) Mr Leck failed to prevent Dr Nydam misrepresenting to Queensland Health that Dr Patel was suitable for registration under the area of need provision of s135 of the *Medical Practitioners Registration Act 2001*.
- (f) Mr Leck failed to ensure, in accordance with good practice, and Queensland Health policy, that a credentials and clinical privileges committee existed at all times at the Base, that the general surgeons at the Base (including Dr Patel) were subject to consideration by the

committee between 2003 and 2005, and that such consideration occurred prior to the commencement of the surgeons' employment.

- (g) Due to the said failure the formal qualifications, training, experience and clinical competence of Dr Patel, amongst others, was not assessed and the opportunity was lost for such a committee to discover Dr Patel's disciplinary history and take appropriate action.
- (h) From February 2004 Mr Leck became aware of numerous complaints about the clinical practices and procedures of Dr Patel and his behaviour, including the complaint contained in Ms Hoffman's letter of 22 October 2004, and the corroboration subsequently given by Drs Berens, Rission and Strahan.
- (i) Upon learning of complaints and concerns about Dr Patel's competence, Mr Leck failed to ensure that they were investigated properly.
- (j) Further, Mr Leck failed to suspend or appropriately restrict Dr Patel's right to practise surgery at the Base or to take steps to ensure that Dr Patel was immediately assessed by a clinical privileges and credentials committee, when he should have done so at least by 5 November 2004.
- (k) On or about 23 March 2005, Mr Leck wrote a letter to the Bundaberg News Mail (Exhibit 473) which was deliberately deceptive in asserting that he had received no advice indicating that the allegations have been substantiated and that a range of systems was in place to monitor patient safety.
- (l) Mr Leck failed to consult with Dr Keating on a continual basis, as required by the latter's job description.
- (m) Mr Leck failed to ensure that Dr Keating did not make inappropriate offers of employment to Dr Patel or misleading statements to the Medical Board, as found above.

3.430 I recommend that:

- (a) The Crime and Misconduct Commission prosecute Mr Leck for official misconduct, in that he may have committed a disciplinary breach sufficient to warrant dismissal.
- (b) Alternatively, or subsequently, that his conduct be referred to the Director-General of Queensland Health for discipline under s.87 of the *Public Service Act* 1996, as he may have performed his duties carelessly or incompetently, or been guilty of misconduct.

Final Remarks

- 3.431 I would take this opportunity to pay tribute to the former patients of Dr Patel, and their families. In the course of hearings at Bundaberg, evidence was received from 12 witnesses who had been patients of Dr Patel, or relatives of such patients. They made clear that, beyond the dry clinical summaries set out here, enormous suffering was occasioned by the events traced in this report. Mr Kemps' widow gave evidence going to her loss. Other witnesses like Mr Halter and Ms Swanson gave evidence of attending the Base for what they understood were routine operations, and then experiencing terrible pain, and near-death conditions, in the course of very long stays in Intensive Care. I did not hear that evidence personally but I have had the benefit of reading the transcripts, and speaking with counsel assisting. In consequence, I can only be impressed by the good humour and resilience with which those affected by Dr Patel (and there were many in a community the size of Bundaberg) have dealt with their misfortune.
- 3.432 I would also like to pay tribute to certain people whose care, passion or courage was instrumental in bringing to light the matters covered here. First and foremost of those is Ms Hoffman. She might easily have doubted herself, or succumbed to certain pressures to work within a system that was not responsive. She might have chosen to quarantine herself from Dr Patel's influence by leaving the Base or at least the Intensive Care Unit. Instead, and under the threat of significant detriment to herself, Ms Hoffman persistently and carefully documented the transgressions of Dr Patel. I would also pay tribute to Mr Messenger, the Member for Burnett. He provided a voice for staff concerns when no others seemed to exist and, although it has not been the subject of this report, he was forced, in the course of so doing, to endure animosity from a number of quarters.
- 3.433 Finally, I would like to thank the media for reporting the work of this Commission in a way which was generally responsible, and Mr Hedley Thomas of *the Courier-Mail* in particular, without whose persistence much of this story may have remained untold.
- 3.434 It will be observed that Bundaberg has occupied a large part of this report. The circumstances which recommend that approach were perhaps best encapsulated by Dr de Lacy in his evidence before the Inquiry:

I currently live in Bundaberg and Bundaberg isn't just an example of what's happening elsewhere in the State, even though it is that as well. Terrible things have happened there, not just to these people that I've mentioned today but to many others, many others, and in a community of less than 100,000 people, it really - it amounts to ... a tragedy. ...I hope that whatever changes are mooted for Queensland Health, can start in Bundaberg because though it's obvious that there are problems elsewhere, Bundaberg is where the patients have died and where all of these complications that I've listed and many others have occurred. And the problems of attracting staff to the regions and rural Queensland is

nothing compared to the problems that Bundaberg Base Hospital specifically is going to have to attract people after all this. So it's going - it is an acute, specific, urgent problem in Bundaberg right now and if it can be used as a case study, as a first step towards, ...ameliorating the problems which are statewide, it would be, you know, a very good thing for the community and for the - for all of us who have been trying to help put these things right which I understand we are all working hard to do...

Chapter Four – The Hervey Bay Hospital

‘What do you want me to do; stop [the doctors] operating and then have no service?’

Mr Michael Allsopp
District Manager
Fraser Coast Health Service District¹

A period of rapid growth

- 4.1 The Hervey Bay Hospital is one of two public hospitals within the Fraser Coast Health Service District. The other is the Maryborough Hospital.
- 4.2 The Hervey Bay Hospital opened as a new hospital at its present location at Cnr Nissen Street and Urraween Road, Hervey Bay in or about May 1997.² Dr Stable, the former Director-General of Queensland Health, said that the hospital’s opening was the only example he could recall of direct political pressure being brought to bear upon Queensland Health to open new beds.³ He said that Queensland Health was directed to open the Hervey Bay Hospital before the 1998 state election.⁴ He advised the then Minister, Mr Horan, that Queensland Health did not have the budget for it. The Minister responded, according to Dr Stable, ‘It does not matter. We’ll fix it after the election’.⁵ Dr Stable said it was a major concern to him. It was premised upon ‘closing a fair bit’ of the Maryborough Hospital.⁶ Dr Stable said it caused subsequent ‘pain’ for the following Minister.⁷
- 4.3 The previous hospital was described as a ‘cottage hospital,’⁸ much the same as many rural hospitals in Queensland.⁹ When the doors of the new hospital opened, the whole of the old service, staff and patients were transferred over to the new hospital.¹⁰ At that stage, it was a 40 bed hospital.

¹ T7358 line 20 (Ms Wyatt)

² T6791 line 50 (Dr Hanelt)

³ T5746 line 55 T5747

⁴ T5747 line 15

⁵ T5747 line 15

⁶ T5747 line 20

⁷ T5747 line 20

⁸ T6791 line 50 (Dr Hanelt)

⁹ T6792 line 5 (Dr Hanelt)

¹⁰ T6791 line 50 (Dr Hanelt)

- 4.4 As required, staff were recruited and services progressively opened.¹¹ The department of internal medicine commenced in September 1997.¹² A specialist service comprising anaesthetic services, obstetrics and paediatric units and elective day surgery commenced at the beginning of the following year. Later, in 1998, an on-call surgical service commenced.¹³ The hospital progressively opened 24 hour services in those major areas. A 24 hour service in internal medicine was immediately provided when that service opened in 1997. A 24 hour service in obstetrics and paediatrics was provided from January 1998. A 24 hour service in surgical services commenced in or about August 1998.¹⁴
- 4.5 Hervey Bay is about a three and half to four hour trip by road to Brisbane, a distance of approximately 293 kilometres. It is about a one hour and 20 minutes trip from Bundaberg.¹⁵ During the past 10 years, the Hervey Bay shire has experienced rapid growth.¹⁶ It has been one of the fastest growing shires in Queensland.¹⁷ As at June 2005, it had a population of approximately 50,000 people. The growth has brought with it demand upon the hospital to keep abreast with the needs of the population. The demographic is skewed towards an elderly population which places a high demand upon the hospital and, in particular, orthopaedic services.¹⁸
- 4.6 The majority of the non-elective orthopaedic throughput at the hospital, initially at least¹⁹, came through the emergency department.²⁰ The majority of elective admissions came through the orthopaedic clinic rather than the emergency department.²¹
- 4.7 Dr Morgan Naidoo commenced employment as staff orthopaedic surgeon at the Hervey Bay Hospital in late 1996.²²
- 4.8 Prior to the appointment of Dr Naidoo, orthopaedic presentations at the hospital were managed by the emergency department, if the condition was straight forward. If the condition was more serious and needed specialist service, the patient was referred to the Maryborough Hospital or, if there was no service available at Maryborough, further afield.²³

¹¹ T6792 line 25 (Dr Hanelt)

¹² T6792 line 30 (Dr Hanelt)

¹³ T6792 line 35 (Dr Hanelt)

¹⁴ T6792 line 50 T6793 line 1 (Dr Hanelt)

¹⁵ T6797 line 35 (Dr Hanelt)

¹⁶ T6794 line 40 (Dr Hanelt)

¹⁷ T6794 line 40 (Dr Hanelt)

¹⁸ Exhibit 456 para 3.7 Statement of Allsopp

¹⁹ In some instances, patients are initially admitted through the emergency department and later return for further procedures as an elective patients

²⁰ T6794 line 50, T6795 line 10 (Dr Hanelt)

²¹ T6795 line 25 (Dr Hanelt)

²² Exhibit 444A, Statement of Hanelt attachment TMH 26 and 26A; Exhibit 431 Statement of Naidoo attachment MMN1

²³ T6793 line 20 (Dr Hanelt)

- 4.9 The Hervey Bay Hospital now has 8-10 orthopaedic beds. It has adequate operating theatres, imaging devices and pathological services for the provision of orthopaedic services for the local community.²⁴ However, it has never had a full complement of medical staff to provide an adequate and safe emergency and elective orthopaedic surgery service notwithstanding that, throughout the period of its operation until May 2005 when it was closed down, that service was offered. It certainly has not kept abreast with the demands of the growing population.

Orthopaedic staff

Minimum orthopaedic staff numbers

- 4.10 Drs North and Giblin recommended in the North Giblin report,²⁵ referred to in detail later, that a minimum of four registered specialist orthopaedic surgeons would be required to deliver orthopaedic services of an adequately safe nature to the Fraser Coast District.²⁶ Possibly five would be required, if continuing professional development activities and recreation leave were to be undertaken with safety. Five would provide a stable base for consideration of an Australian Orthopaedic Association accredited training post in the region in the future.
- 4.11 Dr Naidoo also prepared a document for the future provision of orthopaedic services for the Fraser Coast District. He also recommended that there should be four orthopaedic surgeons.²⁷
- 4.12 Mr Michael Allsopp, the District Manager, and Dr Terrence Hanelt, the Director of Medical Services, both also conceded that, at least since the hospital has been providing a 24 hour orthopaedic service, the hospital has needed a minimum of four specialist orthopaedic surgeons to provide an adequate service.²⁸ Dr Hanelt said a suitable mix of full time staff and Visiting Medical Officers would be two full-time orthopaedic surgeons, so that when one is on leave there is still one on campus, and two visiting medical specialists. Four orthopaedic surgeons also would allow for a one in four on-call roster during normal periods when all surgeons were available and a one in three or, at worst, one in two on-call roster during leave periods.²⁹

²⁴ Exhibit 38 para 8

²⁵ Exhibit 38 Dr John North MBBS FRACS AOrthA and Dr Peter Giblin MBBS FRACS AOrthA *A Review of Orthopaedic Health Care in Fraser Coast Health Region* submitted to the Director-General of Queensland Health Dr Stephen Buckland in May 2005

²⁶ Exhibit 38 para 22

²⁷ T6593 line 10 (Dr Naidoo)

²⁸ T6795 line 50 – 6797 line 1 (Dr Hanelt); Exhibit 456 para 4.42 Statement of Allsopp

²⁹ T6796 line 1 (Dr Hanelt)

Dr Morgan Naidoo

- 4.13 Notwithstanding these opinions, during the period from 1997 until 2000, Dr Naidoo was the only orthopaedic surgeon practising at the Hervey Bay Hospital. Dr Naidoo was registered as an orthopaedic surgeon in Queensland in 1981.³⁰ He arrived in Australia in 1975 after early education and training in South Africa. After securing a surgical training post in Queensland, he obtained his primary fellowship to the Royal Australasian College of Surgeons in 1976, and his final fellowship in May 1980. He became a fellow of the Australian Orthopaedic Association in 1982.³¹
- 4.14 Prior to his appointment to Hervey Bay Hospital, Dr Naidoo had worked in various hospitals in Queensland as an orthopaedic surgeon. Between 1982 and 1986, he held the position of Director of Orthopaedic Surgery at the Rockhampton Base Hospital, a major referral hospital then with 44 orthopaedic beds.³² From 1986 until his appointment to the Hervey Bay Hospital, he worked in private practice in Ipswich with visiting sessions at the Ipswich General Hospital and Military Hospital.³³
- 4.15 Dr Naidoo was employed at the Hervey Bay Hospital between 1997 and 2002 as a Senior Staff Specialist, and after August 2002, as Director of Orthopaedics. Dr Naidoo's conditions of employment were the same as applied to staff specialists throughout Queensland Health.³⁴ In both positions, the terms and conditions of his employment were prescribed under the State Senior Medical Officers and Resident Medical Officers Awards.³⁵ Pursuant to these awards, the ordinary hours of duty of Senior Medical Officers³⁶ must be worked between the hours of 8:00am and 6:00pm.³⁷ They are paid fortnightly and are not paid on an hourly basis, except for the purpose of calculating and paying them overtime. The ordinary hours can not exceed nine hours each day or 90 hours per fortnight exclusive of meals.³⁸ The actual hours they work varies between the hospitals. Some work 40 hours, others 45 hours. The hours depend upon the local requirements of the hospital. Dr Naidoo received the same leave entitlements as did any other staff specialist.³⁹

³⁰ Exhibit 431 para 1 Statement of Naidoo

³¹ Exhibit 431 attachment MMN1 p21 Statement of Naidoo

³² Exhibit 431 attachment MMN1 p21 Statement of Naidoo

³³ Exhibit 431 attachment MMN1 p22 Statement of Naidoo

³⁴ Exhibit 456 para 4.26, Statement of Allsopp; T6798 line 1 (Dr Hanelt)

³⁵ *Regional Health Authorities – Senior Medical Officers' and Resident Medical Officers' Award – State* 21 December 1994 and *District Health Services – Senior Medical Officers' and Resident Medical Officers' Award – State* 15 July 2003

³⁶ The term Senior Medical Officer in this context refers to senior medical practitioner, including College Fellow Specialist - See Chapter 2

³⁷ cl 4.2, 6.2

³⁸ cl 4.2, 6.2

³⁹ Exhibit 456 para 4.6 Statement of Allsopp; T6798 line 15 (Dr Hanelt)

- 4.16 Dr Naidoo's primary residence was in Brisbane, notwithstanding that, as part of his entitlement, he was provided with a house or rental subsidy at Hervey Bay. He said that he commuted to Hervey Bay each week. He said that he usually travelled to Hervey Bay at the beginning of the each week and returned to Brisbane each weekend, unless on-call. When he was on-call, he said, he stayed in Hervey Bay. The concession to allow Dr Naidoo to reside in Brisbane was made, according to the District Manager, Mr Allsopp,⁴⁰ in order to secure an orthopaedic service at Hervey Bay. However, as acknowledged by Mr Allsopp,⁴¹ and as set out below, the concession had limitations and led to problems.
- 4.17 Until the appointment of two Senior Medical Officers, Dr Damodaran Krishna on 20 July 2002 and Dr Dinesh Sharma in February 2003, Dr Naidoo had no full time orthopaedic support.⁴² There were no registrars in the orthopaedic department because the hospital did not meet the standards required for an orthopaedic training post.⁴³
- 4.18 Several years ago, before the appointment of the Senior Medical Officers, the District had approval for another orthopaedic surgeon to be appointed to the hospital.⁴⁴ Dr Hanelt stated that the hospital advertised for another orthopaedic surgeon, at least, a couple of times.⁴⁵ In conjunction with St Stephen's Hospital, it also did a mail-out to every registered orthopaedic surgeon in Australia and New Zealand to try and attract another orthopaedic surgeon to the District.⁴⁶ Dr Hanelt stated that the recruitment attempts proved fruitless.⁴⁷
- 4.19 The gross inadequacy of clinical staff members placed pressure on Dr Naidoo. It made it difficult for him to provide a proper, efficient and safe orthopaedic service.⁴⁸ But, as is plain from the opinion evidence referred to earlier, it was not just difficult; it was impossible. Dr Naidoo also had to run all the fracture clinics.⁴⁹ Elective surgery was cancelled to accommodate emergency surgery.⁵⁰ He said that he made regular complaints at surgical management committee meetings and senior medical staff meetings or on a casual basis to the District Manager at the time and Dr Hanelt about the shortage of junior staff

⁴⁰ Exhibit 456 para 4.38 Statement of Allsopp

⁴¹ Exhibit 456 para 4.38 Statement of Allsopp

⁴² Exhibit 431 para 5.1 Statement of Naidoo

⁴³ Exhibit 38 para 10 North Giblin report

⁴⁴ T6749 line 10 (Dr Hanelt)

⁴⁵ T6749 line 30 (Dr Hanelt)

⁴⁶ Exhibit 456 para 4.42 Statement of Allsopp; T6749 line 30-40, T6797 line 40 (Dr Hanelt)

⁴⁷ Exhibit 456 para 4.42 Statement of Allsopp; T6749 (Dr Hanelt)

⁴⁸ Exhibit 431 para 5.2 Statement of Naidoo

⁴⁹ Exhibit 431 para 5.5 Statement of Naidoo

⁵⁰ Exhibit 431 para 6.4 Statement of Naidoo

and resident medical officers.⁵¹ He was frustrated by the frequent shortage of junior medical staff.⁵² He said he received no real administrative support.⁵³

Dr Mullen's appointment as Visiting Medical Officer

- 4.20 Dr Sean Mullen is a registered orthopaedic surgeon and Fellow of the Royal Australasian College of surgeons (Orthopaedics).⁵⁴ He was appointed a Visiting Medical Officer at the Hervey Bay Hospital in 2000. He had, for the previous year, worked as a full time staff orthopaedic surgeon at the Princess Alexandra Hospital.⁵⁵ He made contact with Dr Hanelt before he moved to Hervey Bay to commence private practice. He offered his services as a Visiting Medical Officer. His offer was accepted.⁵⁶
- 4.21 Dr Mullen's appointment was limited. Initially, Dr Mullen had a two session commitment each week; one operating session and one clinic session.⁵⁷ This amounted to a total of approximately 7 hours.⁵⁸ He was also on-call one week night and one weekend in four for emergencies.⁵⁹ Dr Mullen also performed private specialist medical services. He did this both at the Hervey Bay Hospital and at the St Stephens Private Hospital in Maryborough.⁶⁰
- 4.22 During the period between 30 September 2002⁶¹ and February 2004,⁶² Dr Mullen ceased his visiting operating and outpatients' session work at the hospital.⁶³ He remained available for some on-call work. Dr Mullen accepted that the addition of a new baby to his family was a factor in his mind⁶⁴ and that this was the reason stated in his letter of resignation.⁶⁵ However, he said, and I accept that, it was not the only reason why he withdrew his services at the time.⁶⁶ He said that he had been 'banging [his] head against a brick wall for such a long time' about the issue of patient safety.⁶⁷ He stated that the situation at the hospital had become untenable for him as a professional as regards his relationship with Dr Naidoo and Dr Naidoo's inadequate

⁵¹ Exhibit 431 para 5.7 Statement of Naidoo

⁵² Exhibit 431 para 5.8 Statement of Naidoo

⁵³ Exhibit 431 para 5.4 Statement of Naidoo

⁵⁴ Exhibit 330 para 1 Statement of Mullen

⁵⁵ Exhibit 330 para 1 Statement of Mullen

⁵⁶ Exhibit 330 para 3 Statement of Mullen

⁵⁷ Exhibit 330 para 4 Statement of Mullen; T5447 line 5; Exhibit 431 para 7.2 Statement of Naidoo

⁵⁸ Exhibit 330 para 4 Statement of Mullen; T6590 line 50 (Dr Naidoo)

⁵⁹ Exhibit 330 para 5 Statement of Mullen; T6590 line 60 (Dr Naidoo)

⁶⁰ Exhibit 444A para 33(iii) Statement of Hanelt

⁶¹ Exhibit 444A TMH11 Statement of Hanelt

⁶² Exhibit 456MA11 Statement of Allsopp

⁶³ Exhibit 444A para 33 (ii), TMH 10–14B Statement of Hanelt

⁶⁴ T5478 line 50, 5479 line 10

⁶⁵ Exhibit 444A TMH 11 Statement of Hanelt

⁶⁶ T5479 line 30

⁶⁷ T5479 line 20

supervision of junior staff.⁶⁸ He felt that he could not give his family and private practice the time they needed as well as deal with these problems.⁶⁹

- 4.23 Dr Mullen did return to session work in February 2004. His commitment from then on seems to have lessened to four sessions per month⁷⁰ plus on-call work. He remained a visitor there until his resignation after the delivery of the North Giblin report in early May 2005.⁷¹

Administrators

District Manager

- 4.24 Mr Allsopp was appointed the District Manager for the Fraser Coast Health Service District in April 2001. Mr Allsopp has a business background. He graduated with a business degree in 1986 and a Masters in Business Administration in 1996. His appointment to the District was his first appointment to the position of a District Manager. Prior to this, he had been employed as Director of Finance at the Royal Brisbane and Royal Women's Health Service Districts and before that as Team Leader for the Commissioning Royal Brisbane Royal Women's Hospitals Redevelopment Project.⁷² He resigned from the position of District Manager in September 2005.⁷³

Director of Medical Services

- 4.25 Dr Hanelt has been the Director of Medical Services for the Fraser Coast Health Service District since 1994. Prior to that, he served as a Medical Superintendent at a number of country hospitals including at Kingaroy, Charters Towers, Emerald and Injune. He is medically trained having graduated in Medicine from the University of Queensland in 1982. He is registered as a medical practitioner. Until recently, in addition to general practitioner privileges, he held clinical privileges for the District, obtained through the previously existing Rural and Remote Privileging Committee, in the areas of obstetrics and gynaecology for all forms of vaginal and operative deliveries, a range of gynaecological procedures and for closed orthopaedics.⁷⁴

⁶⁸ Exhibit 330 para 15 Statement of Mullen

⁶⁹ T5479 line 5

⁷⁰ T5812 line 45 (Dr Mullen); Exhibit 456 para 4.19 Statement of Allsopp; Exhibit 330 para 16 Statement of Mullen; T5423 line 50-5424 line 10 (Ms Erwin-Jones); Exhibit 444A TMH14B Statement of Hanelt

⁷¹ Exhibit 444A TMH17 and TMH19 Statement of Hanelt

⁷² Exhibit 456 pp3-4 attachment MA1 Statement of Allsopp

⁷³ T7070 line 45 (Mr Allsopp)

⁷⁴ Exhibit 444A attachment TMH1, Statement of Hanelt; T6722 line 25 (Dr Hanelt)

Appointment of Senior Medical Officers

Appointment of Dr Damodaran Krishna

- 4.26 Dr Krishna was appointed a Senior Medical Officer with the Fraser Coast Health Service District on 20 July 2002.⁷⁵ A condition of his employment was that, as a District employee, he could be required to work within any facility in the District.⁷⁶ He was assigned to the Hervey Bay hospital.
- 4.27 Dr Krishna obtained a diploma in surgery and medicine from the Fiji School of Medicine in 1982. He also obtained a Diploma in Orthopaedics awarded by the Australian Orthopaedic Association in 1995. This diploma, according to Drs North and Giblin, was not recognised or considered as a qualification in orthopaedic surgery by the Australian Orthopaedic Association or the Royal Australasian College of Surgeons.⁷⁷ It was awarded in recognition of participation in professional development organised by the Orthopaedic Outreach Fund Inc where volunteer orthopaedic surgeons travelled to Fiji, amongst other places, to develop the skills of doctors to practise some limited orthopaedic surgery in their home country. According to Drs North and Giblin, the Australian Orthopaedic Association ceased issuing the diploma from 2003 due to the fact that many held out the diplomas as a qualification in orthopaedics, which it was not.⁷⁸
- 4.28 Dr Krishna was registered as a specialist in orthopaedics in Fiji in 1998.⁷⁹ He served in various hospitals in Fiji before coming to Australia including, he stated, as the sole orthopaedic surgeon at Labasa Hospital, a divisional hospital in Fiji, practising in trauma and general orthopaedics.⁸⁰
- 4.29 Dr Krishna was not registered nor assessed for practice as an orthopaedic specialist in Australia.
- 4.30 On 4 December 2000, Dr Krishna was initially granted special purpose registration to fill an area of need within a public hospital on 4 December 2000. This was to commence work as a medical officer at the Toowoomba Hospital. His special purpose registration was subsequently renewed annually.⁸¹ Whilst he was employed at the Hervey Bay Hospital, he was, until recently, registered as a medical practitioner under the special purpose provisions of s135 of the *Medical Practitioners Registration Act 2001*. I shall say something about the form of that registration, from time to time, in Chapter Six – Part C.

⁷⁵ Exhibit 424 para 13, DK4 Statement of Krishna

⁷⁶ Exhibit 424 DK4 Statement of Krishna

⁷⁷ Exhibit 38 p10 North Giblin report

⁷⁸ Exhibit 38 p10 North Giblin report

⁷⁹ Exhibit 444A TMH28 Statement of Hanelt

⁸⁰ Exhibit 424 paras 9, 10 Statement of Krishna

⁸¹ Exhibit 424 para 14 Statement of Krishna

- 4.31 It was made known to the Queensland Medical Board, at the time of his first and each subsequent registration under s135, that he would be practising in orthopaedic surgery.⁸² Before so registering Dr Krishna, the Medical Board made no assessment of his skills or competence to enable it to safely conclude, as it was required to do under s135(2), that he had medical qualification and experience suitable for practising orthopaedic medicine at the Hervey Bay Hospital. I will say something more about that and its consequences also in Chapter Six – Part C.
- 4.32 Dr Krishna did not believe that he was registered in Queensland as a specialist and knew that the Medical Board did not regard him as registered as a specialist. Administrators at the Hervey Bay Hospital, Mr Allsopp and Dr Hanelt also did not believe that Dr Krishna was registered in Queensland as a specialist.⁸³
- 4.33 Curiously absent were any conditions attached to his special purpose registration⁸⁴ or letter of appointment⁸⁵ requiring supervision.
- 4.34 Dr Krishna successfully passed the Australian Medical Council examination on 16 October 2004 and now has been granted general registration on supervised practice conditions by the Queensland Medical Board.⁸⁶ At the time he gave evidence, he was performing practice in accordance with those supervised practice conditions.⁸⁷ This was the first time supervision was imposed as a condition on his registration.
- 4.35 Dr Anthony Wilson, Orthopaedic surgeon, who was a part time staff surgeon at the Toowoomba Hospital, and under whom Dr Krishna acted in the position of non-training Registrar in Orthopaedics in 2002, assessed Dr Krishna as having progressed as expected for a person in his position with supervision at the Toowoomba Hospital.⁸⁸ Dr Wilson had expected him to continue to progress naturally at the Hervey Bay Hospital⁸⁹ provided he obtained the necessary supervision and training.⁹⁰
- 4.36 Dr Krishna gave evidence that he had no privileges in Toowoomba because he had to do everything supervised.⁹¹ Dr Krishna said that, when he worked at the Toowoomba Hospital in 2002, before he came to Hervey Bay, he had '100% supervision'.⁹² Consultants were present all the time and he had to

⁸² Exhibit 446

⁸³ T6718 line 20 (Dr Hanelt); T7079 line 55, T7080 line 20 (Mr Allsopp)

⁸⁴ Exhibit 446

⁸⁵ Exhibit 424 DK4 Statement of Krishna

⁸⁶ Exhibit 424 para 14 Statement of Krishna

⁸⁷ T6465 line 30

⁸⁸ T7339 line 35 - 55

⁸⁹ T7340 line 1

⁹⁰ T7340 line 10

⁹¹ T6532 line 30

⁹² T6515 line 10, T6523 line 35

notify a consultant of any new case.⁹³ Dr Wilson said that 100% supervision may have been overstating it, but the supervision was very strong.⁹⁴ Dr Wilson said that, at the Toowoomba Hospital, if Dr Krishna was not supervised by orthopaedic surgeons, he was often supervised by two other Registrars, one of whom was in training, who were fairly well skilled in orthopaedic and traumatic surgery.⁹⁵ In time, Dr Krishna had done some minor fractures including minor compound fractures on his own.⁹⁶ But a consultant was always available to attend and assist if necessary at the Toowoomba Hospital.⁹⁷

- 4.37 By comparison with Hervey Bay Hospital, the Toowoomba Hospital had two staff surgeons, Drs Punn and Ivers, as well as seven Visiting Medical Officers.⁹⁸

Appointment of Dr Dinesh Sharma

- 4.38 Dr Sharma was appointed a Senior Medical Officer at the Fraser Coast Health District in February 2003.⁹⁹ A condition of his employment also was that, as a District employee, he could be required to work within any facility in the District.¹⁰⁰ He was assigned to the Hervey Bay Hospital.
- 4.39 Dr Sharma has a similar background to Dr Krishna. He was educated in medicine in Fiji at the University of the South Pacific. He practised in a number of hospitals in Fiji as an orthopaedic registrar and, after also obtaining specialist registration in orthopaedics in 1998,¹⁰¹ as a Consultant orthopaedic surgeon at Colonial War Memorial Hospital in Suva until January 2003.¹⁰² Like Dr Krishna, in 1996 he received a diploma in orthopaedics from the Australian Orthopaedic Association.¹⁰³
- 4.40 He first commenced employment in Australia when he was appointed to the Hervey Bay Hospital. This occurred in February 2003. Until recently, whilst he was employed at the Hervey Bay Hospital, he too was registered as a medical practitioner under the special purpose provisions of s135 of the Medical Practitioners Registration Act 2001. I shall say something about the form of that registration also, from time to time, in Chapter Six – Part C. It was known

⁹³ T6515 line 10

⁹⁴ T7329 line 40, T7330 line 35

⁹⁵ T7330 line 25

⁹⁶ T7330 line 50

⁹⁷ T7330 line 45

⁹⁸ T6523 line 40

⁹⁹ Exhibit 357 DS8 Statement of Sharma

¹⁰⁰ Exhibit 357 DS8 Statement of Sharma

¹⁰¹ Exhibit 444A TMH27 Statement of Hanelt

¹⁰² Exhibit 357 Curriculum vitae DS1 Statement of Sharma

¹⁰³ Exhibit 38 para 10 North Giblin report

to the Medical Board, at the time of his first and each subsequent registration under s135, that he would be practising orthopaedic surgery.¹⁰⁴

- 4.41 Before registering Dr Sharma, the Medical Board made no assessment of his skills and competence to enable it to safely conclude, as it was required to do under s135(2), that he had medical qualification and experience suitable for practising orthopaedic medicine at the Hervey Bay Hospital. I will say something more about that and its consequences in Chapter Six – Part C.
- 4.42 Dr Sharma did not believe that he was registered in Queensland as a specialist.¹⁰⁵ He knew that the Medical Board did not regard him as registered as a specialist. Dr Hanelt also did not believe that Dr Sharma was registered as specialist.¹⁰⁶
- 4.43 No conditions were attached to his special purpose registration¹⁰⁷ or letter of appointment¹⁰⁸ requiring supervision.
- 4.44 In 2005, like Dr Krishna, Dr Sharma successfully completed the Australian Medical Council examination.¹⁰⁹ In June 2005, he was granted a general registration on supervised practice conditions. The conditions include practising in accordance with a supervised practice program for a period of 6 months.¹¹⁰ This again was the first time supervision was imposed as a condition on his registration.

Credentialing and privileging

Credentialing and privileging requirements

- 4.45 As discussed earlier in this report,¹¹¹ the process of credentialing and clinical privileging is integral to patient safety.
- 4.46 The 2002 Queensland Health Credentials and Clinical Privileges for Medical Practitioners Policy and Guidelines¹¹² applied to the Fraser Coast Health Service District, as well as to the Bundaberg District. The relevant provisions of that policy and those guidelines have already been outlined in detail.¹¹³ Importantly, they applied to all medical practitioners operating within the service district. The guidelines which set out the process by which the policy

¹⁰⁴ Exhibits 360, 361, 362, 447

¹⁰⁵ T5676 line 20, T5678 line 20

¹⁰⁶ T6718 line 20 (Dr Hanelt)

¹⁰⁷ T5678 line 15 (Dr Sharma)

¹⁰⁸ Exhibit 357 attachment DS8 Statement of Sharma; T5679 (Dr Sharma)

¹⁰⁹ T5676 line 40 (Dr Sharma)

¹¹⁰ Exhibit 358

¹¹¹ Chapter 3

¹¹² Exhibit 279

¹¹³ Chapter 3 para 3.147-3.148, 3.171-3.173

was to be implemented,¹¹⁴ required that all medical practitioners be credentialed and clinically privileged before completion of the appointment process and before making any admissions or commencing any treatment of any patient within the hospital.¹¹⁵

- 4.47 Under the policy, the District Manager, Mr Allsopp, was responsible for ensuring the process was in place and that all medical practitioners operating within the Fraser Coast Health Service District had their credentials and clinical privileges granted before they commenced work and periodically reviewed by a credentialing and privileging committee.¹¹⁶ Dr Hanelt accepted that it was also his duty to consult with Mr Allsopp about such matters.¹¹⁷
- 4.48 A local Fraser Coast Health Service District policy,¹¹⁸ which was written by the Director of Medical Services, Dr Hanelt¹¹⁹ and which came into existence for Hervey Bay sometime after April 2003,¹²⁰ also applied to all senior clinicians, including Senior Medical Officers.¹²¹ Under that policy, the District Manager, Mr Allsopp, was the delegated officer with responsibility for conferring clinical privileges on medical practitioners after recommendation from a credentialing and privileges committee.¹²² The Director of Medical Services, Dr Hanelt, was responsible for convening a Credentials and Privileges Committee to undertake the review of credentials and recommend appropriate clinical privileges. Again the policy specifically applied to Senior Medical Officers.¹²³ Privileges granted under the local policy were subject to a three yearly review.¹²⁴
- 4.49 There was no reason why, under each of the Queensland Health policy and local policy, clinical privileges could not have been limited or delineated by a requirement of supervision.

Failure to credential and privilege

- 4.50 Despite the administrators, Mr Allsopp¹²⁵ and Dr Hanelt¹²⁶, being aware of the need for credentialing and clinical privileging of all medical practitioners before they commenced service, none of the medical practitioners practising in the

¹¹⁴ Exhibit 279 para 2 Queensland Health Instruction accompanying the policy part

¹¹⁵ Exhibit 279 para 6.1 Guidelines Exhibit 279

¹¹⁶ Exhibit 279 para 2

¹¹⁷ T6721 line 35

¹¹⁸ Exhibit 444A attachment TMH35, Statement of Hanelt.

¹¹⁹ Exhibit 444A para 67(i) Statement of Hanelt; T6725 line 10

¹²⁰ T6724 line 50; T6768 line 50 (Dr Hanelt)

¹²¹ Exhibit 444A p1 attachment TMH35 Statement of Hanelt

¹²² Exhibit 444A p2 attachment TMH35 Statement of Hanelt

¹²³ Exhibit 444A attachment TMH35 Statement of Hanelt

¹²⁴ Exhibit 444A, p2 attachment TMH35 Statement of Hanelt

¹²⁵ T7076 line 50 – 7077 line 10

¹²⁶ T6722 line 10, T6722 line 60 – 6723 line 10

Hervey Bay Hospital orthopaedic department were ever credentialed or privileged.¹²⁷

- 4.51 An earlier committee, the Rural and Remote Privileging Committee, which had existed under an earlier policy, ceased to exist in or about 2001.¹²⁸ After that committee ceased to exist, no credentialing and privileging committee existed until late 2004.¹²⁹ Mr Allsopp stated that he assigned the management of the implementation of the policy to Dr Hanelt in or about 2002.¹³⁰
- 4.52 I have already expressed my view that under the Queensland Health guidelines and local policy, the involvement of the relevant colleges was not mandatory. As set out above,¹³¹ under the guidelines, the core membership of the committee had to comprise the medical superintendent of the facility and two other medical practitioners nominated by the District Manager.¹³² In addition to the core membership, additional members were to be 'invited as required, depending on the size and complexity of the facility, with representation from relevant professional and other bodies as dictated by the principle of peer representation'.¹³³ The guidelines provided 'the District Manager will decide on the categories of variable membership of the committee'. The guidelines then specified several groups from which 'where appropriate' additional members were to be selected.¹³⁴ These were not limited to the relevant clinical/professional colleges¹³⁵ but included, relevantly, where appropriate, a representative from relevant clinical departments from larger facilities¹³⁶ and 'other medical practitioners co-opted as appropriate by the committee'.¹³⁷
- 4.53 Similarly, under the local policy, the core members of the committee comprised the Director of Medical Services of each of the Fraser Coast Health Service District and Bundaberg Base Hospital and the Medical Superintendent of the Maryborough Hospital.¹³⁸ Again, in my view, under the local policy, input from the relevant colleges was only required to be invited by the Committee. It relevantly provided: 'In all instances the Committee will also invite input from the relevant Department Director and Specialty College'.¹³⁹

¹²⁷ T6632 line 5-20 (Dr Naidoo); T7617 line 5 (Dr Hanelt)

¹²⁸ T6721 (Dr Hanelt)

¹²⁹ T6725 (Dr Hanelt)

¹³⁰ T7077 line 20

¹³¹ Chapter 3 paras 3.171- 3.173

¹³² Exhibit 279 s5.2 Guidelines

¹³³ Exhibit 279 s5.1 Guidelines

¹³⁴ Exhibit 279 s5.3 Guidelines

¹³⁵ Exhibit 279 first bullet point s5.3 Guidelines

¹³⁶ Exhibit 279 third bullet point s5.3 Guidelines

¹³⁷ Exhibit 279 last bullet point s5.3 Guidelines

¹³⁸ Exhibit 444A TMH35 p2 Statement of Hanelt

¹³⁹ Exhibit 444A TMH35 p2 Statement of Hanelt; T6770 line 30 (Dr Hanelt)

- 4.54 I later express the view in Chapter Six – Part C that the drawing up of a local policy was unnecessary; a district credentialing and privileging committee could have been set up under the Queensland Health policy and guidelines. It was, therefore, a waste of time and effort. Moreover, it oddly narrowed the core membership of the committee to the Directors of Medical Services of Bundaberg and Fraser Coast and the Medical Superintendent of Maryborough Hospital, none of whom were clinicians. It is difficult to see how any of them could have made a peer assessment of, for example, Dr Krishna or Dr Sharma.
- 4.55 As happened in relation to the credentialing and privileging process at the Bundaberg Base Hospital, the district administrators, in particular Dr Hanelt from about mid 2003¹⁴⁰ and then his delegate Dr Gopalan from about January 2004 through to 2005¹⁴¹ attempted to get the Australian Orthopaedic Association and the Royal Australasian College of Surgeons to nominate a representative for membership of the credentialing and clinical privileging committee. The Australian Orthopaedic Association was requested for a nominee by letter dated 14 July 2003¹⁴² and the Royal Australasian College of Surgeons in mid 2003.¹⁴³
- 4.56 The evidence was that no response was received from the colleges¹⁴⁴ although by 15 July 2004 Drs Gopalan and Hanelt had learned that the Queensland branch of the Royal Australasian College of surgeons had been ‘swamped’ with applications from other area health services.¹⁴⁵ Accepting this to be correct,¹⁴⁶ the process was instigated too late for Drs Krishna or Sharma. Pursuant to the provisions of the Queensland Health policy, the process should have been completed before their appointments. Further, any difficulty, whenever encountered, did not excuse the failure to proceed with the credentialing and clinical privileging process at Hervey Bay, without college representation or input, by finding an alternative suitable variable member for the credentialing and privileging committee.
- 4.57 The underlying object of credentialing and privileging is to ensure patient safety. To achieve that object, it is essential that, before a doctor commences to serve at a hospital, he or she is assessed and his or her limitations in practice are clearly defined; and that the limitations on the practice at the hospital are also clearly defined.
- 4.58 Once that purpose is seen, it can also be clearly seen that it is better to have some process of credentialing and clinical privileging applied to a doctor before

¹⁴⁰ T6781 line 40 (Dr Hanelt)

¹⁴¹ T6781 line 50 – 6782 line 20 (Dr Hanelt)

¹⁴² Exhibit 444A attachment TMH23 Statement of Hanelt

¹⁴³ T6781(Dr Hanelt)

¹⁴⁴ Exhibit 444A para 66 Statement of Hanelt; T6781 (Dr Hanelt); T7090 (Mr Allsopp); T5206 (Dr North)

¹⁴⁵ Exhibit 448 DWK 79 email Dr Gopalan to Drs Hanelt and Keating 15 July 2004

¹⁴⁶ Evidence was not given by the relevant colleges in relation to this issue

commencement of service, even one which does not comply with Queensland Health policy and guidelines or local policy, than to have none at all. But, in the case of Drs Krishna and Sharma, it would have been possible to comply with both, without the need for involvement of a representative from its Royal Australasian College of Surgeons, before either Dr Krishna or Dr Sharma commenced service.

- 4.59 In the absence of a Royal Australasian College of Surgeons nominee, approaches should have been made to local specialist surgeons¹⁴⁷ or a staff specialist from a larger hospital¹⁴⁸ or a visiting specialist.¹⁴⁹ Drs Mullen and Khursandi, each of whom was a registered orthopaedic surgeon practising within the Fraser Coast Health Service District, were ideally placed to assist in the process of credentialing and privileging.¹⁵⁰ A privileging committee consisting of the Drs Mullen and Khursandi, as well as Dr Naidoo, together, possibly with core members of the committee under the Queensland Health or local policy would have sufficed.¹⁵¹
- 4.60 Neither Mr Allsopp nor Dr Hanelt, nor for that matter Dr Naidoo, seem to have thought to involve such persons before either Dr Krishna or Dr Sharma commenced service or at any time during Drs Krishna's and Sharma's orthopaedic services at the hospital. Dr Hanelt said that he did not think to do so until the cessation of the orthopaedic department in mid 2005.¹⁵²
- 4.61 The failure to apply any process of credentialing or clinical privileging to Dr Krishna or Dr Sharma before either commenced meant that each commenced without any limitation being imposed on what he could do and without any condition requiring supervision.
- 4.62 With the benefit of hindsight, Dr Hanelt admitted that when he could not get a college representative he should have proceeded with credentialing and privileging the relevant practitioners without any college representation. He suggested this would have been contrary to the policy.¹⁵³ However, he was mistaken about the requirements of the policy in this regard. Mr Allsopp recalled it being suggested at a Central Zone meeting of District Managers, at or about the time of the tilt train disaster,¹⁵⁴ that a possible option for getting the credentialing committees assembled was to go outside the policy and appoint surgeons or other specialists as appropriate to committees without nomination

¹⁴⁷ T5206 line 30, T5227 line 40 (Dr North)

¹⁴⁸ T5227 line 50 (Dr North)

¹⁴⁹ T5227 line 55 (Dr North)

¹⁵⁰ T5151 (Dr North)

¹⁵¹ T5151 line 40 – 60 (Dr North)

¹⁵² T6724 line 20

¹⁵³ T6724 line 20

¹⁵⁴ 16 November 2004

by the colleges.¹⁵⁵ He thought he pursued the option with Dr Hanelt but did not know the outcome.¹⁵⁶

- 4.63 Under the Queensland Health policy, Mr Allsopp had power to grant interim privileges. He said that he delegated this power to the Director of Medical Services, Dr Hanelt.¹⁵⁷ He said he did this when he assigned the management of the implementation of the policy to Dr Hanelt in or about 2002.¹⁵⁸ By a letter signed by Mr Allsopp to Dr Krishna dated 13 January 2003, Dr Krishna was granted interim privileges 'as per the advice of the Director of Medical Services'. However, these were very general and they were granted 'in Trauma Orthopaedics and minor elective Orthopaedics'. There is no evidence of Mr Allsopp or Dr Hanelt having granted any interim privileges for Dr Sharma, other than arranging for the scopes of service documents, referred to below, to be prepared.
- 4.64 Ultimately, the responsibility lay with Mr Allsopp to implement the credentialing and privileging process. Delegation of the actions necessary to implement the policy did not relieve Mr Allsopp from an obligation to ensure that implementation occurred.
- 4.65 Dr Hanelt said he had had discussions with Dr Keating about combining the credentialing and privileging process for the Bundaberg and Fraser Coast Health Service Districts because of the lack of success both districts had in obtaining college nominations¹⁵⁹ and to ensure a big enough and impartial core group.¹⁶⁰ However, no such committee formed until late 2004¹⁶¹ and then only met in areas other than surgery.¹⁶²
- 4.66 Mr Allsopp did not consider Dr Hanelt to have been derelict in failing set up a credentialing and privileging committee. However, Mr Allsopp agreed, in hindsight, that the hospital took too long to establish a credentialing and privileging committee.¹⁶³ Ideally, he said, it ought to have happened in 2002.¹⁶⁴ He said that he did not realise, until about January 2004, when Dr Naidoo prepared written scopes of practice, that neither Senior Medical Officer had had their scope of service documented.¹⁶⁵ But Mr Allsopp said that he understood that what procedures the Senior Medical Officers could do unsupervised, and which ones they could do only with supervision, had been

¹⁵⁵ T7091

¹⁵⁶ T7091 line 55 – 7092 line 1

¹⁵⁷ T7077 line 10

¹⁵⁸ T7077 line 20

¹⁵⁹ T6723 line 40

¹⁶⁰ T6723 line 50

¹⁶¹ T6725 line 20 (Dr Hanelt)

¹⁶² T6782 line 40 (Dr Hanelt)

¹⁶³ T7079 line 20

¹⁶⁴ T7079 line 40

¹⁶⁵ T7083 line 50 – 7084 line 20

orally determined. He was unable to be specific about this.¹⁶⁶ At best, all of this demonstrates, in my opinion, a lack of understanding of the underlying purpose and, consequently, the essentiality of credentialing and privileging doctors before they commence service.

Supervision

The need for supervision

- 4.67 Even more so because their clinical skills and competence were never assessed by a process of credentialing and privileging, each of Drs Krishna and Sharma required supervision. Plainly, until that skill and competence was assessed, supervision should have been constant.
- 4.68 Thereafter, the level of supervision which each of Drs Krishna and Sharma required was the subject of differing views. However, all witnesses agreed that some level of supervision was necessary. As Dr Mullen said,¹⁶⁷ a lack of supervision of junior unqualified or under-qualified doctors leads to decision making which often results in outcomes which are not due to expected routine complications but due to complications from poor decision making or just not knowing what to do.
- 4.69 The level of supervision required may have varied, to some extent, between Drs Krishna and Sharma. In the case of Dr Krishna, although he had not progressed to a stage where he could be left unsupervised, he had obtained some Australian orthopaedic training and experience at the Toowoomba Hospital in the position of non-training Registrar. In the case of Dr Sharma, his appointment to the Hervey Bay Hospital was his first in the country. During the first year of Australian service, any overseas trained doctor, who is not registered as a specialist should, as a matter of prudence, have a supervisor present at all times in an operating theatre.¹⁶⁸
- 4.70 It is ironic that the Queensland Medical Board, when it initially registered Drs Krishna and Sharma under the special purpose provisions of s135 of the *Medical Practitioners Registration Act 2001* did not include any requirement that they be supervised; yet later, when it came to register each of them for general practice, it required a period of practice under a supervised practice

¹⁶⁶ T7083

¹⁶⁷ T5450 line 40

¹⁶⁸ T5138 line 50 – 5139 line 10 (Dr North)

program for a period of 6 months.¹⁶⁹ Dr Sharma, understandably, was surprised about these inconsistent requirements.¹⁷⁰

- 4.71 Dr Sharma said that he was never told that it was a convention or condition of his employment as a Senior Medical Officer that supervision was required of him.¹⁷¹

Scopes of service approved by Dr Naidoo

- 4.72 Sixteen months after the commencement of Dr Krishna and ten months after the commencement of Dr Sharma, Dr Hanelt, by a written memorandum dated 13 November 2003, requested Dr Naidoo, as Director of Orthopaedics, to provide him with some documentation in respect of the services provided by Drs Krishna and Sharma.¹⁷² In evidence, Dr Hanelt said that he asked Dr Naidoo to assess the Senior Medical Officers as a pre-runner to the formal privileging process.¹⁷³ He said that the documentation to be produced by Dr Naidoo was intended to go to the privileging committee.¹⁷⁴ However, in the memorandum itself, Dr Hanelt is recorded as having requested the documentation 'due to the ongoing media and Australian Orthopaedic Association attention to Orthopaedic Services within this District and in particular the services provided by the Senior Medical Officers in orthopaedics'.¹⁷⁵ In the memorandum he said he needed documentation 'as a matter of urgency'. Dr Naidoo's evidence corroborated this as being the reason for the preparation of the documents, saying that he prepared the Scope of Service documents after the Australian Orthopaedic Association had shown an interest in the orthopaedic department.¹⁷⁶ Dr Naidoo said that the documents were presented to the Australian Orthopaedic Association to review as part of their investigation into what services the Senior Medical Officers were providing.¹⁷⁷ It seems plain from the memorandum and the evidence of Dr Naidoo that the reason why Dr Hanelt requested this documentation was his concern about the possibility of an unfavourable outcome resulting from media and Australian Orthopaedic Association attention.
- 4.73 In response to the request by Dr Hanelt, on 16 January 2004, Dr Naidoo provided to Dr Hanelt a memorandum attaching a written recommendation and Scopes of Service for Elective Orthopaedic Surgery and Orthopaedic Trauma

¹⁶⁹ Exhibit 358

¹⁷⁰ T5677 line 45

¹⁷¹ T5678 line 25-40

¹⁷² Exhibit 431 attachment MMN5 Statement of Naidoo

¹⁷³ T6766 line 50

¹⁷⁴ T6767 line 5

¹⁷⁵ Exhibit 431 attachment MMN5 Statement of Naidoo

¹⁷⁶ T6628 line 40

¹⁷⁷ T6626 line 20

for both Dr Krishna¹⁷⁸ and Dr Sharma dated 1 January 2004.¹⁷⁹ In the recommendation for Dr Krishna's Scope of Service, Dr Naidoo wrote that, in making his recommendation, he had 'taken into consideration his CV outlining his previous experience, discussions and references from my orthopaedic colleagues from Toowoomba General Hospital, observation of his clinical and surgical practice and Orthopaedic Audits'.¹⁸⁰ In the recommendation for Dr Sharma's Scope of Service, he similarly wrote that, in making his recommendation he had 'taken into consideration his CV outlining his previous experience, discussions and references from orthopaedic colleagues, observation of his clinical and surgical practice and Orthopaedic Audits'.¹⁸¹

- 4.74 But, it is clear that Dr Naidoo's observation of Dr Krishna's surgery, at least, was very limited. Prior to and for the purposes of Dr Naidoo preparing the Scope of Service documents, a document was prepared summarising the orthopaedic surgery Dr Krishna had performed unsupervised and with consultant assistance for the period from 17 July 2002 to 19 November 2003. It disclosed that Dr Krishna had received consultant assistance on only four out of a total of 323 surgical procedures performed.¹⁸² Although it purports on its face to have been authored by Dr Krishna, he denied he prepared it or knew who had prepared it.¹⁸³ In any event, both he¹⁸⁴ and Dr Naidoo¹⁸⁵ accepted that its contents were correct.
- 4.75 The Scopes of Service documents provided by Dr Naidoo for Drs Krishna and Dr Sharma for both Orthopaedic Trauma and Elective Orthopaedic Surgery dated 1 January 2004 are identical.¹⁸⁶
- 4.76 Dr Naidoo also prepared a Scope of Service for Dr Sharma dated 1 January 2003 which is almost identical to the January 2004 version.¹⁸⁷ However, Dr Sharma did not commence at the Hervey Bay Hospital until March 2003.¹⁸⁸ There was no evidence to explain the circumstances under which the version dated 1 January 2003 was created. I am satisfied that no such document was prepared before January 2004.
- 4.77 Dr Naidoo said that he asked each Senior Medical Officer what procedures they had done in their previous employment and they were given the documents to read before they were submitted to Dr Hanelt.¹⁸⁹ Tellingly, Dr

¹⁷⁸ Exhibit 313

¹⁷⁹ Exhibit 364

¹⁸⁰ Exhibit 431 attachment MMN5

¹⁸¹ Exhibit 431 attachment MMN5

¹⁸² Exhibit 431 pp 50, 51 attachment MMN5 Statement of Naidoo

¹⁸³ T6602 line 55

¹⁸⁴ T6603 line 35 - 45, 6604 lines 10 - 20

¹⁸⁵ T6628

¹⁸⁶ T6629 line 10 (Dr Naidoo)

¹⁸⁷ Exhibit 365

¹⁸⁸ T5706 line 20

¹⁸⁹ T6626 line 5

Naidoo also said that 'the document that I provided on their scope of service was not a certification of what they could do but based on what they indicated to me they had done in the past and my observations of some of the work based on their recommendations or their references they received from Toowoomba, and that's Dr Sharma's (sic) references, and also based on their post-operative review of patients'.¹⁹⁰ He stated that he thought that they were skilled enough to make a clinical judgment as to what they could deal with and consequently instructed them that they were to treat patients whom they thought were within their skill level.¹⁹¹ If they could not handle the situation they were to call him, if he was not on leave, or, if he was on leave, they were to transfer the patients to another tertiary hospital.¹⁹²

- 4.78 Dr Naidoo agreed that the language used in the references relating to Dr Krishna's previous employment in Toowoomba, upon which he purported to rely, was neutral¹⁹³ or unclear about any capacity to perform surgery unsupervised.¹⁹⁴ Much of what he learned about Dr Krishna's range of procedures, he said, he learnt from Dr Krishna himself.¹⁹⁵
- 4.79 Dr Krishna gave evidence that Dr Naidoo discussed the Scope of Service with him and enquired whether there was anything that he was uncomfortable with.¹⁹⁶ Dr Krishna said that he had no input into the Scope of Service.¹⁹⁷ Dr Krishna said that before he received the 2004 Scope of Service documents, he had performed without supervision procedures which were subsequently categorised to be only performed with supervision.¹⁹⁸ He said that he was not earlier given a scope of service in as much detail as the 2004 document. When he arrived he was given a letter of a couple of paragraphs giving him privileges to 'do trauma cases within my scope and minor elective cases'.¹⁹⁹ It is likely that Dr Krishna was referring to the letter forwarded to him by the District Manager granting him interim privileges. The terms of the interim privileges granted, which I have already set out, were not quite as recalled by Dr Krishna. Nevertheless, Dr Krishna stated that he talked to Dr Naidoo after receiving the letter about what was meant by minor elective cases. He said Dr Naidoo told him they meant very simple things like arthroscopies, carpal tunnel

¹⁹⁰ T6593 line 30

¹⁹¹ T6593 line 40 - 45

¹⁹² T6593 line 50 – T6594 line 1 (Dr Naidoo)

¹⁹³ T 6621, 6626 line 10

¹⁹⁴ T6620 line 55

¹⁹⁵ T6624, 6626 line 1

¹⁹⁶ T6467 line 15

¹⁹⁷ T6530 line 35

¹⁹⁸ T6488 line 40

¹⁹⁹ T6466 line 35 - 6367 line 1

- syndromes and bunion surgeries which he had done before.²⁰⁰ He said it was left to him to determine what minor elective cases were to be done by him.²⁰¹
- 4.80 Dr Sharma said that he did not have any discussions with Dr Naidoo about what should or should not be included in his Scope of Service documents nor about what was in it after it was given to him.²⁰² He also could not say with any certainty when he was given the Scope of Service documents.²⁰³
- 4.81 Even as at 1 January 2004, the process by which the Scope of Service documents were produced was deficient. First, no or no adequate assessment was made by Dr Naidoo of each of Dr Krishna or Dr Sharma. As stated, Dr Naidoo had not supervised Dr Krishna, except perhaps, at most, in the four operations in respect of which Dr Krishna recorded he had received assistance.²⁰⁴ In his words, the document 'was not a certification of what they could do'.
- 4.82 Secondly, the assessment by Dr Naidoo alone was not appropriate. As Dr Hanelt acknowledged,²⁰⁵ it increased the risk of mate credentialing mate and lessened the degree of impartiality in the process. More relevantly, as will become apparent, Dr Naidoo was not disinterested in the determination. The greater the scope of the work which each of Drs Krishna and Sharma could be seen to be capable of performing without supervision, the more excusable Dr Naidoo's failure to supervise either of them became. Dr Hanelt gave evidence of recognising the need for a committee assessment²⁰⁶ and, if necessary, proceeding without input from college representatives.²⁰⁷ This recognition is also reflected in the local policy drafted by Dr Hanelt.²⁰⁸
- 4.83 Dr Hanelt said that he understood that the scope of practice of Drs Krishna and Sharma would be restricted to that which Dr Naidoo considered them competent to perform.²⁰⁹ However, he did not take any steps to ensure that this was the case. He did not know whether Drs Krishna and Sharma had been given a copy of their Scopes of Service document,²¹⁰ although, it seems they had.²¹¹

²⁰⁰ T6466 line 50

²⁰¹ T6467 line 5

²⁰² T5704 line 50 – 5705 line 10, 5710 line 30

²⁰³ T5710 line 35

²⁰⁴ Exhibit 431pp 50, 51 attachment MMN5 Statement of Naidoo

²⁰⁵ T6724 line 1, T4139 line 35 (Dr Nydam); T5206 line 35 (Dr North)

²⁰⁶ T 6722 line 40, 6766

²⁰⁷ T 6766 line 15

²⁰⁸ Exhibit 444A THM 35 p2. As stated, under the local policy the District Manager was to convene a Credentials and Privileges Committee comprising a core membership that did not include a representative of the relevant college. The relevant colleges are merely invited to provide input. Also T6770 line 30 (Dr Hanelt)

²⁰⁹ T6767 line 15

²¹⁰ T6728 line 1 (Dr Hanelt)

²¹¹ In the case of Dr Sharma, the fact that a copy was given to Dr Sharma is clear but not when: see T5704. In the case of Krishna, there was no direct evidence of him receiving a copy but evidence certainly implied he had received a copy of it: T6477 line 20, 6479 line 50, 6480 line 1, 6481, 6488 (Dr Krishna)

- 4.84 The Nurse Unit Manager of Operating Theatres, Nurse Erwin-Jones said that she did not receive a copy of either Scope of Service document. She gave evidence that 'when Drs Krishna and Sharma had been with the service a little while,' she had asked Dr Hanelt what the limitations of their surgery were. She said that Dr Hanelt, in response, advised her orally that the Senior Medical Officers could perform 'any type of surgery, excluding joint replacement surgery'.²¹² She would have liked to have had the written Scope of Service documents available to her when booking surgery for Drs Krishna and Sharma. She did not book in any joint replacement surgery on her understanding that this was outside the scopes of practice of the Senior Medical Officers. Otherwise, however, she booked in anything else.²¹³ She said that she was never given any written list of procedures which either Dr Krishna or Sharma were entitled to perform.²¹⁴
- 4.85 Dr Mullen said that he also never saw the Scope of Service documents. He did not know they existed.²¹⁵

Differing views of the procedures which Drs Krishna and Sharma could perform

- 4.86 Dr Krishna gave evidence that he felt confident doing unsupervised most of the procedures that he had been certified as capable of performing unsupervised but not all of them.²¹⁶ He also said that he would have been happier²¹⁷ and more confident in what he was doing,²¹⁸ if he had had more supervision. He admitted that he needed more training.²¹⁹
- 4.87 Dr Sharma gave evidence of a number of procedures, included within his 2004 Trauma Scope of Service document as not requiring supervision, which he felt, at the time, were outside his competence to perform independently. He had not done them before and the procedures were, he thought, too complex.²²⁰ Those procedures were in respect of an ACJ dislocation, acetabulum fracture simple, supracondylar intercondylar fracture simple and a distal tibial fracture simple. He could not explain why Dr Naidoo would have formed the opinion that he could perform these procedures without supervision.²²¹ He identified other procedures, specified as not requiring any supervision, that he also thought may have required supervision, depending upon the type of fracture,²²²

²¹² T5402 line 50

²¹³ T5407 line 20

²¹⁴ T5407 line 35

²¹⁵ T5779 line 55

²¹⁶ T6477 line 40

²¹⁷ T6477 line 45

²¹⁸ T6479 line 30

²¹⁹ T6479 line 15

²²⁰ Exhibit 364; T5706 line 50 – 5707 line 10

²²¹ T5707 line 15

²²² T5707 line 25

or which he would have been happier with supervision even though he probably could have performed them.²²³

- 4.88 Dr Sharma also gave evidence of a number of procedures included in his 2004 Elective Surgery Scope of Service document which he felt were outside his competence to perform independently.²²⁴ Those included the procedures listed in respect of a rotator cuff tendonitis/rupture simple, wrist anthroopathy and subtalar osteoarthritis anthroopathy. Dr Sharma said he would have made the same comments about his 2003 Scope of Service documents.²²⁵ Dr Sharma stated he did not do any of the procedures in respect of which he admitted he required supervision.²²⁶
- 4.89 Dr Wilson, the Othopaedic surgeon under whom Dr Krishna practised in Toowoomba, gave evidence of his assessment of Dr Krishna's competence to perform the procedures listed in his Scope of Service documents. Dr Wilson assessed Dr Krishna as more than adequate in his ability to assess patients.²²⁷ However, Dr Wilson said that he would remove from the Scope of Service documents a number of procedures, approved by Dr Naidoo as not requiring supervision, in respect of which he believed Dr Krishna would have required supervision. From the Trauma Scope of Service list, Dr Wilson said he would remove from the unsupervised list of procedures those in respect of a scaphoid compound fracture, fractured clavicle, ACJ dislocation, simple acetabulum fractures, midtarsal fracture/dislocation, tibial plateau fracture and phalangeal fractures involving vascular injuries.²²⁸ In all of these procedures, in his opinion, Dr Krishna required supervision.
- 4.90 Dr Wilson would have removed a number of procedures from the Elective Surgery Scope of Service list.²²⁹ As a general statement, surgery requiring more than day surgery, he said, should have required supervision.²³⁰ More specifically, he would have excluded from the procedures approved by Dr Naidoo as not requiring supervision those in respect of a rotator cuff tendonitis/rupture simple, Baker's cyst, wrist anthroopathy, extensor tendon transfer, fracture non-unions, hallux valgus bunionectomy and metatarsal osteotomy, subtalar osteoarthritis, knee internal derangement meniscal repair and knee internal derangement ACL/PCL reconstruction.²³¹ Two of these procedures, and another specified in the Scope of Service document as requiring supervision, Dr Wilson stated, should have been done only by a

²²³ T5707 line 40, 5708 line 25

²²⁴ Exhibit 364; T5708 line 9

²²⁵ T5709

²²⁶ T5710 line 40

²²⁷ T7345 line 20

²²⁸ T7331 line 10 – 7335 line 50; also highlighted in Exhibit 482, attachment B, Statement of Wilson Exhibit 482

²²⁹ T7336 line 1

²³⁰ T7336 line 30

²³¹ T7336 – 7338; Also highlighted Exhibit 482, attachment B, Statement of Wilson

consultant. These were a recurrent anterior dislocation, subtalar osteoarthritis and subtalar calcaneo-cuboid arthrodesis.²³²

- 4.91 Dr Mullen said that he had had limited opportunity to observe and assess either Dr Krishna or Dr Sharma because they worked independently of him and were rostered on-call at times different from his.²³³ However, based upon his limited observations and what he knew of their level of experience he would have excluded from each of Drs Krishna's and Sharma's unsupervised trauma list a number of procedures which he thought ought not to have been performed without supervision. These were those in respect of a clavicle fracture, ACJ dislocation, medial epicondyle, lateral condyle, supracondylar, lunate/peri lunate fracture or dislocation, lunate peri lunate fracture or dislocation, scaphoid, phalanges, acetabulum fracture simple, intertrochanteric per trochanteric high subtrochanteric fracture, supracondylar intercondylar fracture simple, tibial plateau fracture simple and severed digital nerve.²³⁴
- 4.92 Dr Mullen also would remove from the unsupervised elective surgery list procedures in respect of rotator cuff tendonitis/rupture simple, Dupuytren contracture, ganglion, bursa, Bakers Cyst, extensor tendon rupture thumb, wrist arthropathy, fracture non unions, hallux valgus, subtalar osteoarthritis and arthropathy, knee effusion, knee infection osteoarthritis, knee internal derangement.²³⁵
- 4.93 Dr North, who had not observed either Dr Krishna or Dr Sharma performing surgery, was understandably conservative in his assessment of what either should have been permitted to do unsupervised. He excluded twenty two procedures from the trauma list of procedures approved to be performed by Dr Krishna without supervision.²³⁶ These comprised all the procedures removed by Dr Mullen with the exception of phalanges and intertrochanteric, per trochanteric and high subtrochanteric fractures. Dr North described the approval of one procedure, an ORIF for an acetabulum or hip socket fracture, without supervision, as 'ridiculous'.²³⁷ Dr North also removed eight procedures approved to be performed without supervision, also removed by Dr Mullen, from the elective surgery list. Dr North said that, without supervision, the Senior Medical Officers should have undertaken only surgical procedures able to be done by a seriously experienced general practitioner.²³⁸ According to Dr North, these procedures may have included simple cuts, haematomas or manipulation of closed fractures. They should not have included manipulation

²³² T7337 line 5, 7338 line 1-10 (Dr Wilson)

²³³ T5780 line 5, 5814 line 55

²³⁴ T5815 - 5816 and circled on Exhibit 365 (A of B)

²³⁵ T5817 - 5818 and circled on Exhibit 365 (B of B)

²³⁶ Exhibit 313, T5141 - 5142 (Dr North)

²³⁷ Exhibit 313 para 2

²³⁸ T5139 line 40

of compound fracture, internal fixation or open bone surgery.²³⁹ Ideally, their participation in orthopaedic and fracture outpatients clinics also ought to have been fully supervised.²⁴⁰ They should, at least, have had easy access to rapid specialist response.²⁴¹

- 4.94 Dr Scott Crawford, an orthopaedic surgeon who gave evidence of his review a number of patients treated by the Senior Medical Officers, was not asked to comment upon all of the procedures in the Scope of Service documents. However, a number of procedures on the elective surgery list relevant to the patients about whom he gave evidence, he said, ought to have been observed by an orthopaedic surgeon for up to half a dozen times before being allowed to be done without supervision.²⁴² Those procedures were rotor cuff tendonitis and rupture simple, CTS, Dupuytren's contraction, ganglion bursar Baker's cyst, MTPJ arthrodesis and hammer toes arthrodesis.
- 4.95 It is unnecessary to make findings preferring the view of one or more of the independent orthopaedic surgeons over that of the others. What emerges clearly is that the Scope of Service documents grossly over estimated the skill and competence of each of Drs Krishna and Sharma. Even more telling was the evidence I referred to earlier, of Dr Naidoo that he instructed Drs Krishna and Sharma that they were to treat patients whom they thought were within their skill level and whom they could deal²⁴³ and the fact that, from time to time, he left them in positions where they were obliged to perform surgery which they felt was beyond their competence. The consequences of this are discussed below. But first it is relevant to say how Dr Naidoo's absences contributed to those dangerous situations.

Absences of Dr Naidoo

- 4.96 Between 1 January 2000 and 13 May 2005, Queensland Health recorded the following approved leave for Dr Naidoo:

Recreation Leave	138 days
Sick leave	111.5 days
Long Service Leave	45 days
Conference	21 days
SARAS Leave	15 days
Special Leave WOP	14.75 days
Study Leave	40 days
External training	20 days
Bereavement	5 days

²³⁹ T5139

²⁴⁰ T5146 line 30 (Dr North)

²⁴¹ T5146 line 40 (Dr North)

²⁴² T6300 line 50 – T6302 line 25

²⁴³ Exhibit 431 para 4.14 Statement of Naidoo, T6593 line 40 – T6594 line 10

Concessional	2 days
Special Response	3 days

4.97 In total, Dr Naidoo was on leave approved by Queensland Health for 415 days for this period.²⁴⁴ In addition, Dr Naidoo has sworn that he had further leave approved which the Human Resources Department at Hervey Bay Hospital failed to record.²⁴⁵

4.98 Following the commencement of Dr Krishna as a Senior Medical Officer on 20 July 2002 until 13 May 2005, Dr Naidoo was absent from the hospital on the following approved leave:

Recreation Leave	69 days
Sick Leave	66 days
Long Service Leave	10 days
Conferences	11 days
SARAS Leave	15 days
Study Leave	40 days
External Training	20 days
Concessional	1 day
Special Response	1 day

In total, during that period, Dr Naidoo's approved leave was 233 days.²⁴⁶

4.99 Much of this leave also was in blocks of continuous leave including the following periods: 13 December 2002 to 14 February 2003 (9 weeks); 1 March 2004 to 2 April 2004 (5 weeks); 4 August 2004 to 8 October 2004 (3 weeks); 29 November 2004 to 17 December 2004 (3weeks); 21 February 2005 to 24 March 2005 (5 weeks); and 18 April 2005 to present.

4.100 There was evidence on which it could be concluded that Dr Naidoo was absent for greater periods than the above approved leave. Dr Naidoo gave evidence that it was his usual practice to travel from his residence in Brisbane to Hervey Bay at 5:00am on Monday morning so he would arrive at work at 9:00am and return to Brisbane on Friday, leaving Hervey Bay Hospital about 4:00pm.²⁴⁷ However, there was clear evidence of Dr Naidoo having arrived at Hervey Bay much later than 9:00am and leaving much earlier than 4:00pm and Dr Naidoo in cross-examination was forced to concede that those times varied.²⁴⁸ Nurse Erwin-Jones, Nurse Unit Manager for Operating Theatres said that, if he was not on-call on the weekend, it was common practice for Dr Naidoo to regularly

²⁴⁴ Exhibit 444A attachment B

²⁴⁵ Exhibit 504

²⁴⁶ Exhibit 444A attachment B

²⁴⁷ T6598 line 30

²⁴⁸ T6620 line 5

leave the District on Friday mid afternoon and not return until Monday lunchtime.²⁴⁹

- 4.101 Refueling records for the motor vehicle provided to Dr Naidoo by Queensland Health for his exclusive use indicate that the car was refueled at a location away from the Hervey Bay Hospital district at a time when Dr Naidoo should have been on duty at the Harvey Bay Hospital. Dr Hanelt provided the Commission with a schedule for the period from 18 July 2002 to 26 June 2005, which details the time, date, odometer reading and location of refueling of Dr Naidoo's motor vehicle. It revealed that the motor vehicle was in Brisbane or elsewhere, at a time when, according to the Human Resources department records, Dr Naidoo was supposed to be on duty. Details of these are:

Day	Date	Time	Location
Friday	16.08.02	15:01	Forest Glen
Monday	19.08.02	8:50	Forest Glen
Wednesday	04.09.02	16:10	Gympie
Monday	16.09.02	9:49	East Brisbane
Monday	21.10.02	10:06	Gympie
Friday	08.11.02	13:51	East Brisbane
Monday	11.11.02	8:08	East Brisbane
Friday	15.11.02	11:44	Cannon Hill
Wednesday	27.11.02	9:43	East Brisbane
Thursday	12.12.02	16:50	Gympie
Friday	09.05.03	16:33	Caboolture
Friday	06.06.03	18:44	East Brisbane
Thursday	21.08.03	12:28	Cannon Hill
Tuesday	26.08.03	7:25	East Brisbane
Thursday	28.08.03	12:51	Milton
Wednesday	03.09.03	15:04	East Brisbane
Wednesday	31.12.03	18:04	Cannon Hill
Sunday	04.01.04	16:36	East Brisbane
Friday	13.02.04	14:41	Forest Glen
Friday	27.02.04	17:04	East Brisbane
Friday	23.04.04	7:21	Hamilton
Friday	07.05.04	16:57	Gympie
Friday	04.06.04	16:51	Gympie
Monday	07.06.04	5:56	East Brisbane
Monday	15.11.04	8:50	Gympie
Monday	04.04.05	8:01	Gympie

²⁴⁹ T5406 line 50

He also travelled only 319 kms between Thursday 21.08.03 and Tuesday 26.08.03, so he could not have travelled to Hervey Bay and return so as to have been there on 22.08.03 or 25.08.03; only 322 kms between Tuesday 26.08.03 and Thursday 28.08.03, so could not have travelled to Hervey Bay and return so as to have been there on 27.08.03; only 328 kms between Thursday 28.08.03 and Wednesday 03.09.03, so he could not have travelled to Hervey Bay and return so as to have been there on 29.08.03, 1.09.03 or 2.09.03; only 307 kms between Saturday 27.12.03 and Wednesday 31.12.03, so he could not have travelled to Hervey Bay and returned so as to have been there on 29.12.03 and 30.12.03; only 370 kms between Wednesday 31.12.03 and Sunday 04.01.04, so he could not have travelled to Hervey Bay and returned so as to have been there on 02.01.04

4.102 This information is limited to investigations based on petrol purchases but reveals that Dr Naidoo arrived late for work on nine occasions, left early on ten occasions and was absent from his place of duty when he should have been there on 11 days.

4.103 Dr Naidoo acknowledged that there were occasions when he arrived late or left work early. He explained that he worked throughout his lunch break, organised in-service meetings, regularly began work before rostered to start, and often took work home without payment. He also said that traffic had contributed to his late arrival at the hospital.²⁵⁰ Dr Naidoo also said that he was on approved leave on 27 February 2003, 11 August to 15 August 2003, 22 August 2003, 25 August to 29 August 2003, 1 September to 3 September 2003, 27 January 2004 to 30 January 2004, 27 February 2004, 13 August 2004, 30 August 2004 to 1 September 2004, 2 September 2004 and 23 December 2004 but the Human Resources department failed to record the leave. Dr Naidoo provided some documentary evidence (eg. medical conference documentation and rosters in which he is noted to have been on leave) in support of his contention in regard to some of the above leave.²⁵¹

4.104 Telephone records ²⁵² of a mobile phone used by Dr Naidoo also reveal that on the following dates Dr Naidoo was at a location away from the Hervey Bay Hospital district at a time when he should have been on duty. Dr Naidoo said that he did not share the phone with his family.²⁵³

Monday 19.01.04

Thursday 22.01.04

Friday 23.01.04

²⁵⁰ Exhibit 504 Supplementary Statement of Dr Naidoo

²⁵¹ Exhibit 504 Supplementary Statement of Dr Naidoo

²⁵² Exhibit 435

²⁵³ T6599 line 30

February 27.02.04

Friday 21.01.05

Thursday 03.02.05

Friday 04.02.05

- 4.105 Dr Naidoo contended that apart from 19 January 2004 on which day he believes he was at work, roster documents showed that he was on leave for the other days but the Human Resources Department failed to record the leave.²⁵⁴
- 4.106 Given the question raised by Dr Naidoo about the accuracy of the Human Resources Department records there is a need for some further investigation before conclusively determining the times when, between August 2002 and February 2005, Dr Naidoo was in Brisbane or otherwise absent from his place of employment without approved leave or absent during some of the normal working hours when those whom he should have been supervising may have needed him.²⁵⁵
- 4.107 But accepting, for present purposes that the records of the Human Resources Department understate his approved leave, Dr Naidoo, nevertheless, was absent from the hospital for vast periods. Whether legitimate or illegitimate, the mere fact that Dr Naidoo was absent from the hospital for these periods and so frequently, and was difficult to contact, had serious consequences in respect of supervision of Drs Krishna and Sharma who required supervision. As Dr Naidoo himself accepted, while he was on leave, the Senior Medical Officers were mostly left unsupervised and this was not ideal.²⁵⁶ Nurse Erwin Jones said the same.²⁵⁷
- 4.108 As Director of Orthopaedics, Dr Naidoo also was responsible for co-ordinating and managing the provision of orthopaedic services within the District. When he was away the level of orthopaedic service dropped.²⁵⁸ There was inadequate coverage for major elective orthopaedic work or anything except work which was plainly, on some objective judgment, within the competence of Drs Krishna and Sharma.²⁵⁹ Nurse Erwin-Jones said Dr Naidoo's absences affected the ability to manage trauma patients.²⁶⁰

²⁵⁴ Exhibit 504, Supplementary Statement of Naidoo. Also Exhibit 444B pp 2, 3 supplementary Statement of Hanelt

²⁵⁵ There was some evidence that Dr Naidoo was known to have often done on-call work from Brisbane. But this was only hearsay evidence. There was no direct evidence to support a finding to this effect. Exhibit 329 para 31 Statement of Erwin Jones, T5408 line 20; T6758 line 30 (Dr Hanelt)

²⁵⁶ T6591 line 1 - 10

²⁵⁷ T5406 line 1 - 10

²⁵⁸ T6736 line 15

²⁵⁹ T6736 line 30

²⁶⁰ Exhibit 329 para 42 Statement of Erwin-Jones; T5401 line 15

Patient P430

- 4.109 An early occasion when the unavailability of Dr Naidoo directly impacted upon the interests of one of Dr Naidoo's own patients involved patient P430. Dr Mullen gave evidence of having been asked on 2 August 2000²⁶¹ by nursing staff, during one of his weekly ward rounds, to see P430.²⁶² The patient was an elderly woman who had been admitted about 10 days previously with a fractured arm. An initial plaster had been then applied. The patient suffered dementia and moved a lot. As a result the plaster had become removed and, according to the patient's notes,²⁶³ the bone had become protruded causing an open wound. In the patient's notes, a nurse had recorded on 27 July 2000: '1340 hours: broken area of skin noted over fracture'.²⁶⁴ On 27 July 2000, Dr Naidoo took the patient back into theatre. He placed a dressing and a new plaster on wound.²⁶⁵ Thereafter, Dr Naidoo had been unavailable to examine the patient for several days.²⁶⁶
- 4.110 When Dr Mullen examined the patient on 2 August 2000, he found that the patient had an open wound with a protruding bone. The wound was severely infected and the patient was very sick.²⁶⁷ The patient's muscle, Dr Mullen said was and had been dead for several days.²⁶⁸ The information given to Dr Mullen was that, in the period after Dr Naidoo had carried out the second procedure, staff had tried to contact Dr Naidoo to seek advice on the care of the patient and had had difficulty doing so.²⁶⁹ The patient's notes showed that Dr Naidoo was contacted by phone on the 29 and 30 July 2000 and advised that the patient was very unwell and deteriorating.²⁷⁰ According to a summary prepared by Dr Mullen, Dr Naidoo was also informed, at least on the 29 July 2000, that the bone was able to be seen and bandages were soaked with fluid.²⁷¹ Thereafter, according to Dr Naidoo, from 31 July 2000 to 2 August 2000, he had been on leave.²⁷² Dr Mullen was not aware of Dr Naidoo having been on scheduled leave.²⁷³
- 4.111 In Dr Mullen's opinion, the treatment by Dr Naidoo on the 27 July 2000 was insufficient and negligent.²⁷⁴ Once the skin was breached, there was risk of

²⁶¹ T5448 line 30

²⁶² T5447 line 9

²⁶³ T6694 line 10 (Dr Naidoo)

²⁶⁴ T6694 line 10 (Dr Naidoo)

²⁶⁵ Exhibit 330 para 8 Statement of Mullen

²⁶⁶ T5448 line 1-20

²⁶⁷ Exhibit 330 para 8 Statement of Mullen

²⁶⁸ T5452

²⁶⁹ Exhibit 330 para 9 Statement of Mullen

²⁷⁰ T6696 line 10 – 20 (Dr Naidoo)

²⁷¹ T6697 line 30 (Dr Naidoo)

²⁷² Exhibit 431 para 8.12 Statement of Naidoo

²⁷³ T5448 line 10 (Dr Mullen)

²⁷⁴ T5449 line 20

infection.²⁷⁵ The wound at that time should have been widely opened and the fracture stabilised to prevent the bone from continuing to move.²⁷⁶ Dr Naidoo denied this. Contrary to the patient's notes, he said that the bone was not an open wound when he had taken the patient back to theatre.²⁷⁷ He said that, although the splintage procedure was not ideal, open reduction and internal fixation with a plate and screws would have failed because of the nature of the fracture and the extent of the patient's osteoporosis and dementia.²⁷⁸ He said that, the ideal procedure would have been an intramedullary nail with some supplementary fixation but the equipment for such procedure was not available in Hervey Bay.²⁷⁹

- 4.112 Dr Mullen contacted Dr Hanelt and brought to Dr Hanelt's attention what he said was Dr Naidoo's unacceptable care of the patient.²⁸⁰ He told Dr Hanelt that the patient needed to go to theatre immediately.²⁸¹ Dr Hanelt agreed with Dr Mullen doing this.²⁸² Dr Mullen sought to contact Dr Naidoo. After a number of attempts, Dr Mullen spoke to Dr Naidoo by telephone shortly before theatre. Dr Naidoo said that he was not available to do the operation himself.²⁸³ He agreed to Dr Mullen taking over the patient and proceeding with the operation.²⁸⁴
- 4.113 Dr Mullen took the patient to theatre. He stabilised the situation. He removed a large amount of dead and infected arm muscle and the radial nerve which had been damaged and was non viable.²⁸⁵ He then applied an external fixated frame and stabilised the fracture.²⁸⁶
- 4.114 Ultimately, Dr Mullen's intervention did not save the patient's arm. The patient's arm had to be amputated about 2 weeks later.²⁸⁷ Dr Mullen said that he had never seen a case study where a low velocity closed fracture of the humerus in an old patient had ended up in amputation of the limb.²⁸⁸ Dr Naidoo agreed with this observation.²⁸⁹ Dr Mullen was in no doubt that the amputation had been caused by the neglect and delay in treatment by Dr Naidoo.²⁹⁰

²⁷⁵ T5448 line 50 – 5449 line 10

²⁷⁶ T5449 line 1 - 20

²⁷⁷ T6694

²⁷⁸ Exhibit 431 paras 8.9, 8.10 Statement of Naidoo; T6693

²⁷⁹ Exhibit 431 para 8.11 Statement of Naidoo

²⁸⁰ T6752 line 10 (Dr Hanelt)

²⁸¹ Exhibit 330 para 10 Statement of Mullen

²⁸² Exhibit 330 para 11 Statement Mullen

²⁸³ T 5451 line 40 (Dr Mullen)

²⁸⁴ T5451 line 40 (Dr Mullen); Exhibit 330 para 12 Statement of Mullen

²⁸⁵ T5451 line 50 (Dr Mullen)

²⁸⁶ T5451 line 55 (Dr Mullen)

²⁸⁷ Exhibit 330 para 13, Statement of Mullen

²⁸⁸ T5450 line 5

²⁸⁹ T6698 line 5

²⁹⁰ Exhibit 330 paras 6–13 Statement of Mullen; T5450 line 10 (Dr Mullen)

- 4.115 Dr Hanelt, who was not an orthopaedic surgeon, was reluctant to attribute blame to Dr Naidoo. After a review of the clinical notes, he stated that the case was a particularly difficult management problem with the patient continuously removing casts, dressings and external fixateurs. He thought that the ultimate need for amputation could have resulted from a number of treatment options.²⁹¹ He said that he spoke to Dr Naidoo when he returned about his clinical management of the patient and appropriate handover of patients if he was not available.²⁹² Otherwise, Dr Hanelt found the explanation of Dr Naidoo about his clinical treatment very logical and quite convincing.²⁹³ He said that he remained in a position, even at the time he gave evidence, of being unsure whose assessment was correct, Dr Mullen's or Dr Naidoo's.
- 4.116 I accept that this patient's case was difficult because of her co-morbidities. However, I find, as recorded in the patient's notes, that on the 27 July 2000, when Dr Naidoo took the patient back to theatre, the fracture had broken the skin. I also accept the evidence of Dr Mullen that the care of Dr Naidoo at that time and subsequently was inappropriate and that the delay contributed to the poor outcome.²⁹⁴ At the very least, Dr Naidoo should have made arrangements for the patient to be attended to when he was informed²⁹⁵ on the 29 July 2000 that the bone was able to be seen medially. As Dr Naidoo accepted, he also should have made arrangements for the patient to be looked after when he went on leave.²⁹⁶

Lack of supervision

- 4.117 Dr Naidoo's absences plainly restricted his capacity to supervise junior doctors, especially Drs Krishna and Sharma.
- 4.118 Dr Sharma said that he had a clinic on the same day as Dr Mullen and on many occasions took the advice of Dr Mullen in the same clinic.²⁹⁷ Generally, however, Dr Mullen, who, until the arrival of a locum orthopaedic surgeon, Dr Kwon, in January 2005, was the only other registered orthopaedic specialist practising at the Hervey Bay Hospital, was unable to provide adequate supervision to either Senior Medical Officer due to his limited sessions at the hospital.²⁹⁸ Dr Hanelt acknowledged that he was aware of this.²⁹⁹ Dr Khursandi, who was a Visiting Medical Officer in orthopaedics at the Maryborough Base hospital, rarely visited Hervey Bay Hospital.

²⁹¹ Exhibit 444A para 88(i) Statement of Hanelt

²⁹² T6752 line 50

²⁹³ T6753 line 5

²⁹⁴ T5453 line 25

²⁹⁵ T6697 line 35 (Dr Naidoo)

²⁹⁶ T6698 line 35, 55

²⁹⁷ T5696 line 1

²⁹⁸ Exhibit 424 para 23 Statement of Krishna

²⁹⁹ T6725 line 55 – 6726 line 10

- 4.119 According to Dr Mullen, throughout the time he visited the hospital, a problem always existed with Dr Naidoo being unavailable to supervise junior staff.³⁰⁰ Dr Mullen said that, because of his concerns about supervision, he did all his own outpatient's clinics and all his own theatre sessions himself.³⁰¹ He did not allow other doctors to do surgery on any of his patients without him being present.³⁰² Teaching and learning opportunities for junior doctors were virtually non-existent. I accept Dr Mullen's evidence in these respects.
- 4.120 As noted above, the document prepared, prior to and for the purposes of Dr Naidoo preparing the Scope of Service documents and which Dr Naidoo³⁰³ acknowledged to be correct, showed that Dr Krishna received consultant assistance in only four occasions out of the total of 323 surgical procedures performed.³⁰⁴ The others he performed unsupervised. In a memorandum dated 2 October 2002, only nine weeks after Dr Krishna had been at the Hervey Bay Hospital, Dr Naidoo indicated to the waiting list co-ordinator that Dr Krishna could do elective cases that he is willing to do without his supervision.³⁰⁵
- 4.121 Effectively, as Dr Naidoo also acknowledged,³⁰⁶ Dr Krishna and Dr Sharma were practising orthopaedic surgery at the Hervey Bay Hospital unsupervised.
- 4.122 Nurse Erwin-Jones, the Nurse Unit Manager for Operating Theatres, said that the absences of Dr Naidoo consistently left holes in the roster, particularly on-call, and left inadequate supervision for the Senior Medical Officers.³⁰⁷ Nurse Erwin-Jones said that the Senior Medical Officers tried to work within their limitations but unfortunately sometimes got into a position of not being able to control that because the surgery was more complex than first expected and they were unsupervised.³⁰⁸ She said that the Senior Medical Officers tried to obtain assistance from Dr Naidoo but this was not forthcoming³⁰⁹ even during normal working hours.³¹⁰ On three or four occasions,³¹¹ Nurse Erwin-Jones said she overheard Dr Krishna try to obtain assistance, from Dr Naidoo or, on occasion, Dr Mullen if they got into trouble but it was not forthcoming.³¹² On two of those occasions Dr Naidoo was contacted during normal working hours

³⁰⁰ T5454 line 50

³⁰¹ T5454 line 50

³⁰² T5454 line 55

³⁰³ T6628

³⁰⁴ Exhibit 431pp 50, 51 attachment MMN5 Statement of Naidoo

³⁰⁵ T6595 line 30

³⁰⁶ T6628 line 25-30

³⁰⁷ Exhibit 329 para 28 Statement of Erwin-Jones

³⁰⁸ T5401 line 10

³⁰⁹ Exhibit 329 para 31, 32 Statement of Erwin-Jones; T5407 line 50 – 5708 line 10, 5408 line 30

³¹⁰ T5406 line 40

³¹¹ T5407 line 40

³¹² Exhibit 329 paras 31,32 Statement of Erwin-Jones; T5404

but, without explanation, would not come to assist.³¹³ On one occasion Dr Naidoo showed up at the end of the operation, after it was completed.³¹⁴

- 4.123 Dr Naidoo certainly did not supervise the Senior Medical Officers to the extent stated in the Area of Need Position Description forms completed by Dr Hanelt for the registration of Dr Krishna³¹⁵ and Dr Sharma.³¹⁶ In the 2003 and 2004 forms, Dr Hanelt had stated that supervision would be 'by a Staff Specialist 'business hours' and as necessary after-hours'. He also stated that 'Consultant advice and/or assistance is available 24 hours a day seven days a week'. In the form completed by Dr Hanelt for Dr Krishna's initial registration in 2002,³¹⁷ it was stated that supervision would be 'Director of Orthopaedics (full time) 2x VMOs' and consultant advice available 'normal working hours and weekday nights. Not all weekends onsite but remote always'; although, in contradiction, the form also stated that the service requirements of the position were 'orthopaedics – provide management of wide range of conditions with minimal supervision'.
- 4.124 After hours there was no direct supervision.³¹⁸ When either Dr Krishna or Dr Sharma was on-call, Dr Naidoo was not rostered on-call with them.³¹⁹ They were essentially on-call unsupervised.³²⁰ Another Senior Medical Officer Dr Padayachey, who was employed at Maryborough Hospital during the normal hours on duty, but did some on-call work, was also in the same position.³²¹ Dr Sharma agreed that ideally there should have been a consultant on-call at all times.³²² Both he and patient care would have benefited by a consultant on-call.³²³ Nurse Erwin-Jones also said that the absences of Dr Naidoo placed a far too high on-call ratio on the Senior Medical Officers which put an unacceptable risk into the system.³²⁴
- 4.125 There was evidence of staff concerns about Dr Naidoo's communication style. Dr Hanelt agreed that this would have been particularly acute for the persons who were to be supervised by Dr Naidoo being Drs Krishna and Sharma.³²⁵ Nurse Erwin-Jones said that Dr Naidoo treated Drs Krishna and Sharma rudely. He embarrassed them in front of staff on a regular basis.³²⁶ She

³¹³ Exhibit 329 para 56 Statement of Erwin-Jones; T5407 line 50 – 5708 line 10

³¹⁴ T5408 line 5

³¹⁵ Exhibit 444A attachment TMH 31 Statement of Hanelt; Exhibits 445, 446

³¹⁶ Exhibit 361; T5691 line 10 (Dr Sharma)

³¹⁷ Exhibit 444A attachment TMH31 Statement of Hanelt

³¹⁸ T6720 line 50 (Dr Hanelt)

³¹⁹ T5674 line 55 (Dr Sharma); T6527 line 40-50 (Dr Krishna); T5405 line 10 (Ms Erwin – Jones)

³²⁰ T6757 line 20 (Dr Hanelt)

³²¹ T5678 line 50 (Dr Sharma)

³²² T5683 line 25; Also T5406 line 1 (Ms Erwin-Jones)

³²³ T5683 line 30-40 (Dr Sharma)

³²⁴ T5403 line 50 – 5404 line 10

³²⁵ Exhibit 444A attachment THM22 Statement of Hanelt; T6730

³²⁶ Exhibit 329 para 56 Statement of Erwin-Jones

believed Drs Krishna and Sharma became extremely disillusioned with their treatment by Dr Naidoo.³²⁷ Dr Naidoo also did not get on with Dr Mullen.³²⁸

- 4.126 Dr Sharma stated he had been able to contact Dr Naidoo if he needed help during business hours when Dr Naidoo was on duty but not after hours when Dr Naidoo was not on-call or away.³²⁹ He agreed that it would have been better if a Senior Medical Officer in the orthopaedics department who did not hold specialist registration always had a specialist on duty.³³⁰ But it did not happen at Hervey Bay.
- 4.127 Dr Hanelt, in evidence, accepted that, at least in retrospect, it was plain that the orthopaedic service which the Hervey Bay Hospital was providing, during the absences of Dr Naidoo and when Dr Naidoo did not supervise the Senior Medical Officers, was inadequate and unsafe.³³¹
- 4.128 Although Dr Hanelt denied any pressure upon the Senior Medical Officers to do more complex procedures, he agreed that basically everybody within the hospital was concerned about and shared responsibility of achieving surgical targets.³³² Mr Allsopp also denied that Drs Krishna and Sharma would have been motivated to do more elective surgery for the financial health benefit of the hospital.³³³ However, he acknowledged that generally he asked that the resources of the hospital be used and as many patients as can be treated with those resources.³³⁴
- 4.129 I find that, except in respect of those simple orthopaedic procedures for which Drs Krishna and Sharma did not need supervision, the provision of orthopaedic services at the Hervey Bay Hospital, during Dr Naidoo's periods of absence, was inadequate in terms of patient care and safety.

Holding out of Drs Krishna and Sharma as specialists

- 4.130 Some evidence exists of the District Manager, Mr Allsopp³³⁵ and Dr Naidoo, in his position as Director of Orthopaedic Surgery, holding out or knowing of others on behalf of the hospital holding out Drs Krishna and Sharma as specialists.³³⁶

³²⁷ Exhibit 329 para 56 Statement of Erwin-Jones

³²⁸ Exhibit 431 para 7.1 Statement of Naidoo

³²⁹ T5691 line 50. Also Exhibit 357 para 31 Statement of Sharma; T5675, 5691 line 40-50, 5696 line 10

³³⁰ T5682 line 20

³³¹ T6736 line 50, 6803 line 30

³³² T6742 line 40

³³³ T7086 line 55

³³⁴ T7087 line 1

³³⁵ T6747 line 40 – 6748 line 15 (Dr Hanelt)

³³⁶ Dr Hanelt stated that these occurred without his knowledge: Exhibit 444A paras 69, 70 and 76, Statement of Hanelt

- 4.131 In an article published on 18 January 2003 in the local newspaper, the Fraser Coast Chronicle, Mr Allsopp was reported as stating that ‘an orthopaedic surgeon had been recruited and another was due to start next month so waiting lists should start to shrink’. He was further reported as stating that ‘the health district plan had recognised the importance of orthopaedics and ophthalmology (eye) and an extra \$300,000 had been channeled to elective surgery to reduce waiting lists’.³³⁷ Mr Allsopp was responsible for the report and acknowledged it to be referring to Drs Krishna and Sharma.³³⁸ Dr Hanelt spoke to Mr Allsopp after the appearance of the article. He explained to him that, to be classed as a specialist or consultant, a medical practitioner had to be registered as such within Queensland and to refer to Drs Krishna and Sharma as specialists was a breach of the relevant Act.³³⁹ Mr Allsopp said that thereafter he made sure that he did not portray them again in that manner.³⁴⁰ There was no evidence that he contacted the newspaper or did anything else to correct the report.
- 4.132 Dr Krishna’s and Dr Sharma’s names also appeared on the District Orthopaedic and Surgical Consultant On-Call Roster under the ‘District Orthopaedic Consultant’ column. This roster was distributed internally to relevant staff. It also was placed on notice boards within the hospital. Dr Naidoo gave evidence that he had prepared those rosters. He said that he included the names of the Senior Medical Officers under the consultant column by mistake.³⁴¹
- 4.133 I accept that the above were minor and, probably, isolated instances. The Senior Medical Officers identity cards carried the designation Senior Medical Officer. Correspondence from them also was signed as Senior Medical Officer and not as consultant.³⁴² Nurse Erwin-Jones said that it was clear to her and other staff that a Senior Medical Officer was not a specialist and at no point did Drs Krishna or Sharma hold themselves out as a specialists.³⁴³
- 4.134 Mr Allsopp acknowledged to the Commission that patients who are being attended to by Senior Medical Officers who are not orthopaedic surgeons should be informed of that fact.³⁴⁴ That was never done. Implementation of such a protocol would remove ambiguity and also assist in the process of informed consent being obtained from those patients.³⁴⁵ Subsequent to the North Gribbin report, Mr Allsopp said that he considered options to ensure that patients were aware of the status of clinicians they were seeing. However, he

³³⁷ Exhibit 314

³³⁸ Exhibit 456 para 4.54 Statement of Allsopp; T7079 line 50 (Mr Allsopp); T6747 line 50, 6748 line 15 (Dr Hanelt)

³³⁹ Exhibit 456 para 4.54 Statement of Allsopp; T7080 line 10 (Mr Allsopp); T6747 line 30 (Dr Hanelt)

³⁴⁰ T7080 line 10

³⁴¹ T6630 line 25, Exhibit 431 paras 5.25 – 4.28 Statement of Naidoo

³⁴² Exhibit 357 para 35 Statement of Sharma

³⁴³ Exhibit 329 para 34 Statement of Erwin-Jones

³⁴⁴ Exhibit 456 para 4.62 Statement of Allsopp; T7080

³⁴⁵ T7080 line 35 (Mr Allsopp)

has been absent from the hospital since that time and these have not been implemented.³⁴⁶

Inaction by administration

Response by Mr Allsopp and Dr Hanelt to lack of supervision

- 4.135 Mr Allsopp and Dr Hanelt were responsible for medical workforce planning, monitoring clinical outcomes and standards and the implementation of policy relevant to clinical services.³⁴⁷ They knew, or ought to have known, that, by reason of the limited registration and limited experience in Australia of Drs Krishna and Sharma, their lack of credentialing and privileging and the absences of Dr Naidoo, the orthopaedic procedures undertaken by each of them ought to have been closely supervised by a specialist and that, for substantial periods of time, they were not.
- 4.136 Dr Hanelt said that, when he completed the Area of Need Position Description form³⁴⁸ for the appointment of Dr Sharma which stated that the supervision available would be 'by a Staff Specialist 'business hours' and as necessary after-hours', the supervision he intended during business hours was primarily by Dr Naidoo and after hours by either a local surgeon or remote orthopaedic surgeon contactable by phone.³⁴⁹ Dr Hanelt said that he thought that remote supervision of after hours services would be sufficient.³⁵⁰ So far as consultant advice was concerned, although the form did not make this clear, Dr Hanelt said that he intended that no more than remote advice would be available 24 hours a day.³⁵¹ Dr Hanelt conceded that, in retrospect, the level of supervision described on the Area of Need Position Description form was inaccurate.³⁵²
- 4.137 The supervision stated to be available for Dr Krishna in the Area of Need Position Description form completed for him for his 2003 renewal of registration was in the same terms.³⁵³ In later forms completed by Dr Hanelt for the 2004 renewal of registration of each of Dr Krishna and Dr Sharma,³⁵⁴ there continued to be a similar overstatement of the level of supervision provided to each of them.

³⁴⁶ T7080 line 40

³⁴⁷ T6715 (Dr Hanelt)

³⁴⁸ Exhibit 361

³⁴⁹ T6715 line 50 – T6716 line 20

³⁵⁰ T6716 line 50

³⁵¹ T6717 line 30

³⁵² T6717 line 50 – T6718 line 10

³⁵³ Exhibit 445

³⁵⁴ Exhibits 362, 446

- 4.138 Both Mr Allsopp and Dr Hanelt allowed Drs Krishna and Sharma to perform orthopaedic procedures and to be rostered on-call without supervision. Drs Krishna and Sharma were on duty when there was no specialist in the district available to supervise them.³⁵⁵ There was usually a Principal House Officer and a Senior Medical Officer or consultant on-call everyday and because of the shortage of consultants, the Senior Medical Officers and the consultants were rostered separately to share the same responsibilities.³⁵⁶ Dr Sharma said the Senior Medical Officers in other units at the Hervey Bay Hospital also were placed on consultant rosters and the situation was not peculiar to orthopaedics.³⁵⁷
- 4.139 No attempt seems to have been made to arrange adequate alternative supervision or to suspend the provision of orthopaedic services during the absences of Dr Naidoo.
- 4.140 Even if the inappropriateness of Drs Krishna and Sharma practising unsupervised was not obvious to the administrators from their knowledge of the doctor's lack of specialist status, lack of credentialing and privileging and Dr Naidoo's absences, and I think it plainly ought to have been, early concerns raised by Dr Mullen, the Australian Orthopaedic Association and nursing staff ought to have aroused this concern.
- 4.141 Dr Hanelt acknowledged that Dr Mullen had made complaints to him.³⁵⁸ In particular, he was aware that Dr Mullen thought that the Senior Medical Officers should be supervised more.³⁵⁹ Dr Mullen's concerns were that the Senior Medical Officers were acting as autonomous surgeons, treating and operating on patients as if they were qualified surgeons without any supervision. Dr Hanelt said that he immediately took action to ensure cessation of the practice of describing the Senior Medical Officers as consultants after he found out about it.³⁶⁰ But he did not remove them from working unsupervised on the on-call roster. It was not until February 2005 that this occurred.³⁶¹ He also did not alter the supervision of the Senior Medical Officers.
- 4.142 Dr Mullen said that he became frustrated with the lack of reaction to what he perceived to be a dangerous situation for patient safety.³⁶² Dr Naidoo was taking large amounts of leave, often 4 to 6 weeks at a time, leaving the two Senior Medical Officers without any supervision at all.³⁶³ Dr Mullen was

³⁵⁵ T6758 line 20

³⁵⁶ Exhibit 357 para 37 Statement of Sharma

³⁵⁷ Exhibit 357 para 37 Statement of Sharma

³⁵⁸ T6799 line 30

³⁵⁹ T6742 line 50, 6799 line 30

³⁶⁰ Exhibit 444A para 76(iii) Statement of Hanelt

³⁶¹ Exhibit 444A paras 99 attachments 'TH37', 'TH38', 'TH38A-D', Statement of Hanelt

³⁶² Exhibit 330 para 22 Statement of Mullen

³⁶³ Also T5696 line 40 (Dr Sharma)

constantly being called to deal with problems that he had not been involved in at an early stage.³⁶⁴ He felt that he had to supervise at a higher level than he should be expected to and that his responsibility as a Visiting Medical Officer was becoming larger.³⁶⁵ Before Drs Krishna and Sharma arrived, he received phone calls at times from junior staff about patients that they wanted advice on because they could not contact Dr Naidoo.³⁶⁶ After Drs Krishna and Sharma arrived, he was concerned at the constant lack of supervision of surgical procedures.

- 4.143 By mid 2003, Dr Mullen had been to management several times.³⁶⁷ He had become so unhappy with inaction by management that he contacted the Australian Orthopaedic Association.³⁶⁸
- 4.144 In or about June 2003, Dr Greg Gillett on behalf of the Australian Orthopaedic Association contacted Mr Hanelt and raised concerns in relation to Drs Krishna and Sharma working or being portrayed as specialists and performing services at which they were not competent. Dr Hanelt responded explaining that the range of surgery being performed by these two doctors was restricted to the range that the Director of Orthopaedics had assessed them as competent to perform and that many medical practitioners performed procedures and operations for which they did not hold the 'gold standard' qualifications and these two doctors were considered to be in a similar category of non-specialists with certain procedural and operative skills.³⁶⁹
- 4.145 In or about July 2003, Dr Mullen raised with Dr Hanelt his concern that Drs Krishna and Sharma were on the hospital rosters as consultant surgeons indicating that they were working completely unsupervised in the care of patients.³⁷⁰ Dr Mullen correctly saw this as both misstating their position and allowing them to work unsupervised.³⁷¹ They were operating autonomously and rostered on-call to work as orthopaedic surgeons. Dr Mullen saw this as dangerous.³⁷² According to Dr Mullen, Dr Hanelt did not see this as a problem. Dr Hanelt was comfortable with the position.³⁷³
- 4.146 Nurse Wyatt, the Nurse Unit Manager in charge of the perioperative unit at the Hervey Bay Hospital from May 1997 until October 2003, said that several times³⁷⁴ she complained to Mr Allsopp about the absences of Dr Naidoo from

³⁶⁴ T5768 line 40 (Dr Mullen)

³⁶⁵ T5455 line 30 (Dr Mullen)

³⁶⁶ T5455 line 30 (Dr Mullen)

³⁶⁷ Exhibit 330 para 28 Statement of Mullen

³⁶⁸ Exhibit 330 paras 27, 28 Statement of Mullen

³⁶⁹ Exhibit 400 This record of the conversation is by Dr Hanelt in his letter to the Australian Orthopaedic Association dated 4 November 2003 a copy of which is attached to Exhibit 400 the Statement of Beh

³⁷⁰ T5456 line 55 (Dr Mullen)

³⁷¹ T5456 line 40 – T5459 line15 (Dr Mullen)

³⁷² T5457 line 15 (Dr Mullen)

³⁷³ Exhibit 330 para 19, 20 Statement of Mullen

³⁷⁴ T7357 line 15

duty when he should have been on duty and his cancellation of patients for major surgery often on the day of surgery.³⁷⁵ She could not remember the date of those conversations but she stated that they occurred from the time when Mr Allsopp started at the hospital as District Manager until when she left in October 2003.³⁷⁶ Mr Allsopp could not recall any conversations with Nurse Wyatt about such matters.³⁷⁷ Nurse Wyatt said she also raised the issue of cancellations with Dr Naidoo. He usually responded, she said, by saying that the cancellations were for clinical reasons.³⁷⁸ She said that she also raised the issue of cancellations at monthly meetings of the Surgical Services Committee or, as later re-named, the Surgical Services Management Advisory Committee.³⁷⁹ These were multidisciplinary meetings attended by nursing staff from theatre and specialist clinics and medical staff from each of the surgical departments. The minutes of those meetings do not record such issue having been raised.³⁸⁰ However, Dr Hanelt corroborated Nurse Wyatt's evidence in this respect stating that complaints were made about the frequent absences of Dr Naidoo and the effect this had on achieving Hospital orthopaedic elective surgery throughput targets at monthly surgical management advisory group meetings.³⁸¹

- 4.147 Similarly, Nurse Erwin-Jones, who started as the Nurse Unit Manager, Operating Theatres, at the Hervey Bay Hospital from January 2004,³⁸² said that she spoke to both Mr Allsopp and Dr Hanelt on several occasions between about April 2004 and July 2004³⁸³ about the lack of support and supervision of Drs Krishna and Sharma.³⁸⁴ She said she understood Dr Hanelt to have agreed that such matters were an issue.³⁸⁵ She understood that Mr Allsopp and Dr Hanelt were looking at ways to 'manage' Dr Naidoo.³⁸⁶ She did not put her complaints in writing nor complete any incident report. This was because she said, to her knowledge, no negative outcomes had resulted.³⁸⁷ She did not feel she had any significant evidence to give to them to say you must act on this.³⁸⁸
- 4.148 Mr Allsopp said that the cancellation or rescheduling of cases due to absences of Dr Naidoo and the effect that had on activity targets had been raised with

³⁷⁵ T7356 line 20

³⁷⁶ T7357 line 1, 7360 line 5-20

³⁷⁷ para 5 Supplementary Statement of Allsopp

³⁷⁸ T7359 line 45

³⁷⁹ T7357 line 25, 7363 line 20-30

³⁸⁰ Exhibit 502

³⁸¹ T6746741 line 20-50

³⁸² T5409 line 10 (Ms Erwin-Jones)

³⁸³ T5409 line 10-40, 5437 line 35-45

³⁸⁴ Exhibit 329 para 65 Statement of Erwin-Jones; T5408 line 45, 5418 line 50-5419 line 20

³⁸⁵ T5414 line 10, 5437 line 20

³⁸⁶ T5408 line 55, 5418 line 50

³⁸⁷ T5408 line 50, 5414 line 50

³⁸⁸ T5419 line 5

him by Nurse Erwin-Jones during the early part of 2004³⁸⁹ He also said that Nurse Erwin-Jones talked about Drs Krishna and Sharma not being supported by Dr Naidoo, which he took to mean the absence of supervision and additional training that they would receive if there was more supervision.³⁹⁰ Mr Allsopp said that he cared about the issue but did not do anything about it.³⁹¹ Remarkably, he said that, if he were to act on what all people talked to him about as a District Manager, 'you [would] cause great confusion and great disharmony'.³⁹² He said that such incidents, if they compromised patient safety, should have been documented by incident reports and dealt with through formal channels.³⁹³ He was not sure if he passed on to Dr Hanelt what was said to him³⁹⁴ but said 'if I thought it was a minor issue, I would have passed it on to him'.³⁹⁵

- 4.149 The reference to the need for documented incident reports and for complaint by 'formal channels' before he would act is disturbing but unfortunately typical of the tendency of administrators, at Hervey Bay and elsewhere, to place form above substance and to ignore problems, even those that threatened patient safety, until forced to act by some formal process or risk of public exposure.
- 4.150 In an email from Nurse Erwin-Jones to Mr Allsopp and Dr Hanelt dated 17 June 2004³⁹⁶ reference was made to the Senior Medical Officers not having any respect for Dr Naidoo. In another email from Nurse Winston to Dr Hanelt dated 18 June 2004 reference was made to infighting between Drs Naidoo, Krishna and Sharma.³⁹⁷ Both these emails were sent a couple of weeks before Drs North and Giblin commenced their investigation. Mr Allsopp said that he expected Dr Hanelt to manage the issues.³⁹⁸ Dr Hanelt said that he decided to await the outcome of that investigation.³⁹⁹ No individual direct action was taken.⁴⁰⁰ There were other verbal complaints about, at least, the unavailability of Dr Naidoo.⁴⁰¹
- 4.151 Dr Hanelt acknowledged that there were constant complaints from members of staff about Dr Naidoo's absences over several years quite likely commencing earlier than 2002.⁴⁰² Dr Hanelt stated that it was reported to him on occasions that Dr Naidoo was absent when not on leave. On those occasions Dr Hanelt

³⁸⁹ T7071 line 20, 7072 line 1

³⁹⁰ T7088 line 10-40

³⁹¹ T7088 line 40

³⁹² T7088 line 55

³⁹³ T7088 line 50

³⁹⁴ T7089 line 15

³⁹⁵ T7089 line 25

³⁹⁶ Exhibit 444A attachment TMH21 Statement of Hanelt

³⁹⁷ Exhibit 444A attachment TMH22 Statement of Hanelt

³⁹⁸ 7072 line 50

³⁹⁹ T6763-4

⁴⁰⁰ T6765 line 30 (Dr Hanelt)

⁴⁰¹ T6761 line 20 (Dr Hanelt)

⁴⁰² T6731 line 20-30

attempted to contact Dr Naidoo. There were a couple of occasions when he was unable to contact him.⁴⁰³ On other occasions, when he was contacted, Dr Naidoo gave reasons for his absences such as that he was held up in traffic on the way back from Brisbane.⁴⁰⁴ On others, he was performing what he was supposed to be doing or on legitimate leave.⁴⁰⁵ Dr Hanelt said that checks had been made with the Human Resources department in relation to Dr Naidoo's leave on occasions. The reports back were that the leave he had taken was within his entitlement.⁴⁰⁶ Dr Hanelt did nothing else about it.

- 4.152 Dr Hanelt acknowledged that over quite a number of years there had also been complaints about cancellation of cases by Dr Naidoo and the general attitude of Dr Naidoo.⁴⁰⁷ Dr Hanelt agreed that there were significant problems in Dr Naidoo's relationship with Drs Krishna and Sharma,⁴⁰⁸ indeed with the majority of staff.⁴⁰⁹ He agreed with the finding of the North Giblin report that dysfunctional aspects of the relationships in the orthopaedic department impacted upon the level of care that the department was able to provide.⁴¹⁰
- 4.153 Dr Hanelt was aware of cases of unsupervised Senior Medical Officer surgery having complications.⁴¹¹ He said that there was conflicting advice from Drs Naidoo and Mullen as to whether these complications were due to a competence issue or an adverse outcome suffered irrespective of competence.⁴¹²
- 4.154 Although Dr Hanelt conceded that the long absences of specialist supervision created by Dr Naidoo's leave was unsatisfactory,⁴¹³ it did not occur to him that it would be dangerous to let Drs Krishna and Sharma perform all of the operations which were within the Scope of Service document. This is despite the expressed concerns of Dr Mullen whom Mr Allsopp described as having an 'excellent clinical reputation' ⁴¹⁴ and Dr Hanelt described as a 'quality orthopaedic surgeon'.⁴¹⁵
- 4.155 Dr Hanelt said that he accepted the view of Dr Naidoo that the Senior Medical Officers could perform the procedures approved in their Scope of Service documents.⁴¹⁶ In his mind, he said, Dr Naidoo was the more experienced and

⁴⁰³ T6731 line 40

⁴⁰⁴ T6731 line 45 (Dr Hanelt)

⁴⁰⁵ T6801 line 30 (Dr Hanelt); Also Exhibit 444B p4 Supplementary Statement of Hanelt

⁴⁰⁶ T6731 line 35 (Dr Hanelt)

⁴⁰⁷ T6738 line 50 – 6739 line 10

⁴⁰⁸ T6807 line 1

⁴⁰⁹ T6807 line 5

⁴¹⁰ T6750 line 40

⁴¹¹ Exhibit 444A para 88(iii) Statement of Hanelt

⁴¹² Exhibit 444A para 88(iii) Statement of Hanelt; T6751 line 30

⁴¹³ T6750 line 50

⁴¹⁴ Exhibit 456 para 4.16 Statement of Allsopp

⁴¹⁵ T6800 line 15

⁴¹⁶ T6728

senior orthopaedic surgeon.⁴¹⁷ He did not doubt Dr Naidoo's integrity. Dr Hanelt said that he tempered Dr Mullen's views with his belief that at times Dr Mullen was prepared to allow these same Senior Medical Officers to perform some of these procedures on patients under his care without supervision.⁴¹⁸

- 4.156 Mr Allsopp said that he had a discussion with Dr Hanelt about the scope of work of the Senior Medical Officers before the time Dr Naidoo documented their scopes of service.⁴¹⁹ He said that he was told soon after the Senior Medical Officers commenced employment that there was an arrangement in place that set out the work they could do independently and the work where they required supervision.⁴²⁰ Mr Allsopp also said that he went to Dr Hanelt with regard to the absences of Dr Naidoo.⁴²¹ Mr Allsopp's concern related to cancellation of surgery rather than patient safety. Dr Hanelt assured him that the leave was approved within award entitlements and that his sick leave was genuine.⁴²² Mr Allsopp became aware of the interest shown by the Australian Orthopaedic Association at the end of 2003.⁴²³ He discussed with Dr Hanelt the concerns of Dr Mullen. His understanding was that Dr Mullen had raised concern about holding out Drs Krishna and Sharma as specialists and also that there was a disagreement between Drs Naidoo and Mullen as to supervision requirements.⁴²⁴ Mr Allsopp said he and Dr Hanelt did not discuss specifics other than in relation to the need for an external review.⁴²⁵ He said that he did not know and did not ask whether the disagreement affected patient safety.⁴²⁶ He accepted that maybe he should have asked.⁴²⁷
- 4.157 Mr Allsopp's evidence, on these and other respects, was, in my opinion, generally unreliable. He appeared to be too ready to say whatever he thought would cast him in a better light. In particular I do not accept that he enquired or was told about the scope of practice in respect of the Senior Medical Officers until about the time that the Australian Orthopaedic Association was making inquiries.
- 4.158 In view of Dr Hanelt's knowledge of the difference of opinion between Drs Naidoo and Mullen as to the competence of Drs Krishna and Sharma, allowing the Senior Medical Officers to continue to perform all operations approved by Dr Naidoo, most of them unsupervised, and to be placed on-call rosters was a

⁴¹⁷ T6728

⁴¹⁸ Exhibit 444A para 51(i), TMH 21 Statement of Hanelt

⁴¹⁹ T7074 line 20-40

⁴²⁰ T7074 line 50 – T7075 line 1, T7083

⁴²¹ T7074 line 5

⁴²² T7074 line 5

⁴²³ T7075 line 10

⁴²⁴ T7075 line 20-40

⁴²⁵ T7075 line 50

⁴²⁶ T7076 line 20

⁴²⁷ T7076 line 40

grossly inadequate response by him in terms of patient safety having regard to the fact that:

- Dr Naidoo was never in a position to properly assess the level of skill or competence of either Dr Krishna or Dr Sharma;
- they were never credentialed or clinically privileged;
- Dr Naidoo, because of his frequent and long absences, had an interest in letting Drs Krishna and Sharma perform most of the work of the orthopaedic unit unsupervised.

Until the question was resolved one way or the other, the Senior Medical Officer's scope of unsupervised practice should have been narrowly limited in the interests of patient safety.

- 4.159 In or about January 2004, Dr Mullen offered to do on-call work one in two for free to assist the hospital ensure specialist cover after hours.⁴²⁸ Remarkably, this offer was rejected. It was rejected for three reasons, according to Dr Hanelt. First, there was a concern, it was said, Dr Mullen would not be able to meet a one in two commitment based upon past unavailability.⁴²⁹ Secondly, it was said, there was a significant financial risk that, because the offer for free service was contrary to award conditions, Dr Mullen might later claim payment.⁴³⁰ Thirdly, Dr Mullen's offer was conditional on Dr Naidoo also providing a one in two on-call commitment. According to Dr Hanelt, Dr Naidoo was only prepared to do a one in four and not a more frequent commitment.⁴³¹
- 4.160 None of these reasons satisfactorily explain why the offer of Dr Mullen was rejected. Having heard Dr Mullen, I have no reason to doubt the sincerity of the offer or that it would have been honoured. And I do not believe that Dr Hanelt had any reason to doubt that either. There does seem to have been some animosity between them. I can only assume this was the real reason for rejecting the offer. In the circumstances, having regard to the interests of patient safety, the hospital had nothing to lose by accepting the offer.
- 4.161 To provide a safe service, according to Drs North and Giblin, in the North Giblin report, even on-call orthopaedic procedures should be supervised by a specialist. Dr Hanelt disagreed with this. He said that there is an essential distinction, particularly in remote areas, between emergency surgery and elective surgery and that, in the case of elective procedures, it would be negligent to allow persons to perform procedures without supervision unless they were competent and preferably credentialed.⁴³² But apparently he did not

⁴²⁸ T6743 line 1 (Dr Hanelt)

⁴²⁹ T6743 line 10 (Dr Hanelt)

⁴³⁰ T6743 line 20-30 (Dr Hanelt)

⁴³¹ T6743 line 20 (Dr Hanelt)

⁴³² T6745 line 25

think that that was necessary for on-call orthopaedic procedures. I prefer the opinion of Drs North and Giblin. To allow Drs Krishna and Sharma to provide on-call orthopaedic services unsupervised, having regard to the matters referred to above, was grossly negligent.

- 4.162 Even in August 2004, when Drs North and Giblin had visited the hospital and Dr Hanelt was aware that their appointment had been made in part because of concerns about the level of competence of Drs Krishna and Sharma⁴³³ to perform, unsupervised, the work which they were performing, and Dr Hanelt knew that Drs Krishna and Sharma were not privileged, Dr Hanelt, remarkably, was still prepared to permit Drs Krishna and Sharma to perform their work unsupervised. During a four week period of absence by Dr Naidoo, Dr Hanelt forwarded an email to relevant staff leaving Drs Krishna and Sharma with a discretion to do whatever procedures they were happy with, other than joint replacements.⁴³⁴ Dr Hanelt knew that there was a divergence of views between Drs Naidoo and Mullen as to the competence of the Senior Medical Officers, that Dr Naidoo was never in a position to assess their skills or competence and that they had never been credentialed or privileged; and he must have at least suspected that Dr Naidoo's view might be coloured by his own frequent absences and the consequent impossibility of their supervision.
- 4.163 It was not sufficient, as Dr Hanelt seems initially to have thought,⁴³⁵ merely to await the outcome of the investigation by Drs North and Giblin, in the meantime continuing to permit Dr Krishna and Sharma to continue unsupervised. Dr Hanelt conceded that, in retrospect, after reading the evidence given by some of the orthopaedic surgeons before the Commission, there should, at least, have been restrictions placed upon the procedures performed by the Senior Medical Officers whilst there was no direct supervision;⁴³⁶ and that this could have been achieved by a proper privileging committee⁴³⁷ including one informally appointed. Plainly that should have occurred to him at the time. I suspect that it did not because, he and Mr Allsopp, were more focused on attaining the elective surgery target than on patient safety.

Quality assurance

- 4.164 Two potential forms of clinical audit, utilised in most clinical areas, were available: first, a weekly meeting that reviewed patients managed within the week to make sure that all results had been followed up and to discuss alternative options, how things may have been done differently if outcomes

⁴³³ T6728 line 10 (Dr Hanelt)

⁴³⁴ Exhibit 444B attachment C (p72) Statement of Hanelt, T6726

⁴³⁵ Exhibit 444A para 88(iii) Statement of Hanelt

⁴³⁶ T6732 line 40

⁴³⁷ T6732 line 50

were not as desired; secondly, a system whereby outcomes were collated so that longer term trends were determined.⁴³⁸

- 4.165 The North Giblin report found, and Dr Hanelt agreed,⁴³⁹ there was a general inadequacy of quality assurance measures in place in the orthopaedic department. According to Dr Hanelt,⁴⁴⁰ the personality and management style of Dr Naidoo affected the openness with which any weekly clinical audits were conducted. Dr Naidoo tended to be rather abrupt in dealing with certain issues.⁴⁴¹ Whilst weekly meetings seemed to have occurred, the longer term review meetings were held quite infrequently.⁴⁴² It seems that no one collated the data for these. This meant that there was an absence of a system whereby outcomes were collated so that longer term trends could be determined. Dr Naidoo, as Director of Orthopaedics, should have been responsible for calling and scheduling those meetings.⁴⁴³
- 4.166 This has changed during the past year with a data program having been purchased by the hospital and a suitable person having been deployed to provide data entry for medical staff.⁴⁴⁴

Investigation

Patient P449 and Dr Mullen's complaint to the Australian Orthopaedic Association

- 4.167 Dr Mullen had been particularly prompted to take his concerns outside the administration of the Hervey Bay Hospital after a particular incident which occurred in April 2003⁴⁴⁵ involving P449.⁴⁴⁶ Dr Mullen was contacted, either by Dr Hanelt or Nurse Wyatt,⁴⁴⁷ to attend theatre to assist with P449 who had been involved in a motor bike accident and had received a fractured femur in his right leg. Nurse Wyatt had tried to contact Dr Naidoo who was rostered on-call.⁴⁴⁸ Dr Naidoo, as frequently had become the case, was unable to be contacted to assist. The patient was being operated on by Dr Krishna. Dr Sharma was also present and scrubbed for the case but was not the

⁴³⁸ T6730 line 1 (Dr Hanelt)

⁴³⁹ Exhibit 444A para 22 Statement of Hanelt, T6750 line 35

⁴⁴⁰ T6732 line 50

⁴⁴¹ T6731 line 5 (Dr Hanelt)

⁴⁴² T6730 line 20 (Dr Hanelt)

⁴⁴³ T5163 line 1 (Dr North)

⁴⁴⁴ T6802-3 (Dr Hanelt)

⁴⁴⁵ T5818 line 40 (Dr Mullen)

⁴⁴⁶ Exhibit 330 para 27 Statement of Mullen

⁴⁴⁷ Dr Mullen thought it was Dr Hanelt: Exhibit 330 para 23 Statement of Mullen. Nurse Wyatt stated it was her:

T7358 line 1

⁴⁴⁸ T7357 line 40-50 (Ms Wyatt)

surgeon.⁴⁴⁹ The patient had been in the operating theatre for some time and had lost a lot of blood.⁴⁵⁰ Displacement of part of a significant fracture had occurred at the site of placement of a retrograde femoral nail by Dr Krishna. Dr Mullen thought that the femur had been partly fractured during the procedure by the insertion of a nail.⁴⁵¹ This was disputed by Dr Krishna.⁴⁵² It is unnecessary to resolve this difference of opinion.

- 4.168 The operation was plainly a complex one. Dr Mullen thought that it should not have occurred without supervision given its complexity, particularly with use of a newer device which required greater skill to place and the assistance of two persons.⁴⁵³ Dr Sharma, who was present, expressed concern about the lack of supervision he was getting from Dr Naidoo.⁴⁵⁴ The view of Dr Mullen is supported by the fact that, subsequently,⁴⁵⁵ when Dr Krishna received his Scope of Service documents from Dr Naidoo, complex femoral shaft fractures requiring retrograde nailing was shown to be a procedure that Dr Krishna could perform only with supervision.⁴⁵⁶
- 4.169 Dr Krishna gave evidence that he did not attempt to contact Dr Naidoo or tell him that this was a procedure that he intended to perform. He said he had done the procedure approximately three times before and thought he was capable of doing it.⁴⁵⁷ He was plainly over confident in that opinion. I accept Dr Mullen's opinion that he should have been supervised. But it is also plain from what I have said that, although Dr Naidoo was supposed to be on-call, he would not have been able to be contacted to supervise the operation.
- 4.170 Dr Hanelt remembered that, afterwards, Dr Naidoo discussed the procedure with him. He said that Dr Naidoo told him that the outcome was a well recognised complication and it was not due to poor performance of the procedure.⁴⁵⁸ Dr Naidoo was of the opinion that Dr Krishna was competent to perform it.⁴⁵⁹ Dr Hanelt said he reviewed the literature and found that there was a well recognised complication rate of about two percent for the procedure.⁴⁶⁰ Dr Hanelt did not recall being told at the time that the fracture had already been cracked and only displaced during the procedure.⁴⁶¹ Rather he assumed that the fracture had cracked during the procedure.⁴⁶²

⁴⁴⁹ T5698 line 25 (Dr Sharma)

⁴⁵⁰ Exhibit 330 para 25 Statement of Mullen

⁴⁵¹ Exhibit 330 para 25 Statement of Mullen

⁴⁵² T6483-4

⁴⁵³ T5767 line 30, 50

⁴⁵⁴ Exhibit 330 para 26 Statement of Mullen; T5698 line 40-50 (Dr Sharma)

⁴⁵⁵ This case occurred prior to the receipt of the scope of service documents

⁴⁵⁶ Exhibit 313 para 2

⁴⁵⁷ T6485 line 40

⁴⁵⁸ T6753 line 30

⁴⁵⁹ T6753 line 40

⁴⁶⁰ T6753 line 20, T6754 line 1

⁴⁶¹ T6754 line 20

⁴⁶² T6754 line 25

- 4.171 The next working day after this incident,⁴⁶³ Nurse Wyatt also complained to Mr Allsopp about what had happened. She was concerned about the incident. She felt it was not fair on Drs Krishna and Sharma to be operating on a patient without the support from a consultant.⁴⁶⁴ Mr Allsopp asked her whether she was telling him that Drs Krishna and Sharma were incompetent. She said that she felt intimidated.⁴⁶⁵ She told Mr Allsopp that she thought that they should not be doing complex surgery unsupervised.⁴⁶⁶ According to Nurse Wyatt, Mr Allsopp responded by stating 'What do you want me to do; stop Dr Naidoo and Drs Krishna and Sharma operating and then have no service?'.⁴⁶⁷ She said that she was upset⁴⁶⁸ and dissatisfied with Mr Allsopp's management of the issue.⁴⁶⁹
- 4.172 Mr Allsopp did not recall such conversation. He stated, to his knowledge, it did not occur.⁴⁷⁰ Nurse Wyatt strongly disagreed with the suggestions that it did not happen⁴⁷¹ or that she was confused with other conversations relating to management of operations between the District's two hospitals.⁴⁷² I have already said that I found Mr Allsopp's evidence unreliable. I accept that the conversation occurred as related by Nurse Wyatt.
- 4.173 After the P449 incident, Dr Mullen contacted the Queensland President of the Australian Orthopaedic Association, Dr Chris Blenkin, to complain. He complained about local management and the seriousness of the lack of supervision which was being provided to the unqualified Senior Medical Officers.⁴⁷³

Appointment of investigators

- 4.174 In or about late October 2003, after the complaint of Dr Mullen and the earlier contact by Dr Gillett on behalf of the Australian Orthopaedic Association, there was media attention in relation to overseas trained doctors in general and specifically in relation to the two Senior Medical Officers at Hervey Bay. An article appeared in *The Courier-Mail* newspaper in which concerns were publicly expressed by some members of the Australian Orthopaedic Association about the Senior Medical Officer's scope of service and supervision. Dr Hanelt was prompted to write to the Chairman of the Queensland branch of Australian Orthopaedic Association, Dr Blenkin by letter

⁴⁶³ T7366 line 10-30

⁴⁶⁴ T7358 line 40

⁴⁶⁵ T7358 line 15

⁴⁶⁶ T7358 line 15

⁴⁶⁷ T7358 line 20

⁴⁶⁸ T7358 line 25

⁴⁶⁹ T7358 line 30

⁴⁷⁰ para 6 Supplementary Statement of Allsopp

⁴⁷¹ T7366 line 25

⁴⁷² T7368

⁴⁷³ Exhibit 330 para 27 Statement of Mullen

dated 4 November 2003.⁴⁷⁴ He expressed disappointment that the association had not further contacted him if it still had concerns after his earlier telephone conversation with Dr Gillett. In the letter he stated that he wanted to work constructively with the Australian Orthopaedic Association to define some guidelines for the Senior Medical Officers. He stated:

From reading the articles, I believe that the AOA has some genuine concerns in relation to the scope of services provided by these two doctors and the degree of supervision provided.

Previous recruitment attempts have demonstrated that it is not possible to recruit an adequate number of registered Orthopaedic Specialists in the District to provide continuous services. Due to the distances involved in transporting patients to a specialist orthopaedic service, cases such as contaminated compound fractures and injuries with acute vascular compromise would potentially suffer serious adverse outcomes if local services cannot be provided. Thus some degree of compromise is necessary to provide the best service possible with the available resources.

- 4.175 On 9 November 2003, Dr Blenkin decided to write to the Minister for Health, the Honourable Wendy Edmonds, expressing concern with the delivery and quality of orthopaedic care at the Hervey Bay Hospital and the need for an independent review. He suggested that the National President of the Australian Orthopaedic Association be contacted to choose two experienced assessors from outside the state to conduct the assessment.⁴⁷⁵
- 4.176 It was not until on or about 28 May 2004 that Drs North and Giblin were notified of their appointment by the Director-General of Queensland Health, Dr Buckland as investigators under Division 1 Part VI of the *Health Services Act* 1991.⁴⁷⁶ Their instrument of appointment was dated 6 May 2004.⁴⁷⁷
- 4.177 The delay in the appointment and notification of Drs North and Giblin of their appointment on or about 28 May 2004, nearly a year after complaints were first raised in mid 2003, was unsatisfactory. Except for the unsatisfactory and unreliable preparation of the scopes of service documents in or about January 2004, the status quo, in the meantime, had continued. Drs Krishna and Sharma continued to operate, almost unsupervised. The delay from late 2003 seems attributable to negotiations between Queensland Health and the Australian Orthopaedic Association relating to an indemnity.⁴⁷⁸ When the investigation commenced, the matter of the indemnity still had not been finalised.⁴⁷⁹

⁴⁷⁴ attached to Exhibit 400 Statement of Beh

⁴⁷⁵ Exhibit 400 Statement of Beh

⁴⁷⁶ Exhibit 400 Statement of Beh

⁴⁷⁷ Exhibit 336 para 233

⁴⁷⁸ Exhibit 400 paras 6 – 9 Statement of Beh and attachments; T5127 line 30 (Dr North)

⁴⁷⁹ Exhibit 400 para 9 Statement of Beh

Example of administrative interference in Dr Mullen's clinical judgment

- 4.178 An incident occurred on a Saturday in August 2004,⁴⁸⁰ sometime after the attendance of Drs North and Giblin on the hospital, when Dr Mullen, who was on-call, attended upon an 87 year old⁴⁸¹ woman. The patient had been admitted the night before with a fractured hip.⁴⁸² After examination, Dr Mullen decided that the patient needed to have surgery that day.⁴⁸³ He said evidence had shown that a much better outcome was likely in terms of reduced morbidity and mortality if surgery was performed within 48 hours.⁴⁸⁴ The patient's risks also were increased due to a chronic chest infection and advanced age.⁴⁸⁵ Dr Mullen organised for Dr Gerry Meijer, a senior Anaesthetist, to be available and booked the patient in for surgery at 4.30 pm.⁴⁸⁶
- 4.179 At the time, a policy existed at the Hervey Bay Hospital that only permitted emergency surgery be performed on a weekend, although exceptions occurred at times⁴⁸⁷ and surgical and theatre staff were available from 10.00am until 6.00pm for surgery.⁴⁸⁸
- 4.180 Nurse Erwin Jones, who was at home at the time and had no direct knowledge of the case, was contacted by the senior theatre nurse and informed that Dr Mullen had wanted to perform the surgery.⁴⁸⁹ She said she saw the case as an example of Dr Mullen seeking to abuse access to emergency theatres on weekends⁴⁹⁰ and to personally gain from the procedure.⁴⁹¹ To her, it was not a life or limb threatening operation⁴⁹² but suited Dr Mullen's convenience to do the case.⁴⁹³ She believed the fracture was 2 weeks old⁴⁹⁴ when, according to Dr Mullen,⁴⁹⁵ who had examined the patient and whose qualified specialist medical opinion I prefer, it was not; the patient had fallen in a nursing home on the day of her admission. Nurse Erwin Jones said it also had cost implications to the District.⁴⁹⁶ She said that if staff was tied up in that case and other emergencies then backlogged, they would have overtime leading to a lot of cost and fatigue.⁴⁹⁷ Dr Mullen's intention to use a more expensive prosthesis

⁴⁸⁰ Exhibit 456 para 4.66 Statement of Allsopp

⁴⁸¹ T5470 line 1 (Dr Mullen)

⁴⁸² Exhibit 330 para 37 Statement of Mullen

⁴⁸³ T5469 line 50

⁴⁸⁴ T5469 line 50

⁴⁸⁵ Exhibit 330 para 37 Statement of Mullen

⁴⁸⁶ Exhibit 330 para 37 Statement of Mullen

⁴⁸⁷ Exhibit 456 para 4.66 Statement of Allsopp; T5805 line 30 – 50 (Dr Mullen)

⁴⁸⁸ T5805 line 25 (Dr Mullen)

⁴⁸⁹ Exhibit 329 para 49 Statement of Erwin Jones

⁴⁹⁰ Exhibit 329 para 49 Statement of Erwin Jones

⁴⁹¹ Exhibit 329 para 48 Statement of Erwin Jones

⁴⁹² T5417 line 35 (Ms Erwin-Jones)

⁴⁹³ T5417 line 20 (Ms Erwin-Jones)

⁴⁹⁴ T5417 line 20 (Ms Erwin-Jones)

⁴⁹⁵ T5470 line 10

⁴⁹⁶ T5427 line 25

⁴⁹⁷ T5417 line 30, 5428 line 5

than routinely used, she thought, also was an unnecessary cost.⁴⁹⁸ She also said she also was aware an anaesthetist had advised that surgery should not be performed because the patient had a chest infection.⁴⁹⁹

- 4.181 Although Nurse Erwin Jones said⁵⁰⁰ that she had been unable to contact either Dr Hanelt or Mr Allsopp and had instructed the theatre nurse herself that Dr Mullen was not to do the case and that it be re-booked for the following Monday, Mr Allsopp said⁵⁰¹ he was contacted by her. Mr Allsopp said that, after discussing the case with Nurse Erwin Jones, but without consulting with Dr Mullen, he advised Nurse Erwin Jones that the policy should be applied⁵⁰² and that the surgery could not proceed.⁵⁰³ Dr Mullen was notified of the decision by the theatre nursing staff.⁵⁰⁴
- 4.182 Dr Mullen rang Mr Allsopp to discuss the case.⁵⁰⁵ He asked the reason for the cancellation of the case. Dr Mullen said that Mr Allsopp told him senior nursing staff had advised him that the case did not need to proceed as an emergency case because the patient was not unwell and, as it was a semi-elective case, it could be carried out the following week⁵⁰⁶ and that he had information that an anaesthetist who had seen the patient would rather the case was done on Monday;⁵⁰⁷ Mr Allsopp also asked why Dr Mullen was proposing to use to use the more expensive prosthesis for the case than normally used.⁵⁰⁸ Dr Mullen said that Mr Allsopp was aggressive and hostile towards him.⁵⁰⁹
- 4.183 A Senior Medical Officer in anaesthetics, who was not a qualified anaesthetist, had earlier seen the patient. He had expressed a concern about the patient proceeding to surgery because he believed she had a chest infection.⁵¹⁰ Dr Mullen, who had felt that this may not have been the case because of the patient's chronic chest condition, thereafter had conferred with a senior qualified anaesthetist, Dr Meijer. Dr Meijer, who also saw the patient,⁵¹¹ had not considered the patient to have had a chest infection. He had told Dr Mullen that she could proceed to surgery.⁵¹² Dr Mullen asked Mr Allsopp to contact Dr

⁴⁹⁸ Exhibit 329 para 49 Statement of Erwin Jones, T5416 line 40, 5427 line 40

⁴⁹⁹ Exhibit 329 para 49 Statement of Erwin Jones, T5416 line 45

⁵⁰⁰ Exhibit 329 para 49 Statement of Erwin Jones

⁵⁰¹ Exhibit 456 para 4.66 Statement of Allsopp

⁵⁰² Exhibit 456 para 4.66 Statement of Allsopp

⁵⁰³ T5805 line 55, 5810 line 20 (Dr Mullen); T7081 (Mr Allsopp)

⁵⁰⁴ Exhibit 330 para 38 Statement of Mullen

⁵⁰⁵ Exhibit 330 para 38 Statement of Mullen

⁵⁰⁶ Exhibit 330 para 38 Statement of Mullen, T5807, 5470 line 40

⁵⁰⁷ T5808 line 40 – 60

⁵⁰⁸ T 5809 line 25, 5470 line 55

⁵⁰⁹ Exhibit 330 para 39 Statement of Mullen

⁵¹⁰ T5469 line 15 (Dr Mullen)

⁵¹¹ T5469 line 35 (Dr Mullen)

⁵¹² T5469 line 20 – 40, 5808 line 55 (Dr Mullen)

Meijer.⁵¹³ He also explained the reasons why the more expensive device was needed.⁵¹⁴

- 4.184 Mr Allsopp contacted Dr Mijer who advised Mr Allsopp that the patient was suitable for surgery and that he agreed with Dr Mullen's assessment that the clinical outcome for the patient may be compromised if the surgery waited until Monday.⁵¹⁵ On that basis, Mr Allsopp allowed the surgery to proceed,⁵¹⁶ although it had to be re-booked for the following morning.⁵¹⁷
- 4.185 The fact that Dr Mullen and Dr Mijer, who were the clinicians treating the patient and who were the most qualified to assess the urgency and appropriateness of the surgery, were not consulted before a decision was made to cancel the surgery was extraordinary⁵¹⁸ and grossly misguided. Mr Allsopp said that he did not consult Dr Mullen because he knew that if Dr Mullen had an issue with the decision and wanted to pursue the case he would contact him.⁵¹⁹ In hindsight, he correctly conceded that he should have contacted Dr Mullen.⁵²⁰ Nurse Erwin Jones said that she did not speak to Dr Mullen because she felt it would just end in an argument between them.⁵²¹
- 4.186 Both Mr Allsopp and Nurse Erwin Jones, plainly, should have asked Dr Mullen, the surgeon concerned, his opinion about the urgency of the case. The fact that they did not manifested an excessive concern for cost savings over patient care and safety and a failure to appreciate that, without clinical expertise or consultation, they should not have interfered in the decision-making of highly qualified medical specialists, thereby compromising patient care and safety. I cannot help but also suspect that Dr Mullen's perception⁵²² of hostility toward him after his complaint to the Australian Orthopaedic Association was, in truth, a reality.

Dr Kwon

- 4.187 In January 2005, following the investigation by Drs North and Giblin in July 2004,⁵²³ a locum full time Orthopaedic surgeon, Dr Kwon, was employed by the Fraser Coast Health Service District to assist in the delivery of orthopaedic services at the Hervey Bay and Maryborough Hospitals. During the whole of

⁵¹³ T5809 line 1 (Dr Mullen)

⁵¹⁴ T5809 line 30, 40 – 60 (Dr Mullen)

⁵¹⁵ Exhibit 456 para 4.66 Statement of Allsopp

⁵¹⁶ Exhibit 456 para 4.66 Statement of Allsopp

⁵¹⁷ Exhibit 330 para 39 Statement of Mullen

⁵¹⁸ Dr Mullen said it had never before been in a situation where an administrator had cancelled a case without notifying him: T5470 line 35

⁵¹⁹ T7081 line 20, 7082 line 20

⁵²⁰ T7081 line 40

⁵²¹ T5426 line 30 - 60

⁵²² of which this was one example cited by Dr Mullen in his Statement: Exhibit 330 para 39

⁵²³ although before the delivery of their North Giblin report Exhibit 38 in May 2005

the time whilst Dr Kwon was employed, Dr Naidoo went on planned leave.
⁵²⁴Dr Naidoo remained on leave until the cessation of the service in May 2005.

- 4.188 Dr Kwon undertook a huge workload to allow, as best he could, the Hervey Bay Hospital to provide a specialist service. He supervised Dr Krishna and Dr Sharma. That supervision went from 100%, initially, to allowing the Senior Medical Officers to perform certain operations without him being in the operating theatre.⁵²⁵ Nurse Erwin-Jones said that Dr Kwon's supervision of the Senior Medical Officers was dramatically greater than that existing previously. He was always available.⁵²⁶ Dr Kwon did an inordinate amount of on-call work to support the Drs Krishna and Sharma.⁵²⁷ During his four months there, the only times Dr Kwon was not on-call was perhaps one or two weekends⁵²⁸ and he was available to assist the Senior Medical Officers whenever required.⁵²⁹ Such a workload was unsustainable in the longer term. No doctor could maintain such a workload.⁵³⁰ Dr Hanelt agreed that, by this time, he had known it was necessary that Drs Krishna and Sharma be supervised constantly by an orthopaedic surgeon until satisfied as to what operations they could perform.⁵³¹
- 4.189 Dr Kwon also conducted weekly Morbidity and Mortality reviews, instigated new procedures in terms of bed management and infection control and participated in the Operating Theatre Review Committee and the Surgical Services Management Advisory Committee.⁵³² He introduced better education processes.⁵³³

Clinical outcomes

Other patients referred to by Dr Mullen

- 4.190 A comprehensive review of all patients who suffered adverse outcomes as a result of surgery performed by the Senior Medical Officers was not undertaken by this Commission of Inquiry. Apart from the incidents already mentioned, Dr Mullen also gave evidence of a number of other incidents where there may have been sub-optimal treatment, in consequence of a failure to provide necessary supervision of Drs Krishna and Sharma.

⁵²⁴ Exhibit 456 para 4.7 Statement of Allsopp

⁵²⁵ T6733 line 20, T6760 line 40; T5694 line 50

⁵²⁶ T5434 line 10 (Ms Erwin-Jones)

⁵²⁷ T5435 line 35 (Ms Erwin-Jones)

⁵²⁸ T6733 line 25 (Dr Hanelt)

⁵²⁹ T5674 line 20-40 (Dr Sharma)

⁵³⁰ T6733 line 30 (Dr Hanelt); Also T5176.20 (Dr North)

⁵³¹ T6733 line 55

⁵³² Exhibit 456 para 4.7 Statement of Allsopp

⁵³³ T5434 line 30 (Ms Erwin-Jones)

Patient P435

- 4.191 This woman suffered a very badly damaged fracture of the tibia, which extended down into the joint surface and a very nasty fracture of the fibula bone, which also was in many pieces. She was operated upon by Dr Krishna on 11 January 2005 after earlier having had her operation cancelled on 5 January 2005.⁵³⁴ Dr Krishna treated the injury by opening the fracture widely and placing large plates on it. In the opinion of Dr Mullen, given the delay of one week in the operation and the swelling at that time, a different technique ought to have been used not involving the opening of the fracture but using frames or nails to try to achieve the fixation without having to widely open the fracture and expose it to the environment with a consequent risk of infection.⁵³⁵
- 4.192 The circumstances were exacerbated by Dr Krishna having initially sought the assistance and advice of Dr Naidoo by telephone and being advised by Dr Naidoo to open the fracture and call him if there was a problem.⁵³⁶ Dr Krishna said that when he opened up the fracture and found the fibula fracture was more comminuted than expected in the x-ray, he again sought Dr Naidoo's assistance.⁵³⁷ Dr Naidoo refused to come stating that Dr Krishna, as a Senior Medical Officer, ought to have been able to handle it.⁵³⁸
- 4.193 Dr Krishna did not dispute the opinion of Dr Mullen that the use of open internal fixation was inappropriate and that it would have been better to use a different technique to achieve the fixation without having to widely open the fracture and expose it to the environment.⁵³⁹ But this had been what Dr Naidoo had told him to do. The consequences of the treatment was that this woman, in the opinion of Dr Mullen, developed post operative infection and delayed healing of the fracture requiring her to be transferred to the Limb Re-construction Department at the Royal Brisbane Hospital for further treatment.⁵⁴⁰
- 4.194 The absence of supervision by a qualified orthopaedic surgeon meant that the treatment of this woman at Hervey Bay Hospital was unreasonable. Alternative treatment and/or her earlier transfer ought to have occurred.⁵⁴¹

Patient P436

- 4.195 This man suffered an unstable fractured hip and was operated upon by Dr Krishna on 26 March 2004. The injury was more than the normal injury that

⁵³⁴ T5775 line 10 (Dr Mullen)

⁵³⁵ T5775 line 20

⁵³⁶ T6492 line 40 (Dr Krishna)

⁵³⁷ T6492 line 45, 6494 line 25

⁵³⁸ T6492 line 50

⁵³⁹ T6492 line 20, 6493 line 40

⁵⁴⁰ T5775 line 50 – 5776 line 10

⁵⁴¹ T5776 line 30 (Dr Mullen)

occurs to a person who falls over at home and breaks his hip.⁵⁴² He was a heavy man. According to Dr Mullen he suffered a subtrochanteric fracture, which is a fracture at the point where the hip bone meets the thigh bone.⁵⁴³ Dr Mullen said that this was an area that was very difficult to treat. Often fixation failure occurs.⁵⁴⁴ The fracture also was comminuted which meant it had multiple fractures.⁵⁴⁵

- 4.196 Symptoms indicative of problems with healing were not detected in outpatients by Dr Krishna. It was only when Dr Mullen became involved a month after the discharge of the patient from outpatients clinic that significant problems of healing were discovered. Dr Mullen's review of the x-rays indicated that the type of fixation used was very inadequate.⁵⁴⁶ There were only four screw holes in the plate to fix the bone to the shaft.⁵⁴⁷ Dr Mullen said that, if this type of procedure was to be used, between eight and 12 holes on the femoral shaft were needed to get good strength on the bone.⁵⁴⁸ In addition, he said that there were some different techniques available at the time of the operation that were better suited to the situation,⁵⁴⁹ such as a very long plate with a different type of screw into the ball of the femur or a big long nail that goes into the canal of the bone.⁵⁵⁰
- 4.197 When seen by Dr Mullen, the patient had a non-united proximal femoral fracture with femoral head osteonecrosis collapse and osteoarthritis.⁵⁵¹ The patient subsequently required a 6 hour joint reconstructive surgery that could have been avoided by appropriate earlier supervision.⁵⁵² Both the absence of an orthopaedic surgeon to assist Dr Krishna through the procedure and in outpatients may have led to this patient suffering significant problems with his fracture not healing properly.⁵⁵³
- 4.198 Dr Krishna disagreed that that the injury was a subtrochanteric fracture saying instead that it was intertrochanteric.⁵⁵⁴ He disagreed that the procedure required supervision.⁵⁵⁵ He disagreed that it is very difficult to get proper fixation of a fracture at the point where the hip bone meets the thigh bone, despite it being unstable, or that fixation failure often occurred.⁵⁵⁶

⁵⁴² T5777 line 35 (Dr Mullen)

⁵⁴³ T5777 line 40

⁵⁴⁴ T5777 line 40

⁵⁴⁵ T5777 line 45 (Dr Mullen)

⁵⁴⁶ T5777 line 50 (Dr Mullen)

⁵⁴⁷ T5777 line 55

⁵⁴⁸ T5777 line 55

⁵⁴⁹ T5777 line 60

⁵⁵⁰ T5778 line 10

⁵⁵¹ T5778 line 20 (Dr Mullen)

⁵⁵² T5778 line 40 (Dr Mullen)

⁵⁵³ T5779 line 10 (Dr Mullen)

⁵⁵⁴ T6496 line 30

⁵⁵⁵ T6494

⁵⁵⁶ T6494-5

- 4.199 I accept the opinions of Dr Mullen. This is another example of Dr Krishna's over confidence. But the real problem was that supervision was not available as it should have been.

Review of patients by Dr Crawford

- 4.200 Following the release of the North Giblin report, Queensland Health set up a Patient Liaison Service whereby patients who had been the subject of orthopaedic procedures by the doctors at the Hervey Bay Hospital could have those procedures reviewed if they wished to do so.⁵⁵⁷ Dr Scott Crawford, a full time staff orthopaedic surgeon at the Prince Charles Hospital, along with other orthopaedic surgeons, visited the hospital a number of times and reviewed a total of 90 patients.⁵⁵⁸
- 4.201 As a result of those reviews, he found a mixture of outcomes. There were patients with good outcomes including some with better than expected outcomes.⁵⁵⁹ There were patients where the outcomes were not satisfactory.⁵⁶⁰ Dr Crawford said the sample was too selective to be able to draw any statistical results about Dr Krishna's or Sharma's practice.⁵⁶¹ He did not see enough to assess their level of competence.⁵⁶² However, he gave evidence of five patients where treatment had been less than optimal. In the last case relating to P446, the treating surgeon was Dr Naidoo; Dr Krishna in that case played only a relatively minor role.⁵⁶³

Patient 442

- 4.202 P442 was a man operated on by Dr Krishna on 28 January 2004. The patient first presented in outpatients in October 2003, suffering bilateral hammer toes more severe to the left side. X-rays showed osteoarthritis but he apparently was not noted to have had a history of rheumatoid arthritis. On 28 January 2004 he underwent surgery involving excision of the 2nd and 4th metatarsal heads, excision of the PIP joints to the lesser four toes, extensor tenotomies and K wiring.⁵⁶⁴
- 4.203 The decision of Dr Krishna that surgery was required was a correct one according to Dr Crawford.⁵⁶⁵ However, the procedure that he performed was wrong and not a standard procedure for such condition for two reasons. First, the MTP joints were dislocated on x-ray and showed rheumatoid arthritis. The

⁵⁵⁷ Exhibit 404 para 6 Statement of Crawford

⁵⁵⁸ Exhibit 404 paras 8,9 Statement of Crawford

⁵⁵⁹ Exhibit 404 para 13 Statement of Crawford

⁵⁶⁰ Exhibit 404 para 13 Statement of Crawford

⁵⁶¹ 6302 line 30 – 6303 line 1

⁵⁶² T6314 line 25-45

⁵⁶³ T6313 line 1-35

⁵⁶⁴ Exhibit 405

⁵⁶⁵ Exhibit 405

standard procedure, in such circumstances, should have been to stiffen one row of joints, the PIP joints, in the toes and to excise a second row, the MTP joints, and leave them floppy.⁵⁶⁶ The patient was booked in for this surgery.⁵⁶⁷ But the operation that occurred stiffened both rows of joints not just one. Dr Crawford was not aware of this as a procedure.⁵⁶⁸ The MTP joints should not have been fused. Secondly, only the 2nd and 4th metatarsal heads were resected.⁵⁶⁹ Bone should have been taken from all four lesser toes.⁵⁷⁰ This potentially would cause increased pressure on the 3rd and 5th metatarsal heads. Insufficient bone also was resected.⁵⁷¹

- 4.204 Dr Crawford said that the procedure is not one that would have occurred if an orthopaedic surgeon had been supervising Dr Krisha.⁵⁷² The procedure for hammer toes was one which, according to the scope of practice approved by Dr Naidoo, Dr Krishna was allowed to do without supervision. Dr Crawford said he would have needed to have seen Dr Krishna perform a number of these procedures before certifying him as capable of performing them without supervision.⁵⁷³ Dr North had had a similar view.⁵⁷⁴
- 4.205 Dr Krishna agreed that he had performed the operation in an inappropriate fashion and that he should have done an incision of the whole four metatarsal heads.⁵⁷⁵
- 4.206 When seen by Dr Crawford on 2 June 2005, the patient had minimal movement in his 2nd and 4th MTP joints, large callosities under the 2nd and 4th heads and pain. The patient said that he was a lot worse off then prior to his surgery.⁵⁷⁶ Dr Crawford, subsequently, performed corrective surgery on the patient.⁵⁷⁷

Patient 443

- 4.207 This patient was operated on by Dr Sharma. She suffered Dupuytren's disease in her left hand. Her operation on 8 December 2004 was for the release of the disease. Dr Crawford said that the location, on the front of the fingers, is a notoriously bad area for scarring.⁵⁷⁸ To avoid scarring and later complications from scarring, incisions of a particular type (known as Brunner incisions) prudently ought to have been performed. The operative notes

⁵⁶⁶ T6298 line 25 (Dr Crawford)

⁵⁶⁷ T6298 line 30 (Dr Crawford)

⁵⁶⁸ T6298 line 40, 6299 line 20

⁵⁶⁹ T6298 line 50-6299 line 10 (Dr Crawford)

⁵⁷⁰ T6299 line 10 (Dr Crawford)

⁵⁷¹ Exhibit 405 p2 second last para

⁵⁷² T6299 line 20

⁵⁷³ T6299 line 35

⁵⁷⁴ Exhibit 313

⁵⁷⁵ T6520 line 30-40

⁵⁷⁶ Exhibit 405 para 1

⁵⁷⁷ Exhibit 404 para 14 Statement of Crawford

⁵⁷⁸ T6304 line 25

recorded these incisions as having purportedly been done.⁵⁷⁹ However, from his observation of the scars, Dr Crawford said that they had not been done.⁵⁸⁰ They were relatively straight scars. Both had formed keloid scars and this resulted in complications.⁵⁸¹ When seen by Dr Crawford, the patient had suffered contracture of the scar and limitation of extension and flexion as a result of the less extensive incision having been made.⁵⁸²

- 4.208 The procedure was within Dr Sharma's scope of service list of unsupervised procedures. Dr Crawford said that it was not the type of surgery that he would have left to be done unsupervised until he was satisfied with a person's competence. In fact, because of its complexity, Dr Crawford stated that he no longer performs it. He refers it to a Hand Surgeon.⁵⁸³
- 4.209 Dr Crawford has referred the patient to Dr Rowan, a Hand Surgeon, for future care and corrective surgery.⁵⁸⁴

Patients P444 and P445

- 4.210 Each of these patients had first MTP joint fusions performed by Dr Krishna unsupervised. Again this was a procedure which, according to the scope of practice approved by Dr Naidoo, Dr Krishna was allowed to do without supervision. Dr Krishna did not ask for supervision for either operation. The results in each operation, as acknowledged by Dr Krishna,⁵⁸⁵ were poor and resulted in some functional limitation and subsequent corrective surgery.⁵⁸⁶ The selection of the procedure that was done was reasonable. The critical aspect related to the position in which the joint was fused. If it is not quite right, patients will often have ongoing pain or difficulty with walking or with footwear.⁵⁸⁷ In each of these cases, the position achieved was not right.⁵⁸⁸ Positioning the joint fusion is a matter of clinical judgment.⁵⁸⁹
- 4.211 Dr Mullen said that this procedure should not have been done without supervision.⁵⁹⁰ Dr Crawford was less committal saying that it depended upon Dr Krishna's technical abilities and past experience with the particular procedure.⁵⁹¹ Dr Crawford, however, said that in respect of P444, an orthopaedic surgeon, in most cases, would have done the procedure better.⁵⁹²

⁵⁷⁹ Exhibit 406 para 2 Dr Crawford's Medical Report to Dr Ogunseye dated 24.6.05

⁵⁸⁰ T6304 line 30, 50

⁵⁸¹ Exhibit 406 para 2 Dr Crawford's Medical Report to Dr Ogunseye dated 24.6.05

⁵⁸² Exhibit 406 para 2 Dr Crawford's Medical Report to Dr Ogunseye dated 24.6.05

⁵⁸³ T6305 line 20

⁵⁸⁴ Exhibit 406

⁵⁸⁵ T6500 and 6499

⁵⁸⁶ Exhibits 407 and 408

⁵⁸⁷ T6306 (Dr Crawford)

⁵⁸⁸ T6306 line 30 (Dr Crawford)

⁵⁸⁹ T6317 line 40

⁵⁹⁰ T5817 line 50 and circled on Exhibit 365 (B of B)

⁵⁹¹ T6306 line 50 – 6307 line 10

⁵⁹² T6306 line 40

He also said that a better result would have been likely if Dr Krishna had been supervised.⁵⁹³

- 4.212 Dr Crawford performed corrective surgery on both P444⁵⁹⁴ and P445⁵⁹⁵ to re-adjust the angle of the joint.

Patient 446

- 4.213 This patient suffered what Dr Crawford described as a 'very nasty'⁵⁹⁶ fracture of the tibial plateau. It was openly reduced and internally fixed on 24 May 2004 by Dr Naidoo, assisted by Dr Krishna.⁵⁹⁷ Subsequently, presumably because the fracture was not properly reduced and held, a second operation was performed on 2 June 2004 again by Dr Naidoo and Dr Krishna.⁵⁹⁸ Both operations caused Dr Crawford concern.⁵⁹⁹
- 4.214 Dr Crawford said that these fractures were complex fractures that are difficult to treat.⁶⁰⁰ It involves a break that extends into the knee joint; the joint services are split apart and some of the bone pushed out.⁶⁰¹ To achieve the best outcome for the patient, the bone needs to be reduced back to the right position and held there.⁶⁰² Upon a review of the x-rays, Dr Crawford found that, in the first operation, the screws used were too short to get across the two pieces of bone and hold them together.⁶⁰³ Dr Crawford also formed the view that the bone had not been reduced and put back together well.⁶⁰⁴
- 4.215 In the second operation, another lot of screws were put in to try and pull the bone back together as the bones were in the wrong place. Dr Crawford said that in his opinion the bones could not be pulled back together with just screws.⁶⁰⁵ An experienced orthopaedic surgeon should have recognised this⁶⁰⁶ and reopened the wound in order to move the bone back into place.⁶⁰⁷
- 4.216 The patient has suffered an increased significant chance of developing arthritis later in life as a result of the way the procedures were performed.⁶⁰⁸

⁵⁹³ T6306 line 50

⁵⁹⁴ T6305 line 40

⁵⁹⁵ T6307 line 30

⁵⁹⁶ T6308 line 30

⁵⁹⁷ Exhibit 409

⁵⁹⁸ Exhibit 409

⁵⁹⁹ T6308 line 50 (Dr Crawford)

⁶⁰⁰ T6308 line 30

⁶⁰¹ T6309 line 15

⁶⁰² T6309 line 20

⁶⁰³ T6309 line 30

⁶⁰⁴ T6309 line 40

⁶⁰⁵ T6310

⁶⁰⁶ T6311 line 1

⁶⁰⁷ T6311 line 10

⁶⁰⁸ T6311 line 20 (Dr Crawford)

- 4.217 Dr Naidoo said that it was a difficult operation.⁶⁰⁹ He said, as best as he could see at the time of the operation, the fracture had been reduced back to its correct position.⁶¹⁰ Dr Naidoo accepted that x-rays after the first operation showed that the bone had not been put back into place.⁶¹¹ Dr Naidoo disagreed the screws used in the first operation were too short or that a proper fixation had not occurred.⁶¹² He also disagreed with Dr Crawford's opinion that the second operation should have involved opening up the wound. He said he did not undertake this more extensive procedure because it would expose the patient to infection.⁶¹³
- 4.218 In all of the above cases, I accept the opinions expressed by Dr Crawford and Dr Mullen generally as I have set them out. They show primarily two problems. The first, a constant and serious problem, was the lack of supervision of two relatively inexperienced surgeons and permission to them to operate, without supervision, in circumstances where they ought to have been supervised. This put at serious risk the safety of orthopaedic patients, both in emergency and in elective surgery and resulted in some harmful consequences. The second was the lack of care and skill shown by Dr Naidoo.

The North Giblin report and aftermath

North Giblin report and the cessation of orthopaedic services

- 4.219 The North Giblin report was delivered on 6 May 2005. It revealed serious deficiencies in the functioning of the orthopaedic department; in particular its grossly inadequate clinical staff numbers and concern about Dr Naidoo being unavailable to provide adequate supervision of the Senior Medical Officers when operating.⁶¹⁴ It recommended that the Director-General of Health cease all orthopaedic surgical health care activity within the District and arrange the transfer and referral of all elective and trauma patients to a hospital sufficient in size and complexity to handle such referrals.⁶¹⁵
- 4.220 On or about the 18 May 2005, Dr Kwon withdrew his services on the basis of the recommendation of the North Giblin report that all orthopaedic services cease.⁶¹⁶ In consequence, the orthopaedic services at the Hervey Bay Hospital ceased.

⁶⁰⁹ T6699 line 45

⁶¹⁰ T6699 line 50

⁶¹¹ T6700 line 30

⁶¹² T6700 line 15, T6711 line 10

⁶¹³ T6700 lines 50 - 60

⁶¹⁴ Exhibit 38 para 22 - 25

⁶¹⁵ Exhibit 38 para 28, 31

⁶¹⁶ Exhibit 336 para 250 Statement of Buckland

Queensland Health's response to the North Giblin report

- 4.221 As Dr Crawford said⁶¹⁷ it would have been reasonably expected that, immediately Queensland Health became aware of any situation, such as that revealed at Hervey Bay, it would have responded to it appropriately regardless of whether the North Giblin report became public or not. However, that just did not happen. Queensland Health delayed at several stages. Each had the consequence of permitting continuation of a serious risk of harm to patients.
- 4.222 There was some delay in Drs North and Giblin finalising the report. It was finalised in late 2004. This delay, Dr North said, was due to delay in obtaining documentation.⁶¹⁸ Dr North understood some of that documentation had been requested before their arrival through the federal office of the Australian Orthopaedic Association but he said that he could not be certain it was done.⁶¹⁹ The request for documentation to be made available on arrival for their inspection was disputed by Mr Allsopp⁶²⁰ and Mr Hanelt.⁶²¹
- 4.223 In any event, despite the report having been completed in late 2004,⁶²² the report was not delivered until 6 May 2005. The reason for this was primarily the concern expressed by the investigators and the Australian Orthopaedic Association about an indemnity.⁶²³ The Australian Orthopaedic Association was concerned that the indemnity did not extend to that organisation, and the investigators were concerned that the indemnity ceased prior to delivery because of the passing of the initial deadline.⁶²⁴ Dr Buckland did not move immediately to dispel those concerns by openly stating that these indemnities were given. Indeed, the matter rested with the report being completed and not delivered because of the indemnity issue until the Australian Orthopaedic Association raised it again on or about 13 April 2005⁶²⁵ which was after the circumstances of Dr Patel were revealed in the media⁶²⁶. There was then a change in attitude by Queensland Health.⁶²⁷
- 4.224 Although I do not suggest that officers of Queensland Health ought to have known of the contents of the report before it was received, given the concerns that led to its commissioning, it was plainly in the interests of patient safety that receipt of the North Giblin report be obtained as soon as possible. It was, at least, careless of Dr Buckland and Queensland Health to permit such a long

⁶¹⁷ T6295 line 50

⁶¹⁸ Exhibit 38 para 4; T5185 line 40 – T5186

⁶¹⁹ T5185 line 45, 5220 line 1

⁶²⁰ Exhibit 456 para 4.9 Statement of Allsopp

⁶²¹ Exhibit 444A para 29 Statement of Hanelt

⁶²² T5156 line 1, 5182 line 50 (Dr North)

⁶²³ T5156 line 30

⁶²⁴ Exhibit 400 paras 15 – 26 Statement of Beh

⁶²⁵ Exhibit 336 para 239 Statement of Buckland

⁶²⁶ Exhibit 400 para 20 Statement of Beh

⁶²⁷ T5181 line 20 (Dr North)

period of time to elapse whilst negotiations continued about matters of indemnity. Dr Buckland said that he had not heard further about the report between about October 2004 and 13 April 2005.⁶²⁸ He then contacted the Australian Orthopaedic Association and the Legal and Administrative Law Unit to progress the matter.⁶²⁹

- 4.225 On the day on which he received the report, 6 May 2005, Dr Buckland wrote to Drs North and Giblin saying that 'there appears to be no hard evidence to support your recommendations' and suggesting an urgent meeting so that Drs North and Giblin could explain how they came to their conclusions. This is an extraordinary response to what appeared to be a dangerous situation requiring immediate action. Yet it bears a striking similarity to Dr Buckland's approach when confronted with the even more serious complaint at Bundaberg; to criticize the critics and to conceal the criticism rather than to deal with the problem. The report was written by two eminent and independent orthopaedic surgeons. Its findings were based upon the interviews of various medical, nursing and administrative staff, and on documentation obtained from the hospital. The mere fact that the findings were not conclusive or, even perhaps only preliminary, did not detract from its integrity or reliability. Its conclusions were so serious as to require immediate action.
- 4.226 Dr Buckland conceded that it was a serious matter to continue a service when two respected doctors had thought that, on the evidence they saw, it should be terminated.⁶³⁰ He said, however, that he knew Dr Kwon had commenced work at the hospital and thought that answered the criticisms contained in the North Giblin report.⁶³¹ But, as Dr Buckland was aware,⁶³² the locum employment of Dr Kwon did not change the numbers of orthopaedic surgeons at the hospital. Dr Kwon was employed because Dr Naidoo was on leave. As Dr Buckland should have seen from the North Giblin report, Drs North and Giblin had expressed the view that a minimum of four specialists orthopaedic surgeons were required to deliver orthopaedic services of an adequate and safe nature.
- 4.227 Dr Buckland was not the only senior Queensland Health officer to adopt this inadequate response. Dr Scott, then Senior Executive Director Health Services, and Dr FitzGerald, the Chief Health Officer, adopted similarly dismissive and careless views of the findings and recommendations of the North Giblin report. Dr Scott, in a memorandum to Dr Buckland dated 10 May 2005, advised Dr Buckland that he agreed that Drs North and Giblins observations seem to be based on advice from a range of parties and not on

⁶²⁸ Exhibit 336 paras 238 – 239 Statement of Buckland

⁶²⁹ Exhibit 336 para 240 Statement of Buckland

⁶³⁰ T5551 line 45

⁶³¹ Exhibit 336 para 242 T5551 line 50; Statement of Buckland

⁶³² T5552 line 15 – 5553 line 10

clinical material. He said that he thought that the management and doctors at the Fraser Coast Health District ought to be given an opportunity to respond in order to deliver natural justice and that he would make arrangements for the operative skills of the doctors to be assessed though the Skills Development Centre at the Royal Brisbane and Womens Hospital.⁶³³

- 4.228 Dr FitzGerald, in a memorandum to Dr Buckland dated 12 May 2005, advised that, although the report identified issues of serious concern, it included material which was potentially defamatory and legal advice was necessary prior to any release. In addition, he told Dr Buckland that the investigators had not sought or been in a position to validate any of the concerns and ordinarily such concerns would require a more formalised investigation; the information collected in relation to clinical standards was circumstantial and not validated; the recommendation to cease orthopaedic services would have significant clinical, legal, industrial and community implications; and it would not be wise to take such dramatic action.⁶³⁴
- 4.229 Drs North and Giblin did not meet with Dr Buckland as requested. They felt the meeting might compromise their recommendations. Moreover, there was concern that the meeting may not be covered by the indemnity from Queensland Health, which protected them from liability arising from their findings and recommendations in the report only until delivery of the report. Drs North and Giblin thought it was more prudent for officers of the State Orthopaedic Association to meet with the Director-General.⁶³⁵ Such a meeting subsequently occurred.⁶³⁶ Despite such meeting, and as was evident in Queensland Health's objection to the making of the report an exhibit in the former Commission of Inquiry, the attitude remained that the North Giblin report was unreliable.
- 4.230 The North Giblin report was produced to the previous Commission upon a summons for its production on 11 May 2005. Queensland Health objected to it becoming an exhibit, submitting that it was highly defamatory, expressed conclusions which were not expressed to be made on the usual evidentiary supports, namely, medical records, and referred to evidence of an unsafe kind, in that it was not evidence within the direct knowledge of the source. There was no substance in any of the objections. I infer that Queensland Health wanted to suppress the report. The report was made an exhibit in the former Commission and made public on 13 May 2005.⁶³⁷

⁶³³ Exhibit 336 attachment SMB75 para 244 Statement of Buckland

⁶³⁴ Exhibit 336 attachment SMB76 para 244 Statement of Buckland

⁶³⁵ T5157 (Dr North)

⁶³⁶ T5158 (Dr North)

⁶³⁷ By Ruling No 2 made 13 May 2005. It was subsequently marked Exhibit 38, T588

Inadequate orthopaedic staff numbers

- 4.231 The major problem facing the orthopaedic department at Hervey Bay throughout the relevant period with which my report is concerned was a grossly inadequate number of specialist staff to provide a safe, adequate orthopaedic service. To achieve a safe adequate service, four specialist orthopaedic surgeons were required. Before Dr Mullen arrived at the Hervey Bay Hospital in 2000, Dr Naidoo was the only specialist there. Although Dr Khursandi from the Maryborough Hospital was available for some on-call consultation and service, he usually did not visit the Hervey Bay Hospital.⁶³⁸ After the appointment of Dr Mullen as a Visiting Medical Officer, the numbers of registered orthopaedic surgeons available rose a little. But Dr Mullen's commitment was only a maximum of two sessions totaling 7 hours per week and a one in four on-call roster and Dr Naidoo was absent from the hospital for substantial periods. From January 2005, Dr Kwon acted as locum in replacement of Dr Naidoo.
- 4.232 Mr Allsopp said that the Senior Medical Officers, Drs Krishna and Sharma were not employed for budget convenience but due to the fact that the hospital was unable to attract additional full time orthopaedic surgeons to the district.⁶³⁹ But the evidence showed that budgetary concerns and activity targets figured prominently in management strategies generally,⁶⁴⁰ as it did at other Queensland public hospitals; in particular, in relation to the employment of the two Senior Medical Officers. The emphasis was on reducing elective surgery waiting lists, not patient safety, as the media statement by Mr Allsopp published in the local news paper on 18 January 2003 relating to the employment of two orthopaedic surgeons showed.⁶⁴¹
- 4.233 Dr Hanelt said that, when it is not possible to recruit an adequate number of specialists to provide a continuous specialist service, as he said had been the case in the Fraser Coast Health Service District, other models of service must be utilised.⁶⁴² He appeared to explain this by saying that, due to the lack of specialists applying for positions, it was necessary to attempt to provide a service with non specialists to manage patients who would potentially have their outcomes adversely affected by treatment delays.⁶⁴³ But there is no evidence of any attempt having been made to assess what patients would have had their outcomes affected by any treatment delay; or to consider the greater risk of permitting unqualified doctors to perform orthopaedic surgery beyond their level of competence. The kinds of injuries referred to by him in

⁶³⁸ Exhibit 431 para 6.1 Statement of Naidoo ; T6734 line 10

⁶³⁹ Exhibit 456 para 4.56 Statement of Allsopp

⁶⁴⁰ See eg Budget Position Summary Exhibit 456 attachment MA14 Statement of Allsopp

⁶⁴¹ Exhibit 314

⁶⁴² Exhibit 444A para 32 Statement of Hanelt

⁶⁴³ Exhibit 444A para 74(i) Statement of Hanelt

his letter to Dr Blenkin, the Queensland President of the Australian Orthopaedic Association, as potentially suffering serious adverse outcomes (namely, contaminated compound fractures and injuries involving acute vascular compromise) were emergency injuries. They were also possibly beyond the competence of the Senior Medical Officers.⁶⁴⁴

- 4.234 The on-call component of the hospital for orthopedic surgeons, from a professional and personal perspective, was impossibly heavy. Dr Hanelt accepted that the on-call roster in the orthopaedic department, indeed in basically every discipline in the Hospital, was too demanding.⁶⁴⁵ In the orthopaedic department, it was unsustainable.⁶⁴⁶ It burnt out and created overtired staff⁶⁴⁷ which increased the risk to patient safety.⁶⁴⁸ Although initially reluctant to accept it,⁶⁴⁹ Dr Hanelt also eventually conceded, correctly, that a one in two on-call roster is so unsafe as to be unreasonable to allow it to continue.⁶⁵⁰

Adverse findings and recommendations

Findings against Dr Naidoo

- 4.235 In view of the doubts raised by Dr Naidoo relating to accuracy of the recording of leave by the Human Resources department, which may upon investigation be justified, I do not make a conclusive finding in this respect but consider there is cause to further investigate whether between August 2002 and February 2005 there were numerous occasions when Dr Naidoo was in Brisbane or otherwise absent from duty when he was not on approved leave and should have been on duty in the Fraser Coast Health Service District.
- 4.236 I find that between July 2003 and August 2004 Dr Naidoo, as Director of Orthopaedics at the Hervey Bay Hospital, authorised Dr Krishna and Dr Sharma to perform, unsupervised, certain orthopaedic procedures which they ought not to have been allowed to perform without supervision by an orthopaedic surgeon. He did this by approving inappropriate scopes of practice and by taking extended leave knowing that was to leave both of the Senior Medical Officers unsupervised.

⁶⁴⁴ Dr Wilson expressed the opinion that he would have excluded surgery vascular work from the elective list of Dr Krishna: see T7335 line 50

⁶⁴⁵ T6757 line 45

⁶⁴⁶ T6756 line 20 (Dr Hanelt)

⁶⁴⁷ T6758 line 10 (Dr Hanelt)

⁶⁴⁸ T6758 line 15, 6756 line 30 (Dr Hanelt)

⁶⁴⁹ T6756 line 40,

⁶⁵⁰ T6758 line 15

- 4.237 The circumstances were not entirely Dr Naidoo's making. Much, and depending upon further investigations, perhaps all, of his leave absences were approved. Further, as the Area of Need position description for the initial appointment of Drs Krishna⁶⁵¹ showed, the person whom the hospital was seeking to assist Dr Naidoo, at least at that time, was someone who, upon appointment, was capable of 'providing management of a wide range of conditions with minimal supervision'. Dr Hanelt said that Dr Naidoo was aware that what the hospital had been seeking was someone who would be, upon appointment, capable of providing management of a wide range of conditions with minimal supervision.⁶⁵² That was plainly not Dr Krishna, at least until some expert assessment of his skill and competence had so certified him. Moreover, as I find below, the situation, which existed and was condoned by the administrators, was one where more specialists than just Dr Naidoo were required to provide an adequate and safe 24 hour orthopaedic service.

Recommendations against Dr Naidoo

- 4.238 I recommend that the Director-General of Queensland Health conduct an investigation into whether Dr Naidoo has been absent from duty without approved leave and without reasonable excuse, and if so, consider disciplinary action pursuant to s87 of the *Public Service Act* 1996. I also recommend that consideration be given to the taking of such disciplinary action against Dr Naidoo for carelessly and incompetently allowing Drs Krishna and Sharma to perform unsupervised orthopaedic procedures which they ought not to have been allowed to perform without supervision.

Drs Krishna and Sharma

- 4.239 I do not propose to make any findings against either Dr Krishna or Dr Sharma. Both were frank in acknowledging that they would have preferred more supervision. Dr Krishna stated he had not applied for an appropriate accreditation because of the lack of supervision. Neither of them can be blamed for being reluctant to speak out about their lack of supervision or the over assessment made of their skills. As Dr Sharma hinted, their employment was in the hands of their supervisors.⁶⁵³ It is true that Dr Krishna was overconfident about what he was capable of doing without supervision. But if he had been assessed by some process, such as credentialing and clinical privileging, and supervised as he also should have been, that would not have been a serious problem. Both now have general registration subject to supervisory conditions.

⁶⁵¹ Exhibit 444A attachment THM31 Statement of Hanelt

⁶⁵² T6760 line 10

⁶⁵³ T5699 line 5

Findings against administrators Mr Allsopp and Dr Hanelt

- 4.240 As in the case of the Bundaberg Base Hospital, the shortcomings of these administrators must be viewed in the context of the high priority placed upon budget integrity and throughput by Queensland Health with potential financial penalties upon Districts that do not achieve activity targets.⁶⁵⁴ Moreover, I accept that a District Manager who exceeded his budget risked dismissal and that that had occurred.
- 4.241 However, as Dr Hanelt acknowledged,⁶⁵⁵ it is the responsibility of administrators to deliver health care, not only in the most efficient manner, but also in the safest manner that is possible within the budget constraints that exist. In Hervey Bay, as in Bundaberg and elsewhere, there was a constant tension between these responsibilities.
- 4.242 But, in the end, the administrators of a public hospital must put patient safety first. The provision of a 24 hour orthopaedic service at Hervey Bay was such a risk to patient safety that no reasonable administrator should have permitted it to continue, as each Mr Allsopp and Dr Hanelt carelessly did. No doubt some limited emergency service should have been provided, in which Drs Krishna and Sharma were substantially limited in the operations they could perform until they were properly assessed. Anything more was plainly beyond the capacity of the medical staff.
- 4.243 Mr Allsopp and Dr Hanelt both carelessly and incompetently failed in their duty to patients by allowing the situation to continue as they did, particularly after problems were brought to their attention by Dr Mullen and nursing staff. Even after the release of the North Gibling report, and initially in statements to this Commission, each of them continued to deny the existence of any patient safety concerns and to protest against the cessation of the orthopaedic service. Only in cross examination was it accepted, at least by Dr Hanelt, that so long as the Senior Medical Officers were not receiving adequate supervision, the services being provided by them were unsafe. This belated response reflects a greater concern by both with maintaining the service and the budget than with patient safety.
- 4.244 The administrators did not, as Mr Allsopp said they did, '[have] to continue to provide the service'.⁶⁵⁶ That this was not obvious to them is alarming. If it is the case that a shortage of doctors did not permit a full service to be provided safely, a full service should not have been provided. A service should have been provided only to the extent that it was safe. Patient safety should never have been compromised. I find that, by their actions and inaction, both Mr

⁶⁵⁴ Exhibit 444A para 74(vi) Statement of Hanelt

⁶⁵⁵ Exhibit 444A para 74(vi) Statement of Hanelt

⁶⁵⁶ T7085 line 15

Allsopp and Dr Hanelt compromised patient safety and that this had harmful consequences at least in the identified cases to which I have referred.

- 4.245 I find that each of Mr Allsopp and Dr Hanelt also carelessly and incompetently failed to implement the Queensland Health policy and local policy on credentialing and clinical privileging, or any alternative process to ensure that the medical practitioners in the Orthopaedic department were credentialed and clinically privileged. This failure resulted in Drs Krishna and Sharma not being properly credentialed or privileged before either commenced in service. Consequently, no limits were properly placed on them in performing orthopaedic procedures or in what they might do when routinely on duty after hours in circumstances where they had inadequate consultant supervision.
- 4.246 The delay of both Mr Allsopp and Dr Hanelt, in having Drs Krishna and Sharma in any way assessed and their scopes of practice reduced to writing until January 2004, was careless and incompetent. Even at that time, Dr Hanelt knew or should have known that the Scopes of Service documents prepared by Dr Naidoo were not sufficiently independent to be relied upon because Dr Naidoo, due to his own frequent absences, was self interested in an over-certification of the competence of the Senior Medical Officers to perform procedures unsupervised.

Recommendations against Mr Allsopp and Dr Hanelt

- 4.247 I recommend that consideration be given to the taking of disciplinary action against each of Mr Allsopp and Dr Hanelt pursuant to s87 *Public Service Act* 1996 for carelessly and incompetently performing their duties.

Findings against Queensland Health and Drs Buckland, Scott and FitzGerald

- 4.248 I find that:
- (a) Dr Buckland and Queensland Health delayed unreasonably in dispelling concerns that Drs North and Giblin, and the Australian Orthopaedic Association, were not indemnified from liability in respect of and of anything arising from the publication of the North Giblin report;
 - (b) Drs Buckland, Scott and FitzGerald and Queensland Health acted unreasonably in failing to close the orthopaedic unit at Hervey Bay Hospital as soon as they received the report; and
 - (c) Drs Buckland and FitzGerald and Queensland Health acted unreasonably in seeking to suppress the report.

I say more about these people in Chapter Six.

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

'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.¹ Townsville is the largest city in Northern Australia,² and has evolved into a government and business centre for North Queensland. In recent years the city's population has swelled to 155,000.³
- 5.7 Approximately 24.2% of the population is over 50 years old,⁴ whilst 6.3% of the population is indigenous.⁵
- 5.8 Townsville is also home to the James Cook University, at which Queensland's second Medical School is located.⁶ 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.⁷ 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.⁸ 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.⁹ 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

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

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

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

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

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

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

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

⁸ http://www.health.qld.gov.au/townsville/Facilities/tville_hosp.asp

⁹ 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.¹⁰ 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.¹¹

- 5.12 The Townsville Hospital is 1375 kilometres from the nearest major hospital, the Royal Brisbane Hospital.¹² 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 Cairns¹³

- 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.¹⁴ 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.¹⁵ 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.¹⁶ Each director carries a clinical workload and an administrative workload.¹⁷ 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.¹⁸ His evidence was that his duties were roughly 50% administrative and 50 per cent clinical.

¹⁰ T3414 line 3

¹¹ http://www.health.qld.gov.au/wwwprofiles/tville_tville_hosp.asp

¹² http://www.health.qld.gov.au/wwwprofiles/tville_tville_hosp.asp

¹³ T3334 line 2

¹⁴ T3328 L51

¹⁵ Exhibit 236 para 8

¹⁶ Exhibit 237 para 8

¹⁷ Exhibit 237 para 8

¹⁸ 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.¹⁹ 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.²⁰ 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.²¹
- 5.17 The budget of each Institute is negotiated each year between the Townsville Executive and the directors of each Institute,²² 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.²³ 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.²⁴ More generally, in that year the Hospital Executive transferred a total of \$8 million from the administrative budget to the clinical institutes.²⁵ 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.²⁶ 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.²⁷ Budget negotiations between the Townsville Executive and the clinical institutes may even take place before the annual

¹⁹ Exhibit 237 para 10

²⁰ Exhibit 237 para 9

²¹ Exhibit 251 para 14; T3573 line 56

²² T3329 line 1

²³ Exhibit 251

²⁴ Exhibit 251

²⁵ T3572 line 8

²⁶ T3572 line 11

²⁷ T3536 line 45

budget of the hospital has been agreed by Queensland Health;²⁸ 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.²⁹

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.³⁰ 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.³¹

5.21 This structure is unique to Queensland Health³² 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.³³ 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.³⁴

²⁸ T3536 line 43

²⁹ T3538 line 59 – T3584 line 8

³⁰ Exhibit 237 para 10

³¹ Exhibit 251 line 42

³² Exhibit 251 para 18

³³ Exhibit 251 para 18

³⁴ 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.³⁵
- 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.³⁶ That person is responsible for balancing competing considerations across the entire health service district.³⁷
- 5.24 In the opinion of Mr Drummond it would be possible to implement a similar model of clinical governance in a smaller hospital,³⁸ 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.³⁹

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.⁴⁰ 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.⁴¹
- 5.27 Both Mr Whelan and Mr Drummond were critical of the level of central control exerted by Queensland Health⁴² complaining of frustration with the level of bureaucracy.⁴³ 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.⁴⁴ Many decisions had to be referred to Corporate Office, and that led to inevitable delay.⁴⁵ Clinicians, frustrated by delay, take out that frustration on the local executive. However, the local executive may not be responsible for that delay.

³⁵ Exhibit 251 para 15; T3574 line 25

³⁶ T3328 line 9

³⁷ T3329 lines 1-15

³⁸ Exhibit 251 para 16

³⁹ see Chapter 6

⁴⁰ Exhibit 237 para 1; Exhibit 251 para 2

⁴¹ T3328 L58

⁴² Exhibit 237 para 11

⁴³ Exhibit 236 paras 2 - 6

⁴⁴ Exhibit 236 para 4 - 5

⁴⁵ 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;⁴⁶
- 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;⁴⁷
- Inflexibility with respect to funding arrangements, financial delegations,⁴⁸ and salary packaging;⁴⁹
- Lack of consultation regarding community needs;⁵⁰
- Lack of consultation concerning directions from Corporate Office on procedures to be performed at Townsville;⁵¹ and
- Excessive delay in decision making by Corporate Office.⁵²

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.⁵³ 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.⁵⁴ 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.⁵⁵

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;

⁴⁶ T3531 line 15

⁴⁷ T3337 line 55

⁴⁸ T3574 line 20

⁴⁹ T3584 line 10-40

⁵⁰ Exhibit 236 para 7

⁵¹ 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

⁵² Exhibit 236 paras 5-6

⁵³ T3334 line 51

⁵⁴ T3334 line 5

⁵⁵ 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;⁵⁶
 - difficulties attracting suitable medical staff;⁵⁷
 - onerous on-call duties;⁵⁸
 - 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 model⁵⁹ 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).⁶⁰
- 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.⁶¹ A large majority of rural generalists are general practitioners⁶² who also perform procedures such as low risk obstetrics and gynaecology, anaesthetics, general surgery, and orthopaedics.⁶³

⁵⁶ T3334 line 2

⁵⁷ Exhibit 233 Paras 16 - 19

⁵⁸ Exhibit 243 paras 8 – 9

⁵⁹ that the southern or central zones of Queensland Health

⁶⁰ Exhibit 56 page 67

⁶¹ Exhibit 297 para 15

⁶² Exhibit 297 para 19

⁶³ 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 Committee⁶⁴ ('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.⁶⁵ 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.⁶⁶ Accordingly, the specific privileges granted to a practitioner will differ between facilities.⁶⁷
- 5.35 It is often difficult to assess a particular practitioner's credentials 'purely on the papers'.⁶⁸ 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.⁶⁹ 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.⁷⁰ Interim clinical privileges for rural practitioners are restricted to general practitioner duties and not for specialty procedures such as obstetrics and anaesthetics.⁷¹ Only after formal assessment by the Rural Committee are any specialist privileges awarded.⁷²
- 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,⁷³ 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.⁷⁴ For example, at present, the Mount Isa Hospital uses the Townsville Hospital's credentialing and clinical privileging

⁶⁴ Exhibit 297 para 32

⁶⁵ Exhibit 297 para 33

⁶⁶ Exhibit 297 para 33

⁶⁷ Exhibit 297 para 33

⁶⁸ Exhibit 297 para 36

⁶⁹ Exhibit 297 para 37

⁷⁰ Exhibit 56

⁷¹ Exhibit 297 para 38

⁷² Exhibit 297 para 38

⁷³ For example, the Mt Isa Hospital

⁷⁴ T3416 L1

committee to assess those of its staff that are providing specialist services,⁷⁵ 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,⁷⁶ and it can call on academic staff from the James Cook University Medical School,⁷⁷ 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.⁷⁸ Dr Andrew Johnson, gave evidence that the hospital needed another 40 beds immediately in order to cope with the demand placed on its services,⁷⁹ 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.⁸⁰ Dr Symmons stated that access block is a direct result of a lack of inpatient beds.⁸¹
- 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.⁸² He considered that the Hospital would be financially punished for cancelling elective surgery even when faced with severe access block in the

⁷⁵ T3416 L29

⁷⁶ T3335 line 40

⁷⁷ T3392 line 45

⁷⁸ T3344 line 16

⁷⁹ T3344 line 17

⁸⁰ Exhibit 249 para 12

⁸¹ Exhibit 249 para 10

⁸² Exhibit 249 para 16

Emergency Department.⁸³ 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.⁸⁴ 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.⁸⁵ Access block has caused numerous adverse effects on patients and staff including:⁸⁶

- 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.⁸⁷

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 1994.⁸⁸ Prior to that Dr Rossato was the only neurosurgeon in Townsville and had been since 1979.⁸⁹ The neurosurgery unit at the Townsville Hospital has been increasingly busy in recent years.⁹⁰ 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.⁹¹ In recent years a neurosurgeon who practised in Rockhampton, Dr

⁸³ Exhibit 249 para 16

⁸⁴ Exhibit 249 para 11

⁸⁵ Exhibit 249 para 11

⁸⁶ Exhibit 249 attachment 'DADS2'

⁸⁷ Exhibit 249 para 17 and 18

⁸⁸ 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

⁸⁹ Exhibit 243 para 7,8

⁹⁰ Exhibit 243 para 20

⁹¹ Exhibit 243 para 21 and 22

John Baker, closed his practice and moved to Brisbane.⁹² 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.⁹³ 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.⁹⁴ For some years, Dr Guazzo had also been advocating for a third neurosurgeon to be employed by the Townsville Hospital.⁹⁵ Dr Rossato, as the Director of Surgery at the Townsville Hospital, had been attempting to recruit a third neurosurgeon to Townsville for some time.⁹⁶

- 5.46 In May 2004, Dr Guazzo resigned as a Visiting Medical Officer.⁹⁷ 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.⁹⁸ 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.⁹⁹
- 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 resume¹⁰⁰ was provided to Dr Rossato in late December 2004. Dr Myers is an American trained neurosurgeon, who passed his American Medical Board Exams in 1980.¹⁰¹ In 1984 he was certified as a neurosurgeon by the American Board of Neurological Surgery.¹⁰² He practised as a neurosurgeon in various hospitals in Philadelphia until 2001.¹⁰³ Dr Myers gave evidence that in 2001 there was a medical indemnity crisis in Philadelphia, and he decided to retire from his practice.¹⁰⁴ 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.¹⁰⁵

⁹² Exhibit 243 para 21

⁹³ Exhibit 243 para 21

⁹⁴ Exhibit 242 para 12

⁹⁵ Exhibit 242 para 5

⁹⁶ Exhibit 243 para 23

⁹⁷ Exhibit 242 para 13

⁹⁸ Exhibit 242 para 14

⁹⁹ Exhibit 242 para 14

¹⁰⁰ Exhibit 243 attachment RGR-1

¹⁰¹ Exhibit 241 para 3

¹⁰² Exhibit 241 para 4

¹⁰³ Exhibit 241 para 7

¹⁰⁴ Exhibit 241 para 7 and 8

¹⁰⁵ 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.¹⁰⁶ Dr Rossato had some concerns about the recency of his practice.¹⁰⁷ However, following an interview¹⁰⁸ and contacting two referees,¹⁰⁹ 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.¹¹⁰ 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.¹¹¹
- 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 2005.¹¹²
- 5.51 Dr Myers was appointed as a locum Senior Medical Officer in neurosurgery.¹¹³ 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.¹¹⁴ Dr Guazzo believed Dr Myers to be a well qualified and capable neurosurgeon. However, he had some concerns about the process of his appointment,¹¹⁵ specifically:
- That he, as the second neurosurgeon at the Townsville Hospital,¹¹⁶ 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;¹¹⁷
 - The level of supervision of Dr Myers that may be required given his recency of practise;¹¹⁸
 - That Dr Myers had, at least initially, been placed on the 'on-call' roster, without supervision;¹¹⁹ 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

¹⁰⁶ Exhibit 243 para 28 - 30

¹⁰⁷ Exhibit 243 para 30

¹⁰⁸ Exhibit 243 para 32

¹⁰⁹ Exhibit 243 para 33 - 35

¹¹⁰ Exhibit 243 para 36

¹¹¹ Exhibit 241 para

¹¹² Exhibit 243 para 43

¹¹³ Exhibit 243

¹¹⁴ Exhibit 234 para 43

¹¹⁵ T3450 line 26

¹¹⁶ Exhibit 234 para 45

¹¹⁷ Exhibit 234 para 43

¹¹⁸ T3454 L 26

¹¹⁹ 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.¹²⁰ 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,¹²¹ and Dr Guazzo, was unwilling to formally supervise Dr Myers although he did offer collegiate support.¹²²
- 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;¹²³
 - Dr Myers admitted that some of his skills were 'rusty' and he needed to refresh his skills in some areas;¹²⁴
 - 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;¹²⁵
 - 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.¹²⁶
- 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.¹²⁷

¹²⁰ Exhibit 234 para 41

¹²¹ Exhibit 234 para 45

¹²² Exhibit 234 para 46 and T3452 L9

¹²³ Exhibit 234 para 51

¹²⁴ Exhibit 234 para 52

¹²⁵ Exhibit 234 para 52

¹²⁶ Exhibit 234 para 54

¹²⁷ 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 qualifications¹²⁸ 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,¹²⁹ the reason being that often the assessment process for deemed specialist status may take longer than the period of the locum itself.¹³⁰ 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.¹³¹
- 5.58 Therefore it was impractical to apply for a deemed specialist review for most locum appointments.¹³² 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.¹³³ 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.¹³⁴ 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 Guazzo¹³⁵ and Dr Rossato¹³⁶ have been impressed with Dr Myers and both support him seeking specialist accreditation with the Royal Australian College of Surgeons.

¹²⁸ T3353 line 7

¹²⁹ T3353 line 9

¹³⁰ T3353 line 20

¹³¹ T3353 line 25

¹³² T3353 line 34

¹³³ Exhibit 243 para 49

¹³⁴ Exhibit 241 paras 22 - 25

¹³⁵ Exhibit 242 para 32 and T3542 line 25

¹³⁶ 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.¹³⁷

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 neurosurgeon¹³⁸ at the Hospital. The Commission had the benefit of receiving evidence from Dr Myers.¹³⁹ 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.¹⁴⁰
- 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.¹⁴¹ 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.¹⁴² The position was offered to Dr Kalavagunta subject to him being granted deemed specialist status by the Royal Australasian College of Surgeons.¹⁴³ 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.¹⁴⁴
- 5.65 Dr Allen had a significant workload as the sole provider of ear nose and throat surgery at the Townsville Hospital.¹⁴⁵ 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.¹⁴⁶ However, the Townsville Hospital made it clear, at least to Dr Kalavagunta, that any appointment was subject to

¹³⁷ Exhibit 234 para 49

¹³⁸ Exhibit 234 para 54

¹³⁹ Exhibit 241 and T3428 to T3434

¹⁴⁰ Exhibit 241 para 26

¹⁴¹ T3348 line 10

¹⁴² T3348 line 8

¹⁴³ T3348 line 25

¹⁴⁴ Exhibit 235

¹⁴⁵ T3349 line 10

¹⁴⁶ 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.¹⁴⁷ 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.¹⁴⁸

5.67 Dr Lindsay Allen was critical of the delay in the recruiting process,¹⁴⁹ 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.¹⁵⁰ Until suitable staff can be recruited, the Townsville Hospital no longer offers ear nose and throat surgery.¹⁵¹ 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.¹⁵²

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 College¹⁵³ 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

¹⁴⁷ T3348 line 3

¹⁴⁸ T3848 line 38

¹⁴⁹ Exhibit 235

¹⁵⁰ T3350 line 45

¹⁵¹ T3350 line 46

¹⁵² T3350 line 47

¹⁵³ T3348 line 30

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

- 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 USSR¹⁵⁵, 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 1977.¹⁵⁶ He then claimed to have continued his post-graduate study in psychiatry between May 1977 and December 1978.¹⁵⁷
- 5.72 Berg also claimed that he had been a staff member and lecturer at the Voronezh State University between January 1978 and April 1982.¹⁵⁸
- 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 1992.¹⁵⁹ 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.¹⁶⁰
- 5.75 Berg then applied to join the rotational training scheme conducted by the Royal Australian and New Zealand College of Psychiatrists.¹⁶¹ However he was not considered suitable for that scheme due to his lack of recent experience in psychiatry.¹⁶² Nevertheless, Dr John Alexander Allan,¹⁶³ 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.¹⁶⁴ 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

¹⁵⁴ Exhibit 254 Statement of Dr John Allan

¹⁵⁵ Exhibit 234

¹⁵⁶ Exhibit 238, medical based file, Curriculum Vitae of Vincent Berg

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

¹⁵⁸ CV of Vincent Berg Exhibit 234 annexure AJJ-1

¹⁵⁹ Exhibit 235 annexure AJJ-1

¹⁶⁰ Exhibit 245

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

¹⁶² Exhibit 245

¹⁶³ Dr Allan was on the board of the rotational training scheme

¹⁶⁴ Exhibit 245

him favourable references.¹⁶⁵ 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.¹⁶⁶

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)*.¹⁶⁷ 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 no 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.¹⁶⁸

5.80 Not long after Berg commenced duties, Dr Allan began to develop concerns about his clinical practice and performance.¹⁶⁹ 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

¹⁶⁵ T3473 line 23 - 35

¹⁶⁶ Exhibit 245 para 20

¹⁶⁷ Exhibit 238, Medical Board of Queensland File of Vincent Berg

¹⁶⁸ Exhibit 245 Statement of Dr Allan, annexure 'JAA-2' confidential audit

¹⁶⁹ T3473 line 45 - 3475 line 14

there were concerns about him practising independently where he had less supervision, especially after hours when on call¹⁷⁰

- 5.81 Berg was insistent that his Russian training should entitle him to specialist registration as a psychiatrist in Queensland¹⁷¹ 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 he, on behalf of the Townsville Hospital, issued a show cause notice asking him to respond to several allegations about his clinical practice.¹⁷² 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 2001.¹⁷³ His conditional registration expired on 3 January 2001.¹⁷⁴

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.¹⁷⁵ 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.¹⁷⁶ 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

¹⁷⁰ Exhibit 245 para 24

¹⁷¹ T3475 line 15 - 42

¹⁷² Exhibit 245 Statement of of Dr Allan at annexure 'JAA-1'

¹⁷³ Exhibit 245 Statement of of Dr Allan and Exhibit 235 Statement of Dr Johnson

¹⁷⁴ Exhibit 238 Medical Board file on Berg

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

¹⁷⁶ 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 1977.¹⁷⁷

- 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.¹⁷⁸
- 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.¹⁷⁹ 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.¹⁸⁰ 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.¹⁸¹

¹⁷⁷ Exhibit 238

¹⁷⁸ Exhibit 238

¹⁷⁹ Exhibit 238 Medical Board File relating to Vincent Berg

¹⁸⁰ Exhibit 238 Medical Board File relating to Vincent Berg

¹⁸¹ 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.¹⁸²

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.¹⁸³ 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.¹⁸⁴

5.96 On 29 January 2002 Berg applied to the Medical Board of Western Australia for conditional registration under an area of need.¹⁸⁵ 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.¹⁸⁶ 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.

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

¹⁸³ Exhibit 238 email from Vincent Berg to the Medical Board dated 23 December 2001

¹⁸⁴ Exhibit 250 Statement of Michael Demy-Geroe, attachment MDG-17

¹⁸⁵ 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

¹⁸⁶ 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 matter¹⁸⁷

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.¹⁸⁸ 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.¹⁸⁹
- 5.99 The College of Psychiatrists replied to Dr Johnson in a letter dated 2 December 2002¹⁹⁰ 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.¹⁹¹ 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.

¹⁸⁷ 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

¹⁸⁸ Exhibit 245 Statement of Dr Allan, T3481 line 12 - 27

¹⁸⁹ Exhibit 234 annexure 'AJJ-2'

¹⁹⁰ Exhibit 234 annexure 'AJJ-3'

¹⁹¹ 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.¹⁹² 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.¹⁹³ 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.¹⁹⁴

- 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.

¹⁹² Exhibit 376 part C para 15

¹⁹³ Exhibit 376 part 3 para 20

¹⁹⁴ 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 qualifications¹⁹⁵

- 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.¹⁹⁶
- 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 appreciated¹⁹⁷

- 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...

¹⁹⁵ Exhibit 238 Medical Board File on Berg

¹⁹⁶ Exhibit 336 para 217

¹⁹⁷ 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'.¹⁹⁸

- 5.109 On 11 December 2002 Mr Whelan replied to Mr Wise advising him to contact Dr Johnson if any further information was required.¹⁹⁹
- 5.110 On 17 December 2002 Mr Schaefer and Mr Wise wrote to the Crime and Misconduct Commission reporting the suspected official misconduct.²⁰⁰
- 5.111 Mr Whelan had no recollection of referring the matter to the Audit and Operational Review Branch.²⁰¹ 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.²⁰²

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.²⁰³ 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 disziess 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.²⁰⁴ 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

¹⁹⁸ Exhibit 248 attachment KDW-2

¹⁹⁹ Exhibit 248 attachment LDW-3

²⁰⁰ Exhibit 239 Queensland Health Investigation File T3563

²⁰¹ Exhibit 248 para 47

²⁰² Exhibit 245 Statement of Dr Allan

²⁰³ 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.²⁰⁵

- 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 issue²⁰⁶

- 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 2003.²⁰⁷ 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.²⁰⁸

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.²⁰⁹ Dr Buckland stated

²⁰⁵ Exhibit 245, 234, T3360 line 2 – 30, T3481 line 17 - 3483 line 5

²⁰⁶ Exhibit 336 annexure SMB 62

²⁰⁷ Exhibit 336 Statement of Steve Buckland, annexure SMB 63

²⁰⁸ Exhibit 336 Statement of Steve Buckland, annexure SMB 63

²⁰⁹ 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.²¹⁰

- 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;²¹¹
- In the context of other reports located by this Commission,²¹² 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;²¹³
- 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,'²¹⁴ 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

²¹⁰ Exhibit 336 paras 224-228

²¹¹ Exhibit 245

²¹² 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)

²¹³ T3365 line 21

²¹⁴ 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.²¹⁵ 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.²¹⁶
- 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.

²¹⁵ Exhibit 236 Statement of Mr Ken Whelan annexure KDW-4

²¹⁶ 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 facts²¹⁷

- 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.²¹⁸ 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.²¹⁹

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'.²²⁰ 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.²²¹

- 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

²¹⁷ Exhibit 236

²¹⁸ Exhibit 236 para 45

²¹⁹ Exhibit 245 para 45, 46 Statement of Dr Allan

²²⁰ Exhibit 245 para 50 Statement of Dr Allan

²²¹ Exhibit 245 para 50

Schaefer, the Director of the Audit and Operational Review Branch of Queensland Health.²²²

- 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.²²³ 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.²²⁴ It is also apparent that the Crime and Misconduct Commission were advised that Berg was no longer a current employee of Queensland Health.²²⁵ 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.²²⁶
- 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.²²⁷ 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.

²²² Exhibit 239 Queensland Health Investigation File into Vincent Berg

²²³ Exhibit 234 annexure AJJ-7 and T3366 line 12 - 23

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

²²⁵ Exhibit 239 Queensland Health Investigation File into Vincent Berg, letter to Ms Couper

²²⁶ Exhibit 239

²²⁷ 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.²²⁸

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:²²⁹

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.²³⁰ 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.²³¹

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.²³² There is also nothing on the

²²⁸ Exhibit 239 Queensland Health investigation file

²²⁹ Exhibit 239 QH investigation file Memorandum to Director-General dated 30 January 2003

²³⁰ Office of Health Practitioner Registration Boards

²³¹ Exhibit 239 QH investigation file

²³² 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.²³³

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.

²³³ 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 \$58,917.00.²³⁴ 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.

²³⁴ 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

27,000²³⁵ and was the largest inland city in Queensland. Nowadays, the main industries in Charters Towers are mining, beef and tourism.²³⁶

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.²³⁷ 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.²³⁸
- 5.161 The Charters Towers Hospital is a rural hospital,²³⁹ staffed by general practitioners. The medical staff of a hospital such as the Charters Towers Hospital are best described as rural generalists.²⁴⁰ 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.²⁴¹ 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.²⁴²
- 5.162 In 2004, the Charters Towers Hospital had 1522 admissions and provided services to a further 40,892 patients.²⁴³ 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.²⁴⁴
- 5.163 The tragedy subject to the Coronial Inquest, and investigation by Queensland Health, surrounded the treatment of a patient by Dr Izak Maree.

²³⁵ http://www.queenslandholidays.com.au/townsville/charters_towers.cfm

²³⁶ http://www.queenslandholidays.com.au/townsville/charters_towers.cfm

²³⁷ http://www.health.qld.gov.au/wwwprofiles/charters_ctowers_rc.asp

²³⁸ http://www.health.qld.gov.au/wwwprofiles/charters_ctowers_rc.asp

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

²⁴⁰ Exhibit 297

²⁴¹ Exhibit 297 para 21

²⁴² Exhibit 56; Exhibit 297 para 11

²⁴³ http://www.health.qld.gov.au/wwwprofiles/charters_ctowers_rc.asp

²⁴⁴ <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.²⁴⁵ The Charters Towers Hospital had been, unsuccessfully, attempting to recruit an Australian trained and registered doctor to the position.²⁴⁶ In May 2000, an international recruitment firm was engaged, and through this firm Dr Maree became a candidate for the position.²⁴⁷ 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.²⁴⁸ 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.²⁴⁹ 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'.²⁵⁰
- 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.²⁵¹
- 5.168 During the months he was employed at the Charters Towers Hospital, Dr Maree treated a variety of patients,²⁵² performed ward rounds and on-call duties. He also performed procedures in obstetrics²⁵³ and administered anaesthetics,²⁵⁴ as would be expected in a rural hospital such as Charters

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

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

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

²⁴⁸ <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p24)

²⁴⁹ T3407 L22

²⁵⁰ <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p24)

²⁵¹ T3407 L29

²⁵² Exhibit 56 para 9

²⁵³ Exhibit 56

²⁵⁴ particularly caesarean sections; see Exhibit 56 para 51

Exhibit 56 para 52

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

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;²⁵⁷
- General surgery, such as tubal ligation;²⁵⁸
- Accident and Emergency;²⁵⁹
- Anaesthetics;²⁶⁰ and
- General Medicine.²⁶¹

5.170 Dr Maree was never granted clinical privileges by a credentialing or clinical privileging committee,²⁶² 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.²⁶³ Ms Sadadina and her children had been living in Charters Towers for some time.²⁶⁴ 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 Sadabina's fiancé who told him that Ms Sabadina was still in severe pain and her face remained

²⁵⁵ Exhibit 56 para 9

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

²⁵⁷ Exhibit 56 para 34

²⁵⁸ Exhibit 56 para 37

²⁵⁹ Exhibit 56 para 37

²⁶⁰ Exhibit 56 para 42, although Dr Maree only performed 4 general anaesthetics

²⁶¹ Exhibit 56 para 49

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

²⁶³ Exhibit 56 para 58

²⁶⁴ 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.²⁶⁵

- 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.²⁶⁶
- 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.²⁶⁷
- 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.²⁶⁸ At 5:40pm Dr Maree began administering the anaesthetic and almost immediately things began going horribly wrong. Her blood oxygen level began to plummet,²⁶⁹ her heart rate dropped to 40 beats per minute, and Dr Maree had difficulty in ventilating her.²⁷⁰ 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

²⁶⁵ Exhibit 56 para 58

²⁶⁶ Exhibit 56 para 58

²⁶⁷ Exhibit 56 para 59

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

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

²⁷⁰ <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.²⁷¹

- 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.²⁷²
- 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.²⁷³
- 5.178 The death was immediately notified to the Queensland Police Service and an investigation ensued.²⁷⁴

The complaint to Queensland Health

- 5.179 On the next day,²⁷⁵ 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.²⁷⁶ Dr Row provided a copy of his letter to the Medical Board.²⁷⁷ 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.²⁷⁸
- 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.²⁷⁹

The Queensland Health Investigation

- 5.181 The Queensland Health Investigation commenced on 20 December 2000 and concluded in February 2001.²⁸⁰ Dr Johnson and Dr Farlow determined that 11 separate issues were raised in Dr Row's letter of complaint. Dr Johnson and

²⁷¹ <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p9)

²⁷² <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p9)

²⁷³ <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p10)

²⁷⁴ <http://www.justice.qld.gov.au/courts/coroner/findings/Sabadina-findings%20final.pdf> (p10)

²⁷⁵ 18 December 2005

²⁷⁶ Exhibit 56 para 4

²⁷⁷ Exhibit 56 para 4

²⁷⁸ Exhibit 56 para 4

²⁷⁹ Exhibit 56

²⁸⁰ 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.²⁸¹ 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;²⁸²

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:²⁸³

- 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 2000.²⁸⁴ On 19 December 2000, the Medical Board communicated with Queensland Health and was advised that Queensland Health was

²⁸¹ Exhibit 56 para 64

²⁸² Exhibit 56 para 64

²⁸³ Exhibit 56 paras 66, 67

²⁸⁴ <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.²⁸⁵

- 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.²⁸⁶ 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.²⁸⁷

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 2003.²⁸⁸
- 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.²⁸⁹
- 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.

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

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

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

²⁸⁸ <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

²⁸⁹ 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.'²⁹⁰
- 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

²⁹⁰ 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]

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.²⁹¹

- 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

²⁹¹ <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 competence²⁹²

- 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 2000.²⁹³ 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.²⁹⁴ 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,

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

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

²⁹⁴ <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.²⁹⁵

- 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.²⁹⁶

- 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.²⁹⁷ As a medical practitioner, the Northern Zone rural credentialing and privileging committee was to assess Dr Maree's credentials and award him clinical privileges.²⁹⁸ 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.²⁹⁹

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

²⁹⁶ Exhibit 56 page 65

²⁹⁷ Exhibit 257 para 33

²⁹⁸ Exhibit 257 para 32

²⁹⁹ <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.³⁰⁰

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

³⁰⁰ <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.³⁰¹ The total population of Rockhampton and its surrounding districts is approximately 120,000.³⁰² Approximately 29.5% of the population is aged over 50 years, slightly higher than the state average of 28.7%.³⁰³ The indigenous population accounts for approximately 5.4% of the population, above the state average of 3.1%.³⁰⁴ 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.³⁰⁵ Proclaimed as a city in 1902,³⁰⁶ 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 Yepoon.³⁰⁷

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

³⁰¹ http://en.wikipedia.org/wiki/Rockhampton%2C_Queensland

³⁰² <http://www.rockhampton.qld.gov.au/articledetail.asp>

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

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

³⁰⁵ http://en.wikipedia.org/wiki/Rockhampton%2C_Queensland

³⁰⁶ http://en.wikipedia.org/wiki/Rockhampton%2C_Queensland

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

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

- 5.211 The Rockhampton Health Service District includes: the Rockhampton Hospital, three rural hospitals,³¹⁰ and a nursing home.³¹¹ 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.³¹²

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.³¹³
- 5.213 The Rockhampton Hospital, a 227 bed facility,³¹⁴ 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.³¹⁵
- 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.³¹⁶ However, for a number of reasons he moved his practice to Brisbane.³¹⁷
- 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.³¹⁸

³⁰⁸ www.health.qld.gov.au/wwwprofiles, viewed 3 November 2005

³⁰⁹ *Queensland Health Systems Review*, Final Report, September 2005, p78

³¹⁰ the Mount Morgan Hospital, the Yepoon Hospital, and the Woorabina Hospital source:

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

³¹¹ www.health.qld.gov.au/wwwprofiles, viewed 3 November 2005

³¹² As above

³¹³ Exhibit 385 para 7

³¹⁴ http://www.som.uq.edu.au/som/CQ_teachinglocations.shtml

³¹⁵ http://www.health.qld.gov.au/wwwprofiles/rocky_rocky_hosp.asp

³¹⁶ T3439 including Dr Eric Guazzo and Reno Rossato in Townsville.

³¹⁷ T3439 line 30

³¹⁸ 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.³¹⁹ 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.³²⁰ 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.³²¹
- 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.³²² Fellows of the College of Emergency Medicine are entitled to use the letters 'FACEM' following their name.³²³ When employed by Queensland Health, Fellows of the Australasian College of Emergency Medicine are entitled to be paid as Staff Specialists,³²⁴ which attracts higher remuneration than a Senior Medical Officer.³²⁵

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.³²⁶ 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.³²⁷ During the first 11 months of the 2003/04 financial year, a total 35,735 patients attended the Emergency Department.³²⁸
- 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

³¹⁹ www.health.qld.gov.au/www/profiles/rocky_rocky_hosp.asp

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

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

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

³²³ *Medical Practitioners Registration Regulation 2002* ss 6-8, Sch2

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

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

³²⁶ Exhibit 129 para 4

³²⁷ T2240 line 50

³²⁸ T2240

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

- 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,³³⁰ although waiting times for well in excess of this can be common for category five patients.³³¹
- 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.³³² 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.³³³ 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 2004.³³⁴ 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.³³⁵ Queensland Health had not previously provided the report to the Commission, or it seems its own solicitors, despite its obvious relevance.

³²⁹ T2240

³³⁰ As above

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

³³² Exhibit 129 page 4

³³³ Exhibit 129 attachment A

³³⁴ Exhibit 129 page 1

³³⁵ 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.³³⁶ This affected the ability of the Emergency Department to manage and track its patients.³³⁷ 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.³³⁸ 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.³³⁹ 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.³⁴⁰ 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 ... process³⁴¹
- 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,³⁴² 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.

³³⁶ Exhibit 129 pages 6-8

³³⁷ Exhibit 129

³³⁸ Exhibit 129 page 8

³³⁹ As above

³⁴⁰ Exhibit 129 page 6

³⁴¹ Exhibit 129 page 6

³⁴² 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.³⁴³
- 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.³⁴⁴
- 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.³⁴⁵

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.³⁴⁶ 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:³⁴⁷
- 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;

³⁴³ Exhibit 129 pages 8,9,18

³⁴⁴ Exhibit 129 pages 7 and 10

³⁴⁵ Exhibit 129 page 17

³⁴⁶ Exhibit 129 page 12

³⁴⁷ 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.³⁴⁸
- 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.³⁴⁹
- 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.³⁵⁰
- 5.236 The absence of a specialist in emergency medicine adversely affected staff recruitment and retention as well as the standard of clinical care.³⁵¹ 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:³⁵²
- 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.

³⁴⁸ Exhibit 129 page 13

³⁴⁹ Exhibit 129 pages 13-14

³⁵⁰ Exhibit 129 page 14

³⁵¹ Exhibit 129 page 14

³⁵² 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.³⁵³ Ordinarily Medical Emergency Teams do not respond to calls in a hospital's emergency department.³⁵⁴ 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'.³⁵⁵ 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.³⁵⁶

- 5.238 The Miller report made a number of recommendations concerning the procedures in the Emergency Department including:³⁵⁷

- 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.³⁵⁸

- 5.239 In respect of staffing of the Emergency Department the Miller Report recommended:³⁵⁹

- 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

³⁵³ T2241

³⁵⁴ Exhibit 129 page 8

³⁵⁵ Exhibit 129 page 8

³⁵⁶ Exhibit 129

³⁵⁷ Exhibit 129

³⁵⁸ Exhibit 129 pages 1-2

³⁵⁹ 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.³⁶⁰ 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.³⁶¹

5.242 In the United States, emergency medicine specialists must undertake examinations (every ten years) to demonstrate their continued competence.³⁶² Dr Kelley had completed those examinations on two previous occasions, the latest occasion being in 2004.³⁶³

5.243 In March 2005, Dr Kelley moved to Rockhampton with his wife and children to work at the Rockhampton Hospital.³⁶⁴ Within weeks of commencing duties at the Rockhampton Hospital Dr Kelley had serious concerns about the operation of the Emergency Department.³⁶⁵ 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.³⁶⁶

³⁶⁰ T2236 line 34

³⁶¹ T2236 line 55

³⁶² T2236

³⁶³ T2237 line 1

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

³⁶⁵ T2238 line 16

³⁶⁶ 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.³⁶⁷ Internet access at the Hospital was not standard issue to all clinicians.³⁶⁸ 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.³⁶⁹
- 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.³⁷⁰
- 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.³⁷¹ 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.³⁷²
- 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.³⁷³
- 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.³⁷⁴ Indeed, while Dr Kelley was

³⁶⁷ T2239, line 20

³⁶⁸ T2239

³⁶⁹ T2240

³⁷⁰ T2239, T2240

³⁷¹ T2239, T2240

³⁷² T2240

³⁷³ T2244, T2245

³⁷⁴ T2241, T2243

there, the core medical staff of the Department were all overseas trained.³⁷⁵ 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.³⁷⁶

- 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.³⁷⁷ 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.³⁷⁸

- 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.³⁷⁹ However, when he informed the executive, it advised that the Hospital would not accept any applicants through Global Medical Services.³⁸⁰
- 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.³⁸¹

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

³⁷⁵ T2243

³⁷⁶ T2243

³⁷⁷ T2241

³⁷⁸ T2241 line 33

³⁷⁹ T2242 line 25

³⁸⁰ T2242

³⁸¹ 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.³⁸²
- 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.

³⁸² 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.³⁸³
- 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.³⁸⁴ 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 Hospital³⁸⁵ 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 2005.³⁸⁶ 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 2005.³⁸⁷
- 5.259 Until 1996 public cardiac surgical services were provided solely by the Prince Charles Hospital.³⁸⁸ 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,³⁸⁹ 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.³⁹⁰
- 5.260 In order to improve access to cardiac services in Queensland, Princess Alexandra Hospital established its service in 1998-1999.³⁹¹ The Prince Charles Hospital was also funded to address the extensive waiting list which existed for cardiac surgery.³⁹² The Prince Charles Hospital was allocated

³⁸³ Exhibit 301C para 3

³⁸⁴ Exhibit 301C para 15

³⁸⁵ Exhibit 403; Aroney T4801 line 55

³⁸⁶ Exhibit 301C para 17

³⁸⁷ Exhibit 317 para 1.6; T5230 line 15 (Dr Scott)

³⁸⁸ Exhibit 301C para 6

³⁸⁹ Exhibit 301C para 5

³⁹⁰ Exhibit 301C para 6

³⁹¹ Exhibit 301C para 19

³⁹² Exhibit 301C para 19

elective surgery funding during the late 1990s.³⁹³ 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.³⁹⁴

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

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.³⁹⁶ The guidelines represent a much more aggressive strategy of doing angiograms on patients and revascularising them before they die or have further heart attacks.³⁹⁷ Following the release of the guidelines the number of inter-hospital transfers to the Prince Charles Hospital has increased significantly.³⁹⁸ 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.³⁹⁹ 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.⁴⁰⁰ 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.⁴⁰¹ These problems were not alleviated, apparently due to financial constraint.

³⁹³ Exhibit 301C para 19

³⁹⁴ Exhibit 301C para 20

³⁹⁵ Exhibit 301C para 20

³⁹⁶ Exhibit 301C para 7 attachment-MIC1; Aroney T4807 line 50

³⁹⁷ Aroney T4807 line 55

³⁹⁸ Exhibit 301C para 9

³⁹⁹ Aroney T 4807 line 55

⁴⁰⁰ Exhibit 263 para 5

⁴⁰¹ 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.⁴⁰² 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.⁴⁰³
- 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.⁴⁰⁴ 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.⁴⁰⁵
- 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.⁴⁰⁶ These refusals, he said, caused dislocation of the operating staff⁴⁰⁷ and, in the second case, delayed surgery.⁴⁰⁸ 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.⁴⁰⁹ The decisions were ultimately reversed. Dr Aroney gave evidence that Dr Pohlner was threatened with a code of conduct violation by Ms Podbury.⁴¹⁰
- 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

⁴⁰² Aroney T3933 line 30

⁴⁰³ Exhibit 263 para 10; Aroney T3933 line 45

⁴⁰⁴ Exhibit 263 para 13

⁴⁰⁵ Exhibit 263 para 14; Aroney T3937 line 40

⁴⁰⁶ Exhibit 263 para 9; Aroney T3931 - T3932

⁴⁰⁷ Aroney T3932 line 10

⁴⁰⁸ Aroney T3932 line 30

⁴⁰⁹ Aroney T3933 line 1

⁴¹⁰ Aroney T3931 line 40

that, if the child required support, the child could be maintained on cardiac bypass overnight and reassessed the following morning.⁴¹¹ He said that this approach was in line with previously accepted clinical practice.⁴¹² 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,⁴¹³ 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.⁴¹⁴ 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'.⁴¹⁵ 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.⁴¹⁶ 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.⁴¹⁷ 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 2003.⁴¹⁸ 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.⁴¹⁹ This decision was made without reference to clinicians at the Prince Charles Hospital. For reasons mentioned below, this may have

⁴¹¹ Exhibit 301C para 88

⁴¹² Exhibit 301C para 88

⁴¹³ Exhibit 301C para 97 attachment – MIC 18

⁴¹⁴ Memorandum dated 8 July 2003 attachment - MIC18

⁴¹⁵ Exhibit 301C attachment -MIC 17B

⁴¹⁶ Exhibit 263 para 8

⁴¹⁷ Exhibit 263 para 8

⁴¹⁸ Exhibit 301C par 21; Cleary T4839

⁴¹⁹ 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'.⁴²⁰ 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.⁴²¹ Of the 17 members of the working party only four were clinicians.⁴²²
- 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.⁴²³ The Prince Charles report, produced by a committee consisting primarily of administrators,⁴²⁴ 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.⁴²⁵ It made clear that assessment had to be made 'in light of the existing resource environment'.⁴²⁶
- 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.⁴²⁷ 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.⁴²⁸ 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

⁴²⁰ Exhibit 301C paras 24, 25 attachment MIC 3

⁴²¹ Exhibit 301C- MIC3

⁴²² See membership list in attachment MIC 3

⁴²³ Exhibit 301C attachment MIC4; Cleary T4839

⁴²⁴ Exhibit 301C attachment MIC 4/p2

⁴²⁵ Exhibit 301C attachment MIC 4 /p77

⁴²⁶ Exhibit 301C attachment MIC 4 /p77

⁴²⁷ Aroney T3934 line 50

⁴²⁸ 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.⁴²⁹ Dr Aroney said that Mr Bergin stated that the cuts would proceed and that the funds were required for the Princess Alexandra Hospital.⁴³⁰

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.⁴³¹ This was to occur between April and July 2004.⁴³² Dr Cleary gave evidence that he personally found it difficult to support the transfer.⁴³³ He said that the decision to make the transfer was made by Dr Buckland.⁴³⁴
- 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 revascularisation procedures at the Prince Charles Hospital.⁴³⁵ Dr Scott was not sure but imagined he would have responded to the submission.⁴³⁶
- 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

⁴²⁹ Exhibit 263 para 12; Aroney T3936 line 10

⁴³⁰ Exhibit 263 para 12; Aroney T3936 lines 10 - 30

⁴³¹ Exhibit 301C para 28 and 29

⁴³² Exhibit 301C para 30; Exhibit 263 para 4

⁴³³ Cleary T4843 line 5

⁴³⁴ Cleary T4845 line 10

⁴³⁵ Exhibit 263 attachment CA 4

⁴³⁶ Scott T5279 line 40

- list.⁴³⁷ 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.⁴³⁸
- 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.⁴³⁹
- 5.278 Dr Scott denied that there was a cut in activity at that time.⁴⁴⁰ 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.⁴⁴¹ 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.⁴⁴² 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.⁴⁴³
- 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.⁴⁴⁴ 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.⁴⁴⁵ 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.

⁴³⁷ Exhibit 301C para 43

⁴³⁸ Exhibit 301C attachment MIC 8

⁴³⁹ Exhibit 263 para 16; Aroney T3929 line 30

⁴⁴⁰ Exhibit 317 para 19.7

⁴⁴¹ Exhibit 317 para 19.7

⁴⁴² Exhibit 317 para 19.7

⁴⁴³ Exhibit 317 para 19.7

⁴⁴⁴ Aroney T3929 line 28

⁴⁴⁵ 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.⁴⁴⁶ Dr Aroney said that it was felt that this was totally untenable.⁴⁴⁷ The cardiologists decided at the meeting in desperation to present this publicly.⁴⁴⁸ 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.⁴⁴⁹ 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.⁴⁵⁰ Dr Aroney states that as far as he is aware the results of this internal inquiry were never released despite repeated requests.⁴⁵¹

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.⁴⁵²
- 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

⁴⁴⁶ Aroney T3937 line 5

⁴⁴⁷ Aroney T3937 line 15

⁴⁴⁸ Exhibit 263 para 20; Aroney T3937 line 15

⁴⁴⁹ Exhibit 301C para 48

⁴⁵⁰ Exhibit 301C para 50 – attachment MIC10

⁴⁵¹ Exhibit 263 para 32

⁴⁵² Exhibit 263 para 23; Aroney T3938 line 55

author.⁴⁵³ Dr Aroney and Dr Galbraith made minutes of the meeting.⁴⁵⁴ 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 him⁴⁵⁵ 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.⁴⁵⁶ 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.'⁴⁵⁷ 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.⁴⁵⁸
- 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).⁴⁵⁹
- 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

⁴⁵³ Aroney T3940 line 15

⁴⁵⁴ Exhibit 263 attachment CA6

⁴⁵⁵ Exhibit 317 para 19.12

⁴⁵⁶ Scott T5281 lines 1-20

⁴⁵⁷ Exhibit 263 attachment CA3

⁴⁵⁸ Exhibit 263 para 6

⁴⁵⁹ Exhibit 301C para 35

erroneous and that, in real terms, the waiting list at Princess Alexandra Hospital were much greater than this.⁴⁶⁰ 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.⁴⁶¹ 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.⁴⁶²

- 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.⁴⁶³ 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.⁴⁶⁴
- 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.⁴⁶⁵ 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.⁴⁶⁶ Dr Aroney said that, in his view, Dr Buckland's outburst intimidated subsequent speakers and discouraged an open discussion of the problems being presented.⁴⁶⁷

⁴⁶⁰ Aroney T6241 - 6242

⁴⁶¹ Exhibit 301C para 41; Cleary T4833, 4865

⁴⁶² Aroney T6241 - 6242

⁴⁶³ Exhibit 301C para 38

⁴⁶⁴ Exhibit 263 para 27 attachment CA7

⁴⁶⁵ Exhibit 263 para 28

⁴⁶⁶ Exhibit 263 para 30; Aroney T 3941 line 15

⁴⁶⁷ Exhibit 263 para 30; Aroney T3941line 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.⁴⁶⁸ Dr Aroney said that Dr Buckland and Dr Scott would not accept that the lists should be public.⁴⁶⁹ 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.⁴⁷⁰
- 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.⁴⁷¹ Dr Scott rejected the allegation of any intention to intimidate speakers or to discourage open discussion of the problems being presented.⁴⁷² 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.⁴⁷³
- 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.⁴⁷⁴
- Drs Buckland and Scott asked the Cardiac Society of Australia and New Zealand provide a submission on cardiac services in Queensland.⁴⁷⁵
- 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.⁴⁷⁶ Additional funding in the sum of \$2.4 m was provided for the 2004-2005 financial year.⁴⁷⁷

⁴⁶⁸ Exhibit 263 para 31

⁴⁶⁹ Exhibit 263 para 31; Aroney T3941 line 35

⁴⁷⁰ Exhibit 317 para 19.18

⁴⁷¹ Exhibit 317 para 19.16

⁴⁷² Exhibit 317 para 19.16

⁴⁷³ Exhibit 317 para 19.17

⁴⁷⁴ Exhibit 263 para 31 attachment CA 8

⁴⁷⁵ Exhibit 263 para 31

⁴⁷⁶ Exhibit 301C para 32 – attachment MIC7

⁴⁷⁷ 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.⁴⁷⁸ 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.⁴⁷⁹

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.⁴⁸⁰

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.⁴⁸¹ 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.⁴⁸² Also following the issue being raised by the Opposition Health Spokesman, Dr Cleary undertook a review of the procedural management of

⁴⁷⁸ Exhibit 263 para 35 attachment CA2

⁴⁷⁹ Exhibit 263 para 35

⁴⁸⁰ Exhibit 263 para 36 attachment CA10

⁴⁸¹ Exhibit 301C paras 57 - 59

⁴⁸² Exhibit 301 C para 61

the patients and prepared a memorandum to Dr Scott dated 22 October 2004.⁴⁸³

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).⁴⁸⁴ 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.⁴⁸⁵ 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.⁴⁸⁶
- 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.⁴⁸⁷ Dr Aroney also said that Ms Wallace stated that she had a list of foreign doctors who were prepared to take our positions.⁴⁸⁸ 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.⁴⁸⁹ Minutes to the meeting taken by Dr Radford make reference to possible locums from an agency in South Africa.⁴⁹⁰
- 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 Catheterisation Laboratory, provided responses to the District Manager in relation to the reduction requirements and identified risks which may result from the requirements.⁴⁹¹ Results of a statistical evaluation of the effect of cutbacks on cardiac catheter laboratory waiting lists which had been

⁴⁸³ Exhibit 301C para 69 attachment MIC 17A

⁴⁸⁴ Exhibit 263 para 39; Aroney T3944 line 40

⁴⁸⁵ Exhibit 263 para 39; T3944 line 45

⁴⁸⁶ Exhibit 263 para 39; Aroney T3944 line 50

⁴⁸⁷ Aroney T3947 line 40

⁴⁸⁸ Exhibit 263 para 39; Aroney T3945 line 1

⁴⁸⁹ Exhibit 263 para 39; Aroney T3947 line 50

⁴⁹⁰ Exhibit 301C para 106, 107 attachment MIC19

⁴⁹¹ 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.⁴⁹² 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 2004.⁴⁹³ 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.⁴⁹⁴ 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.⁴⁹⁵ 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.⁴⁹⁶
- 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.⁴⁹⁷ Dr Scott said that this extra funding was provided.⁴⁹⁸

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.⁴⁹⁹ 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.⁵⁰⁰

⁴⁹² Exhibit 263 para 42 attachment CA12

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

⁴⁹⁴ Aroney T3948 line 10

⁴⁹⁵ Aroney T3948 lines 10, 25

⁴⁹⁶ Exhibit 263 para 44; Aroney T 3950 line 10

⁴⁹⁷ Aroney T3948 lines 15 - 25

⁴⁹⁸ Exhibit 317 para 19.10

⁴⁹⁹ Exhibit 263 para 45

⁵⁰⁰ Exhibit 263 para 37

- 5.307 Dr Aroney said that following his press release he was labeled as dishonest on television by Dr Scott.⁵⁰¹ 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.⁵⁰² He further states that he was repeatedly attacked in the media and elsewhere by the Health Minister, Gordon Nuttall.⁵⁰³ 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.⁵⁰⁴ 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.⁵⁰⁵ On 4 March 2005 the Mahar-Johnson Report which contained 10 recommendations was circulated.⁵⁰⁶ 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'.⁵⁰⁷

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 2005.⁵⁰⁸ 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.⁵⁰⁹ 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.⁵¹⁰ Dr Aroney offered to continue

⁵⁰¹ Exhibit 263 para 46

⁵⁰² Exhibit 263 para 46 Aroney T3945 line 45

⁵⁰³ Exhibit 263 para 47; Aroney T 3947 lines 10 - 30

⁵⁰⁴ Exhibit 317 paras 19, 23

⁵⁰⁵ Exhibit 301C para 64 – MIC15

⁵⁰⁶ Exhibit 301C para 65 – MIC 16

⁵⁰⁷ Exhibit 301C para 66 attachment MIC 17

⁵⁰⁸ Exhibit 403

⁵⁰⁹ Exhibit 263 para 55

⁵¹⁰ Exhibit 263 para 56

as an honorary visiting cardiologist with catheter laboratory credentialing to assist where required in difficult cardiac interventional cases.⁵¹¹ His offer was in effect refused.⁵¹² 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.⁵¹³ 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.

⁵¹¹ Exhibit 403, 263 para 58

⁵¹² Exhibit 263 para 58; T3925 line 40

⁵¹³ Exhibit 301C para 113 attachment MIC 22

Chapter Six – Common causes and suggested remedies

‘... we need to go backwards first... so that we can set the standards for what is appropriate clinical competence up-front and we can monitor that prospectively before things go wrong, so if you like, park the ambulance at the top of the cliff, not the bottom of the cliff, we don’t have that at the moment.’

Dr Wakefield
Executive Director
Patient Safety Centre

Part A – Introduction

Common problems, common causes

- 6.1 As I think already appears from what I have said so far, this examination of the above hospitals revealed a number of common problems, which together resulted in inadequate, even unsafe health care, in some cases with disastrous results. It is, perhaps, unsurprising, that these problems, common to a number of hospitals, also had common causes. It therefore became clear that, unless all of those causes are removed, or their effects substantially diminished, a serious risk of inadequate and unsafe health care in public hospitals will remain. Those problems, their causes, and some remedies are discussed in this chapter.

Inadequate budgets; defective allocation and administration

- 6.2 The first of these was an inadequate budget defectively administered. In a number of cases, for example, in Bundaberg, Hervey Bay, Townsville, Charters Towers and Rockhampton, inadequate budgets resulted either in doctors being appointed to hospitals who should never have been appointed, or in doctors being put in positions beyond their level of competence. In both kinds of cases, the decisions to appoint were made because the hospital budget did not permit the hospital to make an offer generous enough to attract an appropriate applicant; and where the applicant appointed was plainly in need of supervision, the hospital budget did not permit that supervision to be provided. In some cases, Bundaberg and Charters Towers being examples, this led to disastrous consequences; in all others there was a serious risk of harm and, in some, actual harm. At Prince Charles Hospital it resulted in unacceptable delays in urgent cardiac care. There were also serious defects in the way in which budgets were allocated and controlled. The allocation of elective surgery budgets placed too much emphasis on attaining target numbers, and too little on

patient care; and the excessive control exercised by administrators, because of budget constraints, and a culture of economic rationalism, led to poor decisions about patient care. This problem, its causes and some possible solutions are discussed in Part B.

Defective Area of Need Registration

- 6.3 The second was a defective system of special purpose registration for areas of need. The idea of special purpose registration for areas of need was a reasonable one. But it has been abused, rather than used. In many cases, registration was granted under s135 of the *Medical Practitioners Registration Act* when neither of its pre-requisites had been satisfied. The Minister's delegate and the Medical Board were both negligent in the performance of their respective duties under that section. Their failures also contributed to harmful consequences. These defects, their consequences, and the remedy are discussed in Part C.

No credentialing or privileging

- 6.4 The third was an absence of credentialing and privileging. In none of the relevant cases at Bundaberg, Hervey Bay, Townsville, Charters Towers or Rockhampton were the relevant doctors credentialed or privileged. This was astonishing for two reasons. The first was that the obligation to do so, and the manner of doing so, was clear and simple. Even though Mr Berg in Townsville, and Dr Maree in Charters Towers were appointed before the Queensland Health Guidelines came into effect in 2002, there were requirements in much the same terms before then. And the second and more important reason why this failure was astonishing was that it was so obviously vital for patient safety to have a doctor's skill and competence adequately assessed before he or she commenced work. There was no excuse for not doing it. This is discussed in Part D.

Inadequate monitoring of performance and investigating complaints; better protection for complainants

- 6.5 The fourth problem was a failure to monitor the performance of doctors including to record and properly investigate complaints. There were no regular meetings that effectively monitored clinical performance and no adequate recording of complaints in Bundaberg. Moreover, complaints were discouraged by management. The same was true of Hervey Bay. Nor was there any adequate investigation of complaints. To take Bundaberg as an example, there were more than 20 complaints against Dr Patel, in a little under two years, yet that fact was not apparent from the complaints records. Consequently, there was no way in which an accumulation of complaints, some very serious, could be seen to require investigation. Had there been any such system, Dr Patel's conduct would have been investigated properly long before it was. Much of this also applies to Hervey Bay. When one comes to making a complaint outside the

Hospital, the array of bodies to which a complaint can be made, and the appropriate body in any case, is confusing; and the overlap in their powers leads to delay and frustration. And finally, those who do complain need greater protection against retribution than they now have. These problems and their consequences, and some general suggestions about what should be done, are discussed in Part E.

A culture of concealment

6.6 The fifth problem was a tendency of administrators to ignore or suppress criticism. Recognition of these and other problems in the public hospital system was made very much more difficult by a culture of concealment of practices or conduct which, if brought to light, might be embarrassing to Queensland Health or the Government. This culture started at the top with successive governments misusing the *Freedom of Information Act* 1992 to enable potentially embarrassing information to be concealed from the public. Unsurprisingly, Queensland Health adopted a similar approach, and because inadequate budgets meant that there would be inadequate health care, there was quite a lot to conceal. Again unsurprisingly, the same approach was adopted by administrators in public hospitals, and this, in turn, led to threats of retribution to those who saw it as their duty to complain about inadequate health care. These problems and their solution are discussed in Part F.

Part B – A grossly inadequate budget and an inequitable method of allocation

Introduction

6.7 In his final submissions to this Commission, Dr Buckland said:

...it is impossible to address the circumstances of the Queensland Health workforce, and, in particular the pressures under which hospital administrators were required to operate, without addressing:

(a) the budget constraints on Queensland Health in general and on public hospitals in particular; and

(b) the entrenched culture of financial compliance which focuses on throughput and revenue rather than outcomes for the patient and the community.¹

I agree with those statements.

6.8 Consequently, while I have made findings and recommendations against Mr Leck and Dr Keating at Bundaberg, and Mr Allsopp and Dr Hanelt at Hervey Bay, I have borne these matters in mind in making them. These constraints also

¹ Final Submissions of Dr Stephen Buckland, p53

adversely affected the conduct of other administrators; Dr Scott in his dealings with Dr Aroney was an example of this. In fairness to those persons, it is necessary to say something about these dual constraints under which administrators operated; inadequate budgets and an entrenched culture which put throughput and cost cutting ahead of patient care.

- 6.9 Moreover, evidence given in this Commission proved that a root cause of unsafe operation of surgery and orthopaedic surgery units at Bundaberg and Hervey Bay, respectively, was that their budgets were grossly inadequate to enable them to provide adequate, safe, patient care and treatment, including surgery.² Lack of sufficient funds also contributed to the employment of Mr Berg in Townsville, the tragedy in Charters Towers, the dysfunctional emergency department at Rockhampton and the reduction in cardiac care at Prince Charles Hospital.³ The way in which budgets were allocated to and within hospitals also contributed to these consequences. It therefore became necessary to examine the evidence as to how that came about, which led to the identification of the following problems and a need to suggest possible solutions to those problems.
- 6.10 However, it must be emphasised that what is said in this chapter is not intended to be a comprehensive analysis of budget problems, and their solution. That is beyond my terms of reference. It is intended to identify budget problems, the solution of which is necessary, but not sufficient, to prevent the recurrence of what occurred at Bundaberg, Hervey Bay, Townsville, Charters Towers, Rockhampton and Prince Charles and, by inference, other regional and even metropolitan hospitals.

Queensland Health's budget as a whole

- 6.11 Queensland's total operating expenses for 2005–2006 are budgeted at \$25.670 billion.⁴ The amount budgeted on health is \$5.6 billion, or approximately 22 per cent of total expenditure,⁵ marginally behind education, at \$6.3 billion or approximately 25 per cent of total expenditure. By comparison, in 2004-05 the total operating expenses were budgeted at \$24.046 billion⁶ with \$5.1 billion budgeted on health or approximately 22 per cent of total expenditure,⁷ marginally behind education, at \$5.9 billion or approximately 25 per cent of total expenditure.

² Chapters 3 and 4

³ Chapter 5

⁴ *State Budget 2005-06, Budget Strategy and Outlook 2005-06*, p1

⁵ *State Budget 2005-06, Budget Highlights*, p15

⁶ *State Budget 2005-06, Budget Highlights*, p16

⁷ *State Budget 2005-06, Budget Highlights*, p15.

- 6.12 Despite successive Health Ministers announcing yearly increases in health spending,⁸ growing by an average of seven to eight per cent each year,⁹ this is based on the assumptions that the previous year's base budget was adequate and that this increased funding is keeping pace with escalating health costs and population growth, and an increasingly ageing population. These resources allocated to Queensland Health have come under increasing pressure. Demand for services across the community has increased substantially due to population growth,¹⁰ Queensland's increasingly ageing population¹¹ and changes in medical technology and techniques which have made available a wider range of health services accessible to the public.

Under-funding of Queensland Health by successive Governments

Queensland expenditure per person on health services below the national average

- 6.13 The 2005 *Queensland Health Systems Review*, Final Report, using extrapolated Australian Bureau of Statistics data, suggests that Queensland's expenditure on health services¹² per head is 14 per cent (\$200 per person) below the national average of \$1444.¹³ Dr Buckland expressed the view that the gap may be as high as \$400 per person.¹⁴ This is not a recent problem. It is of long standing, spanning successive Governments.
- 6.14 Because of the rapid growth in Queensland's population, in the years from 2000 to 2003, Queensland recorded annual reductions in health expenditure per person. Professor Stable, former Director-General of Queensland Health, gave evidence that he had had an ongoing argument with Government since 1996 about the under-funding of Queensland Health.¹⁵

Queensland expenditure per person on public hospitals below the national average

- 6.15 A more compelling analysis of comparative funding, for present purposes, is public hospital funding. The Commonwealth Productivity Commission, which seeks to compare government services across jurisdictions, highlights a growing gap between Queensland expenditure per person on public hospitals and national average expenditure. The 2003 Productivity Commission report records that in 2000-01, Queensland recorded the lowest government real recurrent expenditure per person on public hospitals (in 1999-00 dollars) at \$660 per

⁸ See for example: *State Budget 05-06: Queensland Health - Budget Highlights*, p 3 (\$250 million increase) ; *State Budget 04-05: Queensland Health - Budget Highlights*, p1 (\$500 million increase); *State Budget 03-04: Queensland Health - Budget Highlights*, p 1 (\$300 million increase)

⁹ *Queensland Health Systems Review*, Final Report, p 39

¹⁰ See para 6.20

¹¹ See para 6.20

¹² Includes public hospitals (representing approximately 64 per cent of total expenditure), mental health, public and community health and oral health

¹³ *Queensland Health Systems Review*, Final Report, pp 11 and 39

¹⁴ Exhibit 336 para 77 (Dr Buckland)

¹⁵ T5720 line 57 – T5721 line 5 (Prof Stable)

person, well below the national average of \$776 per person,¹⁶ a gap of \$116 per person. This trend has continued. For the 2004 financial year, Queensland again recorded the lowest government real recurrent expenditure per person on public hospitals (in 2001-02 dollars) at \$712 per person, well below the national average of \$895 per person,¹⁷ a gap of \$183 per person.

- 6.16 Further evidence of the significant under-funding of Queensland public hospitals can be found in *The state of our public hospitals*, June 2004 report, which claims, on different data,¹⁸ that Queensland's recurrent expenditure per person on public hospitals in 2001 was the lowest in Australia at \$322, 13 per cent lower than the national average of \$371 per person.¹⁹
- 6.17 The most recent data, in *The state of our public hospitals*, June 2005 report, suggests that the gap in under-funding of Queensland public hospitals is growing. Queensland's recurrent expenditure per person²⁰ on public hospitals in 2004 was still the lowest in Australia, at \$440, now 20 per cent (worsening from 13 per cent) below the national average of \$552 per person.²¹

Under-funding of public hospitals is exacerbated by several factors

- 6.18 This under-funding of public hospitals is exacerbated by several factors which suggest that to provide the same level of services as other states, funding of Queensland Health should not merely be in line with national average but should be much higher.²² These factors are:

Queensland is the most decentralised state

- 6.19 Queensland is the most decentralised state in mainland Australia.²³ More than 48 per cent of the population of Queensland resides outside our major cities.²⁴ The decentralised nature of Queensland's population necessitates some duplication of health services infrastructure and dilution of the medical workforce across the State.²⁵ As technology advances and the cost of providing

¹⁶ Steering Committee for the Review of Government Services, *Report on Government Services* 2003, p 9.5

¹⁷ Steering Committee for the Review of Government Services, *Report on Government Services* 2005, p 9.4

¹⁸ Commonwealth Department of Health and Ageing data

¹⁹ Australian Government, Department of Health and Ageing, *The state of our public hospitals*, June 2004 report, p17

²⁰ This data is calculated using the following 'weighted' population data – as utilised by the Commonwealth Department of Health and Ageing [NSW 7.0; VIC 5.1; QLD 3.8; WA 1.9; SA 1.7; TAS 0.5; ACT 0.3; NT 0.2] This 'weighted population' is age-weighted by modifying each age group of the population to account for the different hospital usage of that age group. This means a population with a higher than average number of older people will have a higher weighted population to take account of the higher than expected hospital usage of that older population. The weighted populations are also weighted to account for different expected hospital usage by each gender.

²¹ Australian Government, Department of Health and Ageing, *The state of our public hospitals - June 2005 report*, p 5

²² See for example: T5061-T5064 (Ms Edmond)

²³ See Department of Premier and Cabinet, *Premier's policy scan*, Issue 13 February 2004, p 4; T5721 lines 22-29 (Prof Stable).

²⁴ Exhibit 336 paras 60-65 and 78 (Dr Buckland)

²⁵ Exhibit 336 paras 60-63 (Dr Buckland)

technological infrastructure increases in investigative, diagnostic and treatment areas, there needs to be greater investment for the same outcome in a less decentralised setting, or the same investment for a lesser outcome.²⁶

Queensland has the highest level of population and of ageing population growth

- 6.20 Queensland has the highest level of population growth in Australia.²⁷ Moreover the mean age of the Queensland population has increased steadily and consequently health costs have increased.²⁸ The Commonwealth Productivity Commission estimates that expenditure on people aged over 65 is approximately four times more per person than on those under 65 years of age and that that increases to between six and nine times for those over 75.²⁹
- 6.21 As a result, the Commonwealth Department of Health and Ageing uses age-weighted population to try to standardise the population across states and territories for the purpose of making comparisons more meaningful. The age-weighted population is calculated by modifying each age group of the population to account for the different hospital usage of that age group. This means that a population with a higher than average number of old people will have a higher weighted population to take account of the higher expected hospital usage of that older population.
- 6.22 Queensland has recorded the largest percentage increase, 14.3 per cent, in age-weighted population³⁰ between 1999 and 2004 compared to a national average of 10.2 per cent.³¹

Queensland has a lower than average number of medical practitioners

- 6.23 The shortage of doctors and nurses in Australia, and indeed world-wide, is well documented.³² For a number of reasons³³ these staff shortages are more acute in Queensland than in other states.³⁴ Whilst remuneration rates for Australian doctors are low by first world standards, Queensland Health specialist rates are low by Queensland and Australian standards.³⁵

²⁶ Exhibit 336 para 60 (Dr Buckland)

²⁷ *Queensland Health Systems Review*, Final Report, p 92

²⁸ See the *Queensland Government's Submission to the Productivity Commission Study of the Health Workforce*. July 2005

²⁹ Productivity Commission, *Economic Implications of an Ageing Australia*, March 2005, p 147

³⁰ Percentage change in weighted population from 1998-99 to 2003-04:QLD 14.3 per cent; WA 11.7; ACT 11.5; NT 10.1; VIC 9.4; NSW 9.3; TAS 6.9; SA 6.8 [National average:10.2]

³¹ Australian Government, Department of Health and Ageing, *The state of our public hospitals - June 2005 report*, p6

³² See T824 line 8 (Dr Molloy); Exhibit 209 (Dr Young - Chair of the Australian Medical Workforce Advisory Committee); T2863, and T2861 (Dr FitzGerald, Dr Woodruff, Dr Molloy and Dr Lennox); T876 and see Exhibit 28 paras 55 - 64 (Mr O'Dempsey)

³³ See Chapter 2 of this report

³⁴ T700-702(Dr Bethnell); T899 (Dr Lennox); T2864 line 18 (Dr Young); and T2871-2 (Dr Young)

³⁵ Exhibit 34, paras 6 and 9 (Dr Molloy); Exhibit 35 (Dr Cohn); T575-6 (Dr Molloy); T846, line 40 (Dr Molloy)

- 6.24 For this and other reasons outlined earlier, the number of medical practitioners in Queensland in proportion to the population of Queensland has declined,³⁶ and the statistics for nurses are similar.³⁷ Queensland has a lower than national average proportion of doctors in the population.
- 6.25 Dr Buckland has attempted to put these medical practitioner shortages into some perspective:
- Assuming a Queensland population of 4 million people, this equates to 2480 doctors less for the same population in Victoria which does not have the rural, remote, indigenous or decentralised difficulties experienced in Queensland. In hours worked, there is 5.8 million hours less practitioner time per year in Queensland than Victoria for the same population. ...³⁸
- 6.26 The greater shortage of Australian trained doctors in Queensland, than in other states, has led to a greater reliance by Queensland Health on overseas trained doctors than by other states. By 2003, the proportion of Resident Medical Officers who were overseas trained doctors in Queensland was approaching 50 percent.³⁹ This is an unsatisfactory situation for health services in Queensland, as a growing share of overseas trained doctors are being drawn from countries with different cultures and first languages from ours, from a medical education system which is either less developed than ours or one in respect of which it is difficult to make an informed judgment, and from a medical and hospital system which is less developed than ours, or one about which it is difficult to make an informed judgment.
- 6.27 It seems likely that this shortage of Australian trained doctors, the under-funding of Queensland Health and the decreasing competitiveness of medical remuneration in Queensland⁴⁰ were significant factors leading to the need to employ overseas trained doctors in Bundaberg and Hervey Bay.

Queensland is the only state to provide substantial specialist outpatient services under the public health system

- 6.28 Queensland is the only state to provide substantial specialist outpatient services under its public health system.⁴¹ Former Minister Edmond gave evidence that Queensland was unique in providing a 'specialist outpatient service'. She indicated that in other states, this service is not provided.

If your general practitioner refers you to a specialist, you go privately, the cost of that is picked up by Medicare and what you pay is out of your own pocket.

³⁶ T2864 line 18, T2871-2, T2887; See also *Queensland Health Systems Review*, Final Report, p 13

³⁷ T2887 (Dr Young); See also *Queensland Health Systems Review*, Final Report, p 14

³⁸ Exhibit 336 para 101(iv) B (Dr Buckland)

³⁹ Exhibit 55 - DR12, p 5 (Dr Lennox); See also Birrell B, 'Australian policy on overseas trained doctors', *Medical Journal of Australia*, 2004 181, p 638 – previously published in Birrell B, Hawthorne L, 'Medicare Plus and overseas-trained medical doctors', *People and Place*, 2004; 12(2), p 91-92 - sourcing unpublished data provided by the Department of Immigration and Multicultural and Indigenous Affairs

⁴⁰ See Footnote 35

⁴¹ T5721 line 50 – T5722 (Prof Stable); T4959, line 58 – T4960, line 9 (Ms Edmond); Exhibit 336, para 180 (Dr Buckland).

Queensland is the only State that provides specialist outpatient services prior to people coming to the hospital for a particular function.⁴²

- 6.29 Dr Stable gave evidence that Queenslanders utilise specialist outpatients services 20 per cent above the national average. The provision of these services reflects the policies of successive governments.⁴³ Dr Stable has given evidence that while other states were limiting or ceasing outpatient services, Queensland was continuing to increase them.⁴⁴ Any discussion of the extent to which the Australian Health Care Agreement prevents this from being changed is beyond my terms of reference.
- 6.30 Specialist outpatients waiting lists are large and growing as are waiting lists for cardiac care.

A combination of those factors

- 6.31 A combination of those factors, greater decentralisation, a higher population growth and a higher growth in the ageing population, a lower number of medical practitioners and the provision of outpatient specialist services, appears to require greater expenditure per head of population in Queensland than the Australian average expenditure, to provide the same level of service.

Defective allocation

The allocation process; historical budgets

- 6.32 Successive governments used a 'historical funding model' to allocate health funding annually; that is, each budget was based on the budget for the previous year,⁴⁵ indexed annually for labour and non-labour cost increases and supplemented for specific government programs or election commitments.⁴⁶ However, the amounts allowed for increases in labour costs were 'discounted' and were less than the real costs of enterprise bargaining increases.⁴⁷ And the amounts allowed for increases in non-labour costs, at the rate of Consumer Price Index increases, were usually less than the actual increased costs in the health sector.⁴⁸ As a result, these increases in labour and non-labour costs allowed by Treasury never kept up with the real increases in costs.⁴⁹
- 6.33 These budgets were further eroded through an 'efficiency dividend'.⁵⁰ This was not a dividend but a reduction made each year on the assumption that increased

⁴² T4880 line 55 – T4881 line 5 (Ms Edmond)

⁴³ T5722 line 8 (Prof Stable) – sourcing Commonwealth Department of Health and Ageing data

⁴⁴ T5722 lines 15-35 (Prof Stable)

⁴⁵ For example – See T1830 line 40 (Dr Thiele)

⁴⁶ Exhibit 336, p 17 (Dr Buckland); T4978-99 (Ms Edmond); *Queensland Health Systems Review*, Final Report, p 102

⁴⁷ T4978 line 9 (Ms Edmond)

⁴⁸ T4978 line 19 (Ms Edmond)

⁴⁹ T4978 lines 15-25 (Ms Edmond)

⁵⁰ T4980 line 3 (Ms Edmond)

efficiencies would be made during the course of the year. This was invariably a reduction of one or two per cent each year.⁵¹ I shall say more about this when discussing the culture of economic rationalism.

- 6.34 In addition, budgets were affected by political promises. Dr Buckland accepted that government policy must play a significant role in determining the allocation of Queensland Health resources and that a key priority of any government was to honour election commitments, but he quite appropriately observed that 'some commitments do not necessarily deliver the best health outcomes in an environment in which public funding of health can never be enough to keep up with demand'. Dr Buckland cited as an example, that 'it may not be the best policy or the most sensible allocation of limited resources to establish a new facility in a specific location, and the significant capital and recurrent cost of doing so may be better allocated to upgrading and operating an existing facility at a nearby centre'.⁵² Although he did not say so, Dr Buckland may have been thinking of the establishment of Hervey Bay Hospital. It was opened, against the advice of Queensland Health because, according to Dr Stable, Mr Horan, then Minister for Health, directed that a hospital be opened at Hervey Bay before the 1998 election.⁵³

The problems with historical budgets

- 6.35 Historical budgets were not based on the needs of a community, linked to clinical services promised or demographic trends, but on an original budget, fixed many years ago, updated in a rather mechanical way. This gave rise to at least three problems. The first of these was that, if the original budget was not fixed fairly to provide an adequate service, it would be unlikely that this mechanical updating would change that. As Dr Nankivell put it:

Our funding was based on what I call an historical funding model ... which basically means you have been duded in the past, you are going to be duded next year.⁵⁴

- 6.36 The second problem was that, even if the original budget was based on the then needs of a community, subsequent budgets failed to take into account changes in those needs. Communities change size and demographics, sometimes quickly. Hervey Bay was an example of this. It had substantial population growth and a substantially increasing ageing population.
- 6.37 And the third problem was that, because some communities were perceived by medical practitioners to be more attractive than others, they ended up having a greater number of medical practitioners per head of population than others. No doubt that occurred also in the case of nurses. It was, therefore, and remains

⁵¹ T7180 lines 21-53 (Mr Leck)

⁵² Exhibit 336 para 89 (Dr Buckland)

⁵³ See Chapter 4.2 of this report

⁵⁴ T2943 lines 8-15 (Dr Nankivell)

necessary to provide incentives to attract doctors and nurses to those communities which are perceived to be less attractive. As I mention later, Area of Need Registration was premised on the assumption that incentives would be provided to general practitioners, both newly registered and established, to relocate to regional and rural areas of the State. But more generally, unless some incentives are provided, some areas of the State will be better served by medical practitioners than others. Historical budgets did not take into account the number of practitioners in an area who could provide support to a hospital on a part-time, or visiting sessional basis.

- 6.38 There was a further problem which, though not necessarily the result of historical budgets, was a consequence of the budget process. Public hospitals were required to carry forward any debt to the following year. The consequence was, of course, that the budget was effectively reduced in the following year. That practice was discontinued only in July 2004.

The allocation process; elective surgery targets

- 6.39 In addition to the historical budget, further funding was based on a target for elective surgery, weighted for complexity, aimed at increasing elective surgery throughput. If the target was not met, funds so allocated would not be paid or would be taken back by Queensland Health. More importantly, the elective surgery target and, consequently, the budget as a whole, would be reduced by that amount for the following year. This put pressure on hospitals to meet elective surgery targets at the expense of emergency surgery and medical services. Targets for elective surgery have now been abandoned.
- 6.40 This was in addition to the pressure placed on District Managers, like Mr Leck and Mr Allsopp, to maintain budget integrity.⁵⁵ A budget overrun was viewed very seriously, and little flexibility was permitted. District Managers had been dismissed for over-running budget. The Queensland Nurses Union summarised the practice accurately in the following submission:

Staying within budget (while at the same time having to meet unrealistic performance objectives) is the overriding imperative in Queensland Health: all else appears to take second place to this. The primacy of the budget bottom line is demonstrated again and again. In 1999 the whole District Executive at Toowoomba Health Service District (HSD) were removed for failing to come in on budget. Not long after that the District Manager in Cairns HSD was dismissed for reportedly failing to come in on budget. These dismissals were powerful symbols for the rest of the system and helped achieve better budget compliance by instilling fear of job loss on senior management across the agency, a fear that was in turn passed down to middle management and beyond.⁵⁶

As the evidence of Mr Leck and Mr Allsopp shows, this fear was ever

⁵⁵ T7179 line 30 (Mr Leck); T6048-6050 (Dr Bergin) and T7121 line 22 (Mr Leck)

⁵⁶ Queensland Nurses Union submission to the Queensland Health Systems Review, July 2005

present in their minds.⁵⁷

A culture of economic rationalism rather than patient care and safety

6.41 The plight of public hospitals funding was worsened by a philosophy of economic rationalism rather than of patient care and safety. The 'efficiency dividend' was one indication of this. Others were the concept that Queensland Health was 'purchasing' services from public hospitals, and that patients were 'consumers' of those services. Similarly, the system of elective surgery budgets focused on throughput and revenue rather than outcomes for the patient and the community.

6.42 Dr Buckland submitted:

In the mid late 1990s, Funder Purchaser/Provider Models were introduced, and the Performance Management Unit was established. This was part of the philosophy of economic rationalism that has dominated health and other government services during the last decade. Dr Buckland's evidence was that it has a major focus on linking throughput and revenue. It does not focus on outcomes for the patient or the community.⁵⁸

6.43 The philosophy that budget, including throughput and reputation, were more important than patient care is epitomised by Queensland's Risk Management Policy which grades risks in categories of seriousness from 'low risk' to 'extreme risk'. It is not surprising that, in the category of 'extreme risk' we find 'multiple deaths'. But the other matters sharing that category are 'claims greater than \$1m or multiple claims resulting from multiple similar exposures', and 'sustained national adverse publicity, Queensland Health's reputation significantly damaged'. In the 'major risk' category we find 'loss of life'. But sharing equal seriousness with that we find 'claims greater than \$500,000 or multiple claims resulting from a single response', and 'significant and sustained adverse statewide publicity'. And in the 'moderate risk' category we find 'loss of function, major harm caused' sharing equal seriousness with 'significant adverse State wide publicity', and 'experience will result in a single claim'. This approach, it seems to me, is hardly conducive to the declared purpose of the policy 'to improve the health and well being of Queenslanders'. Rather, it seems as much concerned with adverse publicity and civil damages as with death and serious injury.

6.44 The results of this philosophy and pressure can be seen in the approaches of administrators at Hervey Bay and Bundaberg. Although Mr Allsopp at Hervey Bay Hospital was concerned about Dr Naidoo's absences, his concern seemed to be more about losing throughput than about the absence of supervision of Dr Krishna and Dr Sharma. Even more concerning, is the e-mail which Dr Keating

⁵⁷ T7129 line 37 (Mr Leck); T6051 line 10; T6051 line 40 (Dr Bergin). See also Final Submissions on behalf of Mr Leck

⁵⁸ Exhibit 336 para 48 (Dr Buckland); Final Submissions on behalf of Dr Buckland, para 159

at Bundaberg sent to a member of staff on 8 February 2005, after Dr FitzGerald had been called in to investigate complaints about Dr Patel. It read in part:

...At the present time BHSD is 92 WTD separations behind target. The target is achievable. [Bundaberg Health Service District] must achieve the target – for many reasons, including financial (over \$750,000 per year), ability to undertake range of operations, new equipment for OT, repair of equipment, education and training of staff.

....Therefore, it is imperative that everyone continue to pull together, and maximise elective throughput until June 30. All cancellations should be minimal with these cases pushed through as much as possible.

- 6.45 The e-mail goes on to say that all elective surgery cancellations were to be discussed by Dr Patel and others.⁵⁹ The e-mail becomes even more disturbing when it is seen in a context in which, without Dr Patel, that target could not realistically be achieved.
- 6.46 There will always be a tension in hospitals, private as well as public, between, on the one hand, patient care and safety, and, on the other, cost. And of course there is a difference, as to what is acceptable treatment in a rural or regional area, between an emergency procedure, and an elective one. In an emergency, it may not be possible to provide specialist care in a regional, or, especially, a remote area. But where a procedure is not urgent, and a patient is able to be transferred, the position is different. Then there is no excuse for providing inadequate and consequently unsafe surgery, as occurred in Bundaberg and Hervey Bay. In both cases the perceived need to meet the elective surgery target was paramount in the minds of administrators, blinding them to the evident danger.

Some specific consequences to patient care and safety

- 6.47 There were many examples in the evidence of cost control being put ahead of patient care and safety, and of clinical decisions based on the latter being overruled by administrative decisions based on the former. Some of these examples follow.

Dr Thiele

- 6.48 Dr Thiele gave evidence, of his struggle to obtain a CT scan machine which Bundaberg did not have because it had been considered 'too expensive'.⁶⁰ This CT scanner was, according to Dr Thiele, a critical piece of equipment in modern trauma medicine used to identify the extent of patient injuries. Patients were, instead, transferred by ambulance to the Mater Hospital in Bundaberg, which had such a scanner and then brought back to Bundaberg Base Hospital. Quite understandably, Dr Thiele considered this was unacceptable. The Bundaberg

⁵⁹ Exhibit 72

⁶⁰ T1820 line 28 (Dr Theile)

Hospital did ultimately purchase a CT scanner but only in the course of a re-building project at the hospital.⁶¹

Dr Nankivell

- 6.49 Dr Nankivell gave evidence of an increasing demand for specialist outpatient clinics, endoscopy and colonoscopy services,⁶² and of the Bundaberg Hospital being unable to meet those demands. He attempted to have the problems he had identified in the course of his clinical practice brought to the attention of the hospital management and to Queensland Health's corporate office, but to no avail.⁶³ He became frustrated at what he saw as the serious failings in the budget allocation process. He also became disillusioned with the failure of Queensland Health to respond to what he had identified as serious failings that were affecting the health of the community that relied upon the Bundaberg Base Hospital.

Dr Jason Jenkins

- 6.50 Dr Jenkins is a vascular surgeon, and former Director of Vascular surgery at the Royal Brisbane Hospital.⁶⁴ He said that at the Royal Brisbane Hospital there has been a huge decrease in bed numbers;⁶⁵ that he had been directed not to use what he considered the best prosthesis due to its cost;⁶⁶ that he was required to put together a 'business case' in order to get changes made to the delivery of clinical services such as the type or prosthesis that could be used;⁶⁷ that on a daily basis he was given a message on his pager that he was not to admit any more patients as the hospital had no beds;⁶⁸ that the clinical demand for vascular surgery had increased dramatically in the previous 12 months;⁶⁹ that he had been given a direction that he was given a budget to perform 56 aortic aneurysms in a particular year and he was not to perform any more than 56 aortic aneurysm procedures,⁷⁰ even though he had performed approximately 145 such procedures each year previously;⁷¹ that patients were discharged from hospital prematurely to make beds available for elective surgery,⁷² that he had to regularly cancel elective surgery due to there being an inadequate number of Intensive Care beds available to provide post operative care;⁷³ that clinicians were powerless as the system was run by administrators;⁷⁴ that the

⁶¹ T1820 lines 35-38 (Dr Thiele)

⁶² T2945 line 40; T2946 line 28; T2963 line 30 (Dr Nankivell)

⁶³ T2948 line 58 (Dr Nankivell)

⁶⁴ T3674 line 40, T3675 line 22 (Dr Jenkins)

⁶⁵ T3678 line 28 (Dr Jenkins)

⁶⁶ T3678 line 32 (Dr Jenkins)

⁶⁷ T3678 line 42 (Dr Jenkins)

⁶⁸ T3678 line 35 (Dr Jenkins)

⁶⁹ T3676 line 18 (Dr Jenkins)

⁷⁰ T3680 line 2 (Dr Jenkins)

⁷¹ T3680 line 5 (Dr Jenkins)

⁷² T3683 line 15 (Dr Jenkins)

⁷³ T3685 line 48 (Dr Jenkins)

⁷⁴ T3684 line 3 (Dr Jenkins)

funding for the Royal Brisbane Hospital was inadequate given the area that it had to cover, and the result was that the Hospital was 100 beds short of what it needed to cope with the demand placed on its services;⁷⁵ and that he, along with other vascular surgeons, had been directed to drive to the Nambour Hospital to provide vascular surgery services at that hospital rather than having patients travel to Brisbane for treatment.⁷⁶ He considered the extra travel involved a waste of the valuable time of clinicians and an inefficient use of resources. He and the other vascular surgeons were given \$400,000 in funding to provide a 'carotid artery stenting service' at the Royal Brisbane Hospital. However that funding would only be given on the condition that the vascular surgeons would travel to Nambour and provide vascular surgery services there.⁷⁷

- 6.51 Dr Jenkins, as a doctor treating patients on an almost daily basis, had a clear understanding of the increasing demands being placed on a hospital such as the Royal Brisbane Hospital. Notwithstanding this wealth of knowledge he had little or no power to influence the distribution of funds in such a way as to meet that demand. There was no consultation with him on these issues:

They need to speak to clinicians and ask them what needs to be done, not have administrators telling us what clinicians should be doing.⁷⁸

Dr Sam Baker

- 6.52 Dr Baker, the former Director of Surgery at the Bundaberg Base Hospital, gave evidence of the difficulties he experienced with the inadequate funding and lack of consultation at the Bundaberg Base Hospital when he was the Director of Surgery, including an inability to purchase replacement surgical equipment;⁷⁹ decisions made by administrators of the Hospital about increasing the efficiency of the operating theatre without consulting him,⁸⁰ and an unaddressed lack of experienced doctors working in the Emergency Department at the Bundaberg Hospital.⁸¹

Dr Sean Mullen

- 6.53 Dr Mullen was an orthopaedic surgeon and a Visiting Medical Officer at Hervey Bay Hospital. When on call on a Saturday morning he saw an elderly woman who had been admitted with a fractured hip the previous night. In his opinion it required surgery as soon as possible, a better outcome being achieved if surgery is performed within 48 hours. He booked her in for surgery that day

⁷⁵ T3689 line 21 (Dr Jenkins)

⁷⁶ T3691 line 31 (Dr Jenkins)

⁷⁷ T3691 line 50 (Dr Jenkins)

⁷⁸ T3683 line 1 (Dr Jenkins)

⁷⁹ Exhibit 410 para 14 (Dr Baker)

⁸⁰ Exhibit 410 para 20 (Dr Baker)

⁸¹ T6349 line 58 (Dr Baker)

notwithstanding a general policy that emergency surgery only be performed on the weekend. Nurse Erwin-Jones, who was at home at the time, mistakenly thinking that the fracture was two weeks old, contacted Mr Allsopp, the District Manager, who cancelled the surgery without reference to Dr Mullen. It was only after Dr Mullen and a senior anaesthetist both spoke to Mr Allsopp that the surgery was rescheduled for the following day. This was clearly a case of putting economic matters ahead of patient care.⁸²

Dr Con Aroney

- 6.54 Dr Aroney, a cardiologist, gave evidence of the difficulties that he faced in providing cardiology services at the Prince Charles Hospital. The cardiology unit of that hospital experienced a reduction in funding without any, or any sufficient consultation with cardiologists about the funding cuts or the reasons for them. He also spoke of a prohibition by administrators on the use of certain prosthetic devices⁸³ and administrative interference in clinical decision making to save costs.⁸⁴ He gave an example of Dr Pohlner, the most experienced paediatric cardiac surgeon in the State, being twice refused a ventricular assist device, which he considered necessary for surgery in each of the two cases. Dr Aroney believed that the refusal was based on the cost of the device, and of the consumables. The refusal was ultimately reversed but surgery was delayed.⁸⁵

Mr Whelan

- 6.55 Mr Whelan is the District Manager of the Townsville Health Service District. As discussed below, he, with the assistance of others, has introduced a different model of funding and administration into the Townsville Hospital. However, he also experienced overbearing central control when it came to the allocation of funding. He gave evidence of the failure of Queensland Health to consult with the community adequately or appropriately in a number of cases including a lack of consultation with the community regarding the redevelopment of the Ingham Hospital, the redevelopment being pushed along for political reasons without considering the health care needs of the community in sufficient detail;⁸⁶ a lack of consultation with the Hospital over the nature of procedures to be performed;⁸⁷ and a funding model based on funding positions rather than outcomes. One example of this was Queensland Health agreeing to fund an additional physician to provide renal services, but not providing funding for nursing and allied health staff to support that physician.⁸⁸

⁸² See Chapter 4 - paras 4.179 - 4.187

⁸³ Exhibit 263 para 10 (Dr Aroney)

⁸⁴ Exhibit 263 para 11 (Dr Aroney)

⁸⁵ Exhibit 263 para 9; T4804, line 51 – T4805 line 3 and T6282 lines 32-50 (Dr Aroney)

⁸⁶ Exhibit 236 para 7; T3531 line 15 (Dr Whelan)

⁸⁷ See Chapter 5 of this report

⁸⁸ T3338 lines 24-35 (Dr Johnson)

Some more general consequences

- 6.56 Because budgets were fixed on an historical basis, with little consultation with clinicians, the Australian Medical Association, specialist colleges, specialist associations or nursing bodies, there was no point in involving local doctors and nurses in determining changing needs. Take the example of Hervey Bay Hospital. When it opened its orthopaedic unit, it did so with one specialist orthopaedic surgeon. Had there been any consultation with the Royal Australian College of Surgeons or the Australian Orthopaedic Association, it would have become clear to Queensland Health that that was a grossly inadequate number of orthopaedic surgeons to provide an adequate and safe orthopaedic service to include elective surgery. Similarly at Bundaberg, the general surgery unit was understaffed by qualified surgeons, anaesthetists and nurses for at least three years before Dr Patel was employed and Dr Patel might never have been permitted to operate as he did, notwithstanding complaints, if it had been adequately staffed; that is, if he had had peer review.
- 6.57 Nor was there any flexibility in sharing services between districts. Dr Thiele gave the example of there being, at one time, a long surgery waiting list at Bundaberg, and almost none at Hervey Bay. Yet the system did not permit transfer of patients from Bundaberg to Hervey Bay for this purpose. Bundaberg, Maryborough and Hervey Bay seem obvious places where specialist elective services could be rationalised.

A cost-efficient system?

- 6.58 It is said that Queensland Health has, for some time been recognised as the most cost-efficient jurisdiction in Australia in delivering hospital services. The latest data records that Queensland's total recurrent cost per case-mix weighted separation⁸⁹ is \$2885 compared to the national average of \$3184,⁹⁰ more than 10 per cent lower than the national average. This lower cost at which Queensland delivers health services reflects a lower expenditure on nursing, allied health and medical services (staff numbers and average salaries) and lower relative stays in hospital than other states.⁹¹ More specifically, Queensland has a lower than average number of medical practitioners; has the lowest number of nurses per capita of any state in Australia (except Tasmania) and has a critical shortage of nurses. It employs 11 per cent fewer public hospital staff per 1000 people; and pays 5.6 per cent less in average salaries for

⁸⁹ This data is 'case-mix adjusted' to take into account the complexity of the admission

⁹⁰ Steering Committee for the Review of Commonwealth Service Provision, *Report on Government Services 2005*, Table 9A.4

⁹¹ *Queensland Health Systems Review*, Final Report, p 12

public hospital staff.⁹² Yet Queensland Health spends 82 per cent more on health administration than other states.⁹³

- 6.59 The last figure is concerning. It might be explained, in part, by the much greater decentralisation in Queensland than in other states. But whilst the limitations on my terms of reference prevent me from examining it further, it is necessary to remark that whilst it is undoubtedly the case that Queensland has too few qualified doctors and nurses, it may well be that it has too many administrators.
- 6.60 Even more concerning is that the lower cost in Queensland, in delivering health services, has come at the cost of lowering the standard of healthcare to one which is grossly inadequate and dangerous. It has been thought better to employ poorly trained foreign doctors under the area of need scheme than, for example, to make greater use of Visiting Medical Officers or to provide incentives to Australian trained doctors to relocate. And it was thought better to provide a system which was so grossly inadequately staffed as to be dangerous (as in Hervey Bay) than to provide none at all. This last appeared to be the stated views of Mr Leck and Mr Allsopp, and also of Dr FitzGerald to Ms Hoffman.

Possible solutions: The overall public hospitals budget

- 6.61 What is needed and what must be done in this respect are beyond my terms of reference. But it would be remiss of me not to point out difficulties in solutions already proposed as these difficulties have emerged from the evidence before this Commission.
- 6.62 The *Queensland Health Systems Review*, Final Report, argues that to bring the Health budget up to the national average would require an extra \$1.2 billion a year, increasing to \$1.9 billion a year by 2009 – 2010.⁹⁴ It suggests or implies that \$1.2 billion a year may not be required because, for many services, Queensland Health provides a similar level of activity but with a lower level of expenditure.⁹⁵
- 6.63 Significantly, one of the 'efficiencies' relied upon in that Report is that Queensland performs weighted separations at a lower cost than other states; that is, more efficiently.⁹⁶ But the evidence given in this Commission has shown that weighted surgical separations in public hospitals in Queensland were often provided unsafely, primarily because there were too few, too poorly qualified or supervised doctors, and too few nurses. But that lowered their cost.

⁹² *Queensland Health Systems Review*, Final Report, p 14

⁹³ *Queensland Health Systems Review*, Final Report - quoting data from *Australian Institute of Health and Welfare, Health Expenditure Australia 2002-03* (2004). See also *Australian Institute of Health and Welfare, Health Expenditure Australia 2003-04* (2005).

⁹⁴ *Queensland Health Systems Review*, Final Report, p 39

⁹⁵ *Queensland Health Systems Review*, Final Report, p 40

⁹⁶ *Queensland Health Systems Review*, Final Report, p 40

That was also true of a number of other services including psychiatry in Townsville, emergency care in Rockhampton and anaesthetics in Charters Towers. By using unqualified doctors to perform complex orthopaedic surgery (Hervey Bay), by permitting doctors to perform surgery beyond their competence or the competence of the hospital (Bundaberg and Hervey Bay), by requiring too few doctors to work unsafe hours (Bundaberg and Hervey Bay) and by 'dumping' inadequately trained doctors employed under the 'area of need' scheme, in an emergency department (Rockhampton), substantial costs were saved, but at huge cost to patient safety.

- 6.64 If, as seems to be the case from the evidence before the Commission, weighted surgical separations have been carried out more cheaply in Queensland than in other states, at least in part because they have been provided inadequately and unsafely, it would be wrong to assume that, if they are provided at a reasonable level of competence and safety, they will still be provided more cheaply than in other states. For that reason, it may be wrong, as that Report posits, that, because of a greater level of efficiency in Queensland Hospitals, less than \$1.2 billion will be required to bring Queensland Health budget up to the national average.
- 6.65 It is also wrong, in my opinion, to assume that, to bring health funding in Queensland up to national average per head, is sufficient to provide the same level of services as the other states. There are several reasons why Queensland needs to spend more than the other states. I have mentioned these earlier. Queensland is the most decentralised state in mainland Australia; Queensland's age-weighted population is growing faster than other jurisdictions; and Queensland provides a free specialist outpatients service, much greater in its scope and cost than that provided by other states.
- 6.66 And it is also wrong, in my opinion, to assume that the other states are providing an adequate and safe system. Concerns similar to those investigated by me have been investigated in other jurisdictions; at the King Edward Memorial Hospital in Western Australia (1999),⁹⁷ the Canberra Hospital in the Australian Capital Territory (2000),⁹⁸ and Campbelltown and Camden Hospitals in New South Wales (2002).⁹⁹ The most recent example in New South Wales concerned allegations made by nurse whistleblowers of unsafe or inadequate patient care or treatment, disregard for quality and safety, and an indifferent hospital administration, following a number of patient deaths at the

⁹⁷ Douglas N, Robinson J, Fahy K, *Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital*, 2001

⁹⁸ The report was not made public. See the ACT Community and Health Services Complaints Commissioner, *Annual Report 2002-03*, Canberra, 2003 – which outlines a summary of the major findings of the Inquiry

⁹⁹ NSW Health Care Complaints Commission, *Investigation report, Campbelltown and Camden Hospitals - Macarthur Health Service*, December 2003

Campbelltown and Camden hospitals.¹⁰⁰ The New South Wales Health Care Complaints Commission investigated some 47 clinical incidents, including 19 deaths,¹⁰¹ at those hospitals. The Health Care Commission's investigation supported the allegations made by nurse whistleblowers, finding that there were inadequate standards of patient care and safety¹⁰² at both hospitals.

- 6.67 An associated patient care systems review of the relevant hospitals in October 2003¹⁰³ concluded, amongst other things, that the relevant health service had many fewer resident, registrar, and consultant medical staff for each occupied bed than at other facilities;¹⁰⁴ that there was a shortfall in appropriately qualified and skilled nursing and allied health workforce and extremely limited numbers of academic clinicians;¹⁰⁵ that the lack of adequate numbers in the medical workforce with adequate skill and experience levels was perceived to be the greatest weakness in the delivery of health services, most notably in the Intensive Care Unit and the Emergency Department;¹⁰⁶ that additional resources were required in the area of clinical nurse consultants in intensive care, Emergency Department and medical ward;¹⁰⁷ that the Camden Hospital had a number of limitations, including a lack of adequate numbers of skilled staff and high level facilities resulting in the need to transfer acutely ill patients;¹⁰⁸ and that the development of a supported safe reporting culture needed to be a priority.¹⁰⁹ These bear a striking similarity to inadequacies found in Queensland public hospitals by this Commission.
- 6.68 Therefore it may well be that, in order to provide safely all of the health services in Queensland, now promised at the locations at which they have been offered, a sum greater than the \$1.2 billion a year would be required. And it seems to me from what I have said so far, that the required amount can never be ascertained merely by comparing Queensland's expenditure with that of other states.
- 6.69 In October 2005, the Premier and Treasurer, in delivering a 'Special Fiscal and Economic Statement', announced net new funding for Queensland Health. It is beyond my terms of reference and, as I have already indicated, in any event impossible for me to say whether that will be adequate, or if not the extent of the inadequacy, to provide an adequate safe public hospital system. What I have

¹⁰⁰ These hospitals service the sprawling working class suburbs on Sydney's southwestern outskirts.

¹⁰¹ NSW Health Care Complaints Commission, *Investigation report, Campbelltown and Camden Hospitals - Macarthur Health Service*, December 2003, p 3

¹⁰² NSW Health Care Complaints Commission, *Investigation report, Campbelltown and Camden Hospitals - Macarthur Health Service*, December 2003, p 4

¹⁰³ Conducted by a review team led by Professor Bruce Barraclough

¹⁰⁴ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁵ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁶ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 157

¹⁰⁷ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁸ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 155

¹⁰⁹ *Special Commission of Inquiry into Campbelltown and Camden Hospitals*, Final Report, p 157

endeavoured to do in this Part is merely to point to evidence before my Commission which casts doubt on the assumption, apparently made in the Final Report of the Queensland Health Systems Review that the amount referred to there would be adequate to provide, safely and adequately, all of the services now promised to all of the people to whom it is promised, at no cost to them.

- 6.70 In order to determine what that amount would be, it would be necessary, in each public hospital in Queensland, to estimate the cost of providing, at an adequate, safe level, the services which it offers. In order to determine what would be needed to provide any health service at any specified location, Queensland Health would need the advice of the Australian Medical Council and the specialist colleges. To take the example of the provision of an orthopaedic service at Hervey Bay, it is primarily only orthopaedic surgeons who can say what are the requirements, in terms of surgeons and supporting doctors and nurses, to provide such a service. And it is now plain that, if their advice had been sought before such a service commenced at Hervey Bay, it would never have been commenced. Without such an exercise first being carried out, it seems to me that Queensland Health cannot even begin to know what it would cost to provide a reasonably safe, adequate health service.

Can the promise ever be fulfilled?

- 6.71 Dr Waters is a hospital administrator of considerable experience. He had been District Manager of the Princess Alexandra Health Service District and the Royal Brisbane and Womens Hospitals Health Service District. He had also been the General Manager of the Wesley Hospital. He put the question this way:

The primary question is an issue of scope ... Queensland Health promises to the Queensland community to do all things to all people at all times and yet, clearly, it has a defined budget.¹¹⁰

This statement gives rise to a fundamental question which requires an answer. Can Queensland, or for that matter Australia, ever provide, at no cost and at an adequate and safe level, all of the services promised to all people, at least without a substantial increase in taxation or a substantial increase in income from other sources? The evidence before this Commission shows that it is not being provided in Queensland public hospitals. And from the indications from inquiries in other states it may be that it is not being provided there either.

- 6.72 Yet, if recent reported events are any guide, this seems to be a question which national leaders, on both sides of politics, seem reluctant to face or even admit exists. When the Queensland Government raised the possibility of co-payment for some services, both the Australian Health Minister and the Leader of the Opposition stated that all Australians were entitled to a free health system -

¹¹⁰ T4662 lines 45-51 (Dr Waters)

whatever that may mean. But neither questioned what it would really cost to provide all of the free health services, now promised to all Australians, at a level which is reasonably adequate and safe; or whether indeed that is realistically possible. That is a question which is beyond the scope of this Commission.

- 6.73 If it is not possible, then it may be necessary to consider whether either the number or extent of free services should be limited, or the classes of people to whom such services are provided should be limited, or both of these. It may not be possible for Queensland alone to do this consistently with its obligations under the Australian Health Care Agreement, but that question is outside the terms of reference of this Inquiry. The question whether free hospital services may be limited in any significant way may be one which can be, and should be addressed only on a whole of Australia basis. The reality is that Australia's national real health care spending¹¹¹ has been growing faster than the Australian economy in every year since 1990.¹¹² Sooner or later this imbalance must be addressed, as must the reality that, in Australia generally, free public hospitals do not appear to be providing those services adequately.

Possible solutions: abandonment of the culture of economic rationalism

Greater involvement by clinicians

- 6.74 There are two points to be made here. The first of these is, I think, now accepted by Queensland Health. A system which included an historical budget with an efficiency dividend was wrong and should be abandoned. And elective surgery targets diminished the quality of surgery and gave priority to elective surgery over emergency surgery. It is now accepted, I think, that individual hospital budgets must be based on the changing needs of each community.
- 6.75 The second point may not yet be accepted by Queensland Health. It is that there must be much greater involvement by doctors and also nurses, and less by administrators, in the allocation of individual hospital budgets, both among and within individual hospitals. I discussed earlier how administrators have triumphed over clinicians, at the expense of patient care and safety. This is likely to continue unless clinicians are given greater control in this respect.
- 6.76 I note that the *Queensland Health Systems Review*, Final Report, recommends that administrative staff be transferred from central office to the districts.¹¹³ This

¹¹¹ Total expenditure (recurrent and capital) on health care services in Australia was estimated to be \$72.2 billion in 2002-03 (Australian Institute of Health and Welfare 2004; table EA.1). This total was estimated to account for 9.5 per cent of gross domestic product in 2002-03, up from 9.3 per cent in 2001-02 and 8.2 per cent in 1992-93 (Australian Institute of Health and Welfare 2004)

¹¹² Australian Institute of Health and Welfare, *Health Expenditure Australia 2003-04*, Health and Welfare Expenditure Series - Number 25, September 2005, Canberra, p 7. See also Steering Committee for the Review of Commonwealth Service Provision, *Report on Government Services 2005*, E.5

¹¹³ *Queensland Health Systems Review*, Final Report, p xiv and pp 71-72.

may be a good thing if its purpose is to provide administrative support to doctors and nurses to ease their administrative burdens; for example, in the implementation of clinical governance policies, and those with respect to recording of complaints. But if it is, as I perceive it might be, so that they can determine budgets at a local level at the expense of clinician involvement, then I think that is a matter of some concern.

Townsville model

- 6.77 While the Townsville Hospital has little control over how much funding it receives from Queensland Health, the process by which that budget is allocated within that hospital has included greater clinician involvement. That process is described in Chapter Five, and while it may not be appropriate to every hospital in Queensland, the model may be capable of adaption to smaller hospitals.
- 6.78 The key features of the model are that the hospital is divided into clinical institutes. Each institute is headed by a medical director who is a doctor with both administrative and clinical responsibilities, and an operations director, who is a member of the nursing staff. The annual budget for each institute is negotiated between the executive and the directors of the Institute each year. This allows the director of each institute, who has a clinical role, to have input into the funding allocation each year. Each director is given financial delegation to enable him or her to purchase equipment and consumables; he is, to an extent, given the authority to hire nursing staff and junior medical staff; and he is accountable to the executive in the sense that he is required to meet the service standards agreed and ensure that budget integrity is maintained. The role of the executive is one of supporting the Hospital as a whole and balancing competing priorities across the Hospital.

Flexibility in the provision of services within a District and across Districts

- 6.79 Some flexibility is required in the provision of services within a District, especially in respect of specialist services. The *Queensland Health Systems Review*, Final Report, recommended a number of options to provide greater flexibility, which are worth repeating, including; greater use of Visiting Medical Officers,¹¹⁴ including on a per operation basis; and possible contracting out of surgical services to private hospitals and private specialists based on a fee for performance agreement.¹¹⁵ I mention in Chapter Six - Part C, the need to consider these matters when determining 'area of need' under s135 of the *Medical Practitioners Registration Act*. But they should be considered in all cases.

¹¹⁴ See the earlier discussion about Visiting Medical Officers in Chapter 2

¹¹⁵ *Queensland Health Systems Review*, Final Report, p129.

- 6.80 There should also be greater flexibility of services, especially specialist services, between neighbouring hospitals and districts. It may be necessary, for this purpose, to give greater discretion to those in charge of the respective Health Zones after consultation with specialists concerned and possibly also specialist colleges, to alter these priorities from time to time on a needs basis.

Financial incentives to experienced doctors and nurses

- 6.81 Queensland Health should also provide financial incentives to experienced doctors, especially specialists and nurses, to take positions, full time or on a part time, including sessional basis, in and to remain in, regional hospitals. I mention this also in Chapter Six - Part C when discussing the application of s135. The area of need scheme was premised on the assumption that such incentives would first be offered, but that has never occurred. It should be done, not just to comply with the spirit of the 'area of need' scheme, but to ensure better patient care in provincial areas.

Part C – A defective system of Area of Need Registration and its consequences; remedies

The defective system

- 6.82 This defective system has been discussed earlier in this report.¹¹⁶ It is proposed here to summarise the principal defects, to explain how they contributed to inadequate and even dangerous medical treatment and to make some consequent findings against the Minister, by her or his delegate, and against the Medical Board of Queensland.
- 6.83 There were two aspects of such registration and it is plain from the evidence before this Commission that there were defects in the administration of each. The first involved the making of decisions by the Minister's delegate, pursuant to s135(3) of the *Medical Practitioners Registration Act 2001*, that an area was an area of need; that is, that there were insufficient medical practitioners practicing in that part of the State to provide the service required at a level that met the needs of people living in that part of the State¹¹⁷. The second involved the process of registration under s135.¹¹⁸

¹¹⁶ See Chapter 3

¹¹⁷ especially in Chapter 3 – Defects in deciding that there is an area of need

¹¹⁸ especially in Chapter 3 – Defects in deciding that there is an area of need

Defects in deciding that there is an area of need

- 6.84 The scheme to which s135 of the *Medical Practitioners Registration Act* gives effect, is the result of an Australian Health Ministers Conference which on 4 August 1999 adopted a national framework to facilitate the recruitment of overseas trained doctors to work in rural areas.¹¹⁹ That provided that the State recruitment schemes, implemented in Queensland pursuant to s135, 'aim to attract general practitioners who do not require training or supervision whilst undertaking placement in rural and remote areas'. Plainly there was no point in recruiting overseas trained doctors to positions in rural or remote areas if they required training or supervision, unless it was contemplated that there would first be some period of training and supervision for it was unlikely that either would be forthcoming in such areas. Yet, though neither Bundaberg nor Hervey Bay is remote or rural, that is precisely what occurred in Bundaberg and Hervey Bay, and no doubt in other places.¹²⁰
- 6.85 Notwithstanding the apparent aim of the scheme, the Act is not, in terms, confined in its relevant operation to rural and remote areas, and an area of need is defined, in effect in s135(3), in the way in which I have described it in Chapter Two. Indeed it appears, on its literal meaning, that the whole or any part of the State could be an area of need for the purpose of the operation of this scheme; and almost any medical position in Queensland might be the subject of an area of need decision. Moreover the determination of whether an area is an area of need, as so defined, is left to the discretion of the Minister or his or her delegate.
- 6.86 Notwithstanding its apparent breadth, there may be nothing intrinsically wrong with a provision such as s135(3) if it is properly applied. But it wasn't. No serious attempt was made to ensure that an area in which an overseas trained doctor was sought to be appointed was an area of need; that is an area in which no Queensland registered doctors, or even Australian registered doctors would provide the relevant service. It was apparently envisaged that such a determination would be made' by examining a range of factors, including Medicare statistics, health workforce data and evidence of unsuccessful attempts to recruit an Australian doctor to a position'.¹²¹ But that was never done.
- 6.87 Moreover another equally important aim of the scheme to which s135 was to give effect was 'to encourage both new and existing GPs to relocate to rural areas through a variety of incentive programs.' Yet there seems to have been little in the way of encouraging newly registered general practitioners to relocate

¹¹⁹ See Appendix A to Exhibit 36. It nevertheless continues a similar scheme which existed under the Medical Act 1939; see former ss.17 C(d), 17C(2)

¹²⁰ Dr Patel in Bundaberg should have had supervision and been subject to peer review but neither was available. Drs Krishna and Sharma should have had close supervision in Hervey Bay but that was never available.

¹²¹ Exhibit 36 page 7

to rural areas¹²² and none to encourage existing general practitioners to do so. Obvious ways of doing so would have been to offer them part time employment in public hospitals with a right of private practice, or to offer higher salaries or conditions in employment in non metropolitan hospitals than those offered in metropolitan Brisbane hospitals, or to offer opportunities for further study which might not be available to those who work in metropolitan hospitals.

- 6.88 Indeed the converse appears to have been the case. There were many more advantages in working in tertiary hospitals in metropolitan areas than there were in working in provincial cities, let alone rural or remote areas.¹²³
- 6.89 The rationale of the scheme was such that area of need would be assessed only in a context in which sufficient incentives had been offered to new or existing duly registered general practitioners to make working in non metropolitan areas attractive to at least some of the general practitioners who might otherwise choose to work in metropolitan areas. Because that was never the case, assessment of area of need, even if the Minister's delegate had turned his or her mind to it, could never properly have been made. The scheme was therefore doomed from the start.
- 6.90 The result of all of this was that applications for area of need decisions were made and granted when in fact no such need could be demonstrated. It is unsurprising then that Queensland Health has many more overseas trained doctors than any other State, or that it has a very high proportion of overseas trained doctors in its workforce.¹²⁴
- 6.91 The Minister's delegate assumed that, if an application was made for an area of need certification, that was, in itself, proof of a need because it was assumed that hospital administrators would prefer Australian trained doctors.¹²⁵ But indeed the converse may well have been the case. There is at least some cause for the suspicion of Australian trained doctors that overseas trained doctors are preferred by administrators because they are more compliant and more accepting of conditions and directions than their Australian trained counterparts, because of the control which administrators have over the visas of such doctors.¹²⁶

Finding against the Minister's delegate

- 6.92 I find that, during the relevant period, the Minister's delegate failed to perform her statutory duty under s135(3).

¹²² Except for the rural scholarship scheme: see Chapter 2

¹²³ See Chapter 2

¹²⁴ About 50 per cent. See Chapter 2

¹²⁵ See Chapter 2

¹²⁶ See Chapter 2

Defects in Area of Need Registration of doctors other than registration in a speciality¹²⁷

- 6.93 In the first place, the Medical Board, whose function it was to register such doctors, performed the role of checking credentials in only a cursory way. The most striking illustration of a disastrous consequence of this is the registration of Dr Patel in circumstances in which a more thorough examination of his Certificate of Licensure from Oregon would probably have led to the discovery that he had been disciplined and prevented from practising in certain surgery in Oregon and that his licence to practise surgery in New York had been suspended; and a more than cursory examination of his employment history would have led someone to have enquired why there was a discrepancy between two versions of this and why, according to one of them, he had been unemployed for about a year. But an earlier example was the registration of Mr Berg pursuant to s17C(l)(a) of the *Medical Act* in circumstances in which inquiry from the University from which he claimed to have graduated, would probably have revealed that his credentials were forgeries.
- 6.94 Secondly, the problems in the administration of the scheme were compounded, and the risk to patient safety further threatened, by the fact that no-one, the Minister's delegate, the Medical Board or Queensland Health, made any assessment of the capability of the proposed applicant for registration pursuant to s135 to perform adequately the role to which he or she was to be appointed. The decision which initiated this scheme, that of Australian Health Ministers of 4 August 1999 included the following decision:
- Assessment processes for overseas trained GPs to be consistent with processes in specialist colleges
- 6.95 As appears from what I say below, deemed specialist registration required a process of assessment by the relevant college of the applicant's suitability to practise in the speciality. It need hardly be said that, without such an assessment by some competent body, the Medical Board could not make an informed judgment that an applicant had the qualification and experience suitable for practising the profession in the designated area of need.
- 6.96 These failures to verify independently the credentials of an applicant and to assess his suitability for the position were compounded by the fact that, increasingly, applicants for these positions tended to come from countries with different cultures and first languages from ours, from a medical educational system which was either less developed than ours or one in respect of which it was difficult to make an informed judgment.

¹²⁷ See Chapter 2

- 6.97 Moreover no attempt was made by any of the persons or bodies to whom I have referred, before May 2004, to assess the language skills, or knowledge by applicants of the Queensland medical and hospital system, or to provide any instruction in respect of either. The result was that doctors were appointed under this scheme who had communication problems or who had difficulties in understanding the system in which they operated.
- 6.98 And finally, the Medical Board seemed never, or at least rarely to impose conditions upon registration, such as a condition requiring supervision, as it could have done. It did not do so in this case of Dr Patel in Bundaberg or Dr Krishna or Dr Sharma in Hervey Bay.
- 6.99 A consequence of the failure to assess suitability of applicants in the course of the registration process, but also of the absence of any adequate credentialing and privileging process, is that many area of need appointees were appointed in circumstances in which they should never have been appointed, or plainly needed supervision at least until their skills could be assessed, but were nevertheless permitted to work immediately in positions in which it was plain that no such supervision would be provided. This occurred in the case of Dr Patel at Bundaberg, in the cases of Dr Krishna and Dr Sharma at Hervey Bay,¹²⁸ and in the case of Dr Maree in Charters Towers. It is likely that it occurred elsewhere.¹²⁹ Indeed, it seems, those who were most in need of peer assessment or of supervision were appointed to positions where neither was likely to be provided. That is because, unsurprisingly, those whose skills were most demonstrably evident, those who came from educational and hospital systems which were closely comparable to our own, were appointed to the most sought after jobs, those in metropolitan tertiary hospitals.
- 6.100 As mentioned earlier, appointment as a Senior Medical Officer, or to any level below that, generally implies that the appointee would be supervised. And in the case of each of Dr Patel at Bundaberg Base Hospital, and Dr Krishna and Dr Sharma at Hervey Bay Hospital, the applications for registration indicated that each would be supervised, although that could never have occurred at either place, and Dr Nydam at Bundaberg and Dr Hanelt at Hervey Bay knew that. It would have been appropriate in the interests of patient safety, for the Board not only to impose a condition of the registration of each, that he be so supervised, but to ensure that such a condition was enforced.
- 6.101 The scheme for special purpose registration in areas of need, as so administered, had this disastrous result. Those who lived in other than metropolitan areas suffered a lower standard of medical care in public hospitals

¹²⁸ Although, as appears from the evidence of Dr Wilson, Dr Krishna had, to some extent, had his skills assessed at Toowoomba

¹²⁹ See Chapter 2

than those who lived in metropolitan areas. This remains the position today. It is plainly a morally unacceptable position.

Deemed specialist registration

- 6.102 Where a person registered under s135 is registered 'to practise the profession in a specialty', the registrant 'is taken also to be a specialist registrant in the specialty'.¹³⁰ The purpose of this provision, it is said, is to ensure that areas of need registrants who have been assessed and approved for registration by a relevant specialist college should, in order to claim Medicare benefits, be deemed to be a specialist.¹³¹
- 6.103 This process of assessment of suitability by the specialist colleges seems to have worked reasonably well because such colleges have tended to accept as deemed specialists only those persons who are adequately qualified as such.¹³² Additionally, almost invariably the relevant specialist college will require, as a condition of the applicant's registration, supervision and continuing medical education. However, I suggest in this Part that a period of probation in a tertiary hospital under the supervision of specialists in that speciality, may assist in making that assessment.

English language assessment

- 6.104 It was plainly assumed by the Commonwealth, from the commencement of the *Medical Practitioners Registration Act* 2001 that there would be an English language assessment of all applicants for registration under s135.¹³³ By then, because of the substantial increase in the number and proportion of applicants from countries whose first language was not English that was necessary. So also was some assessment of the applicant's knowledge of the Queensland medical and hospital system. Yet, as already mentioned, it was not until May 2004, after the events which gave rise to this Inquiry, that the Medical Board introduced any such language assessment. No system of assessment of an applicant's knowledge of the Queensland medical and hospital system or any instruction on that subject yet exists.

Circumvention of the requirements for deemed specialist registration

- 6.105 No doubt because of the failure in practice to make the process of deemed registration consistent with the process of deemed specialist registration, which, as I have said, in practice required a process of assessment of suitability, the

¹³⁰ s143A which is reproduced in Chapter 2

¹³¹ See Chapter 2

¹³² The process is set out in Exhibit 36. See Chapter 2

¹³³ See Exhibit 36 pp 16-17

latter process has been circumvented in two ways. One of these is deliberate; the other, it appears, is inadvertent.

- 6.106 Because there was no effective system of monitoring, by the Medical Board or anyone else, the employment of a doctor registered under s135 became easy to circumvent the requirements for deemed specialist registration. What happened to Dr Patel is an example of this and of the appalling consequences which may follow.
- 6.107 Dr Patel was appointed as a Senior Medical Officer in surgery. As already mentioned, he was able to obtain registration under s135 without any independent assessment having been made of his suitability. Had an application been made for him to be appointed as a deemed specialist, the Royal Australasian College of Surgeons would, no doubt, have conducted a thorough assessment of his qualifications, experience and competence. It is, at least, very possible that that process would have revealed his suspensions, and the circumstances in which he ceased to be employed in Portland, Oregon. What occurred, however, as is now clear, is that his application did not follow the deemed specialist path notwithstanding that, at the time it was made, it was the intention of his future employer to appoint him immediately to the position of Director of Surgery at Bundaberg Base Hospital, a position in which, it was known, he would neither be supervised nor subject to peer review. This occurred again upon the renewal of his registration in March 2004. This, it seems, was a common way in which to circumvent the requirements for deemed specialist registration.¹³⁴
- 6.108 The other way in which, it seems, the requirements for deemed specialist registration were circumvented appears to have been by an inadvertent but negligent failure by the Medical Board to advert to the effect of s143A(2). This may be illustrated by the cases of Dr Krishna and Dr Sharma in respect of neither of whom was deemed specialist registration sought. Section 143A provides that a registrant is taken to be a specialist registrant in a specialty if the registrant is registered 'to practise the profession in a specialty in an area of need'. Orthopaedics is a specialty within the meaning of s143A(2).¹³⁵ And both Drs Krishna and Sharma were thereby, on one occasion each, registered to practise their profession 'in a specialty' in an area of need.
- 6.109 Dr Krishna's first registration under the *Medical Practitioner's Registration Act*, (he had previously been registered under the *Medical Act 1939*) was in July 2002. No reference was made in that registration or in his registration certificate to any specialty. Curiously, however, in the following year he was registered for special purpose registration 'under section 135 to fill an area of need as a Senior

¹³⁴ See Chapter 2

¹³⁵ See Chapter 3, definition of 'specialty'; and the *Medical Practitioners Registration Regulation 2002*.

Medical Officer in Orthopaedics'.¹³⁶ Then in the following year, he was once again registered in a way which made no reference to a specialty.

- 6.110 Dr Sharma was first registered on 25 February 2003. No reference was made in that registration to any specialty. He was registered in the following year again with no reference being made to a specialty. Yet, curiously, on 17 January 2005 he was registered for the following year as 'Senior Medical Officer in Orthopaedics'.¹³⁷
- 6.111 It is accepted that, at no time, was it the Medical Board's intention to register either Dr Krishna or Dr Sharma as a deemed specialist.
- 6.112 Some other examples of the Medical Board having registered doctors pursuant to s135 'in' a designated specialty where there had plainly been no intention to register the applicant as a deemed specialist, were uncovered by this Commission. There is no evidence that any of the certificates issued to that effect had any detrimental consequences. Whilst it is true that Mr Allsopp represented to the public, through the local newspaper in January 2003 that, in effect, Drs Krishna and Sharma were both orthopaedic surgeons, there is no evidence that this was because of the terms of any certificate of any registration issued to either of them.
- 6.113 Nevertheless, this apparently random and idiosyncratic practice of registering and certifying registration in a way that sometimes did and sometimes did not describe the registrant as a deemed specialist in circumstances in which there was no intention to register the registrant as such, is alarming. So too is the fact that, before this Commission, the Board sought to maintain the untenable position that, for example, Dr Krishna's certificate of registration in 2003, and Dr Sharma's certificate of registration in 2005 did not represent that each was a deemed specialist. To be fair to the Board and its representatives before this Commission I should refer specifically to that submission.
- 6.114 At page 27 of its submission, the Board submitted as follows:
- It is submitted that it would be inconsistent with the evident scheme of ss 135, 139(2), and 143A of the Registration Act to construe the words 'to practise the profession in a specialty in an area of need' as having the effect that any reference on a special purpose registration certificate to a branch of medicine in which a junior practitioner will practise means that that practitioner is deemed to be a specialist.
- 6.115 That may be right. But if, more specifically, a certificate of registration issued pursuant to s.135 states that a registrant is registered to practise 'in X' and X is a defined specialty (as Orthopaedics was) that certificate represents that the registrant is to be taken to be a specialist registrant in that specialty. That is

¹³⁶ Exhibit 461, JPO 16-N JPO 16-P

¹³⁷ Exhibit 461, JPO 17 - K

what happened in the case of Dr Krishna in 2003, and in the case of Dr Sharma in 2005. It also appears to have happened in respect of other registrants. And there were other examples of the Board acting in ignorance of the meaning and effect of s.135.¹³⁸

Findings against the Medical Board with respect to registration

6.116 In the light of what I have said so far, it is convenient that I now discuss specifically the findings which I propose to make against the Medical Board in this respect.

6.117 In the first place, it was the obligation of the Medical Board to consider and determine whether an applicant for registration under s135 had the medical qualification and experience suitable for practicing in the designated area of need. In the case of registration of a person in a specialty, the Medical Board was entitled to rely on the recommendation of the relevant College which carried out an assessment of that suitability. As already mentioned, there does not appear to have been any similar process of assessment with respect to registration of persons other than as deemed specialists. The result appears to have been that no assessment by anyone qualified to do so was made of suitability of an applicant to practise the profession in the designated area before May 2004, and thereafter an assessment was made only in respect of English language skills.

6.118 The Medical Board sought to answer this apparent failure by submitting that:

the primary responsibility for matching the clinical skills of an area of need applicant with the position description of the area of need position as certified by the employer rests, in the case of Queensland Public Hospitals, with Queensland Health during the recruitment and selection process. To effect registration the Medical Board is then charged with the obligation to ensure that the applicant has the requisite qualifications and experience 'suitable for practicing the profession in the area'. This obligation upon the Medical Board requires the exercise of discretion upon facts which are subjective in each case.¹³⁹

6.119 Whatever that submission may mean and whatever the responsibilities were of Queensland Health or the relevant hospital, the Medical Board had the statutory responsibility referred to in s135(2), and that required it to make its own independent assessment of suitability.

6.120 It is plain, from what I have said so far, that the Board failed to discharge that obligation. It did not seek the assistance of the Royal Australian College of General Practitioners or of the Australian Medical Council upon whose recommendation, in either case, it perhaps could have relied. Nor did it seek the

¹³⁸ See Chapter 6

¹³⁹ Submissions of the Medical Board at p2

assistance of any tertiary hospital in assessing the suitability of an applicant as it perhaps could have done.

- 6.121 Prior to May 2004, the Board failed in its obligation even to assess the understanding and communication skills of the applicant in the English language. There is no rational reason why, from the commencement of operation of this scheme under the *Medical Practitioners Registration Act*, the requirement, belatedly introduced in 2004, was not in force in respect of applications made under s135.
- 6.122 It also failed in its obligation to ensure that the applicant knew sufficient about the Queensland medical and hospital system to enable him to practise in the designated area. The term 'experience' in s135(2) plainly included the experience of all matters sufficient to make him suitable to practise in that area. That determination of this aspect of the question might result in refusal of registration, or registration subject to certain conditions.
- 6.123 I find the Medical Board failed to make any adequate assessment upon which to conclude that applicants under s135 had the medical qualifications, and experience suitable for practising the profession in the designated area of need.
- 6.124 The Medical Board has the power and the duty to impose conditions where it considers it 'necessary or desirable for the applicant to competently and safely undertake the activity the subject of the application. Consistently with that obligation, the Medical Board should have, but failed to, impose a condition on the registration of medical practitioners registered under s135, that they not treat patients before they have been credentialed and privileged. And it should have, but failed to, impose a condition on the registration of each of Drs Patel, Sharma and Krishna that he be subject to the supervision of the Director of Surgery, in the case of Dr Patel, and the Director of Orthopaedics, in the cases of Drs Sharma and Krishna. The extent of that supervision could, of course, be refined by a credentialing and privileging committee. These should ordinarily be common conditions. But I would not be prepared to find that, in the case of Dr Patel's first application, the Board should have enquired into whether there was, in fact, a Director of Surgery who could have provided that supervision.
- 6.125 I find the Medical Board failed to impose necessary conditions upon the registration of applicants under s135.
- 6.126 Nor am I prepared to find that the Medical Board failed to require the applicant in any of these cases, to identify the person or persons who were to provide supervision. No doubt, with hindsight, that would have been a desirable course and should now be required. But I think that the Medical Board was entitled to assume, in each of the cases of Bundaberg Base Hospital and Hervey Bay Hospital, that there was indeed a person who could provide that supervision if it were ordered.

- 6.127 When one comes to the inquiries which the Board made with respect to Dr Patel before accepting on their face what appeared, from a cursory examination, to be adequate evidence of qualifications and experience, I think that its conduct fell short of what would reasonably have been expected. The problem for the Medical Board, and also for Queensland Health, is that each appears to have delegated its responsibilities to check Dr Patel's credentials to a commercial entity, Wavelength, which had a financial interest in securing Dr Patel's appointment.
- 6.128 An additional problem for the Board in any assessment of the adequacy of its scrutiny of applications for Area of Need Registration is that, by the time of Dr Patel's appointment there had been, for many years, a steady increase in applications for Area of Need Registration by applicants from countries with less developed educational and hospital systems than ours, and from countries of whose educational and hospital systems little was known. As the demand in Queensland for overseas trained doctors continued to outstrip supply, the risks of insufficiently competent and even fraudulent applicants were steadily increasing. Yet the Medical Board did not consider the need for any increased scrutiny.
- 6.129 The Board now acknowledges that if it had sought a certificate of good standing from the issuing authority, Dr Patel's suspension would have been revealed. And it was, in my opinion, plain that if the Board had checked with Dr Patel's former employer, that would also have revealed that he left employment a year before, in his amended CV, he said he had, and, probably also, that he had been disciplined in his practice as a surgeon. In my opinion, the Board should have taken both of these courses.
- 6.130 In its submission, the Board points to Queensland Health's 'primary responsibility' for making these checks and to the apparent reliability of Wavelength. But it is plain that the Board had a statutory duty to ensure that an applicant had the medical qualification and experience to practise the profession in the area. The Board could not avoid that responsibility by referring to the responsibility of Queensland Health or the apparent reliability of Wavelength.
- 6.131 So far as the Board made any checks of an applicant's credentials, that was only of documents supplied by the applicant.¹⁴⁰ That process was plainly inadequate. Moreover it was performed by low level clerks who should not have been asked to assume that responsibility.¹⁴¹ It is one thing to employ clerks to check on formal completion of documents and to ensure that they came directly from the maker. But it is quite another to require them to assess the completeness of certificates of good standing, given that they may be in different forms from the

¹⁴⁰ The process is described at Chapter 2. 29.

¹⁴¹ See Chapter 2

different countries. It is unclear whether the deficiency referred to in this paragraph was because of inadequate resources or of poor administration or a combination of both.

6.132 I find that:

- (1) The Medical Board failed, before registering Dr Patel, to obtain directly from the registering authority in all jurisdictions in which he had practised, a certificate of good standing.
- (2) The Medical Board failed, before registering Dr Patel, to obtain from his last employer a certificate of good standing, and an explanation of the circumstances in which he left that employment.
- (3) The Medical Board failed, before registering Dr Patel, to adequately check the documents supplied by him on the basis of which he sought registration.

6.133 Finally, the certificates of registration issued to Dr Krishna in 2003, and to Dr Sharma in 2005 shows, worryingly, that the Medical Board failed to understand the effect of those certificates. There are other examples of the failure of the Medical Board to understand the effect of s135, for example, the letter from the Medical Board to Dr Patel, upon the renewal of his registration in 2004 that 'special purpose registration enables you to fill an area of need at Bundaberg Hospital, *or at any other public hospital authorised by the Medical Superintendent* on a temporary basis'. As I pointed out earlier, this had no legislative basis. Special purpose registration under s135 enabled a registrant to practise in and only in an area of need, not in any other public hospital authorised by a medical superintendent.

Recommendation

6.134 That the Medical Board obtain legal advice upon the meaning and effect of the Act under which it operates, so that it does not issue misleading certificates, or give misleading advice.

Delay

6.135 There was also criticism before this Commission of the delay in the time taken to obtain Area of Need Registration. The causes of this were not explored before this Commission though they appear to be an insufficiency of resources and consequently of qualified staff. They should be investigated and this delay reduced. It has caused substantial problems. No doubt the additional requirements referred to in paragraphs 6.136 to 6.167 will add to that delay in the absence of further adequate resources. On the other hand, if the recommendation in Chapter Six - Part E is adopted the removal of the Board's power to investigate and adjudicate against doctors will permit the resources presently deployed in performing those functions to be deployed elsewhere.

What is needed to make Area of Need Registration effective and safe: steps taken since 2003

Area of Need determination

6.136 There do not appear to have been any material changes relevant to the matters to be considered for area of need certification. Those deposed to by Dr Huxley relate to the adequacy of the credentials of the applicant.¹⁴² However, it is apparently proposed that the task of such certification will be delegated to the Executive Officer of the Office of the Health Practitioners Registration Board. I shall discuss that later.

Registration by the Medical Board

6.137 Since 2003 the following changes have been made by the Medical Board of Queensland to its system for determining, pursuant to s135(2) of the *Medical Practitioners Registration Act*, whether a person has a medical qualification and experience suitable for practising the profession in a designated area of need:

- (1) Certificates of Good Standing to be provided directly by the registering authority in all jurisdictions in which the applicant has practised and from his/her jurisdiction of training. In addition, a software driven process for searching the Internet about an applicant's disciplinary history is now being used;
- (2) The applicant to provide a full practise history, in the form of a standard curriculum vitae, from the time of qualification to the time of application, and to explain any gaps in the practise history to the Board's satisfaction;
- (3) The applicant to advise whether he/she has attempted any medical qualifying examination(s) and, if so, the results of that examination(s);
- (4) The applicant to advise of any skills assessment, bridging program or periods of observer-ship undertaken in any Australian or New Zealand health care or skills assessment facility (and specifically at the Skills Development Centre, Royal Brisbane and Women's Hospital);
- (5) The applicant to consent to the Board seeking assessment reports relating to any practise of medicine, periods of observer-ship, bridging programs or assessment of skills undertaken in any Australian or New Zealand health care facility;
- (6) The applicant to acknowledge that making a materially false or misleading representation or declaration in the application is a ground for cancellation of registration and that the giving of materially false information or a document to the Board in connection with the

¹⁴² Exhibit 58 par 17; T939/55 to 940/10

application is an offence punishable with a maximum penalty of AUS\$150,000.00 or 3 years imprisonment.

- (7) Queensland Health, if it is the employer, to provide a copy of the appointment letter or offer of employment;
- (8) The employer to certify it has assessed the applicant and, based on that assessment, is satisfied the applicant has the qualifications, experience and capabilities needed for the position;
- (9) The employer to certify, utilising mandatory reference check questions, that verbal reference checks have been undertaken and that the referees verify; the experience and capabilities of the applicant; and the accuracy and completeness of any information supplied by the applicant in relation to his/her previous employment history and experience during the previous five years;
- (10) The employer to nominate a clinical supervisor who has current, general, specialist or s138 registration. For senior doctors, it is required that a Visiting Medical Officer, staff specialist or Director of the speciality department (who is Australian qualified) to be the nominated supervisor;
- (11) The clinical supervisor to agree to supervise the applicant and provide the Board any adverse reports as they are identified, and to provide an assessment form at the end of the applicant's approved period of registration;
- (12) The clinical supervisor to provide details as to how the supervision will be provided.
- (13) The applicant to organise, from 1 October 2005, provision of a certificate of primary source verification from the International Credentials Service of the US Educational Commission for Foreign Medical Graduates directly to the Board.¹⁴³

6.138 There are several matters omitted from this list which should by now have been included. These, and the apparent reliance in (8) and (9) above upon the proposed employer to perform the Board's statutory obligation to satisfy itself that the applicant has the medical qualification and experience suitable for performing the profession in the identified area of need, show, in my opinion, that the Board still does not appear to appreciate its statutory duty.

6.139 The first and most notable omission from the above list is an obligation upon the Board to check, directly with the applicant's last supervisor, the applicant's previous employment history, the circumstances in which he or she left his last employment if he or she has already done so, and his or her standing. That, it seems to me is a fundamental and necessary part of the performance by the Board of its statutory obligation. In the case of Dr Patel, it would have revealed

¹⁴³ Exhibit 420

that, in fact, he had been unemployed for a year, and probably also, the limitations placed upon his practise by disciplinary proceedings against him.

- 6.140 The second omission, even in (9) above, is of an obligation to check directly with referees, including some not nominated by the applicant for such an approach. Again, in the case of Dr Patel, such an approach ought to have put the Board on inquiry as to Dr Patel's true standing.
- 6.141 The Board cannot discharge its obligation under s135 (2) by, in effect, leaving it to the employer to perform that obligation and relying on it as it appears to have done in (8) and (9) above. There is nothing wrong with requiring the employee to perform those tasks. But that does not relieve the Board from performance of its stated obligation. It must, itself or by a competent independent delegate, assess the clinical skills and competence of the applicant as being suitable for practicing the profession in the designated area of need. I shall discuss later what that should involve. It must also check directly with at least some referees.

Steps which must now be taken

A decision that an area is an area of need for a medical service

- 6.142 It need hardly be said that there must be a genuine decision that an area is an area of need for a medical service. As mentioned earlier, it seems that, to date, there has been no genuine decision that this is so.
- 6.143 Exhibit 36 provides:
- An [Area of Need] refers to a geographic area....in which the general population need for health care is not met. It is determined by examining a range of factors, including Medicare statistics, Health Workforce data, and evidence of unsuccessful attempts to recruit an Australian doctor to a position.
- 6.144 It is necessary to consider the last of these factors, evidence of unsuccessful attempts to recruit an Australian doctor to a position, in a context in which steps have already been taken to fulfil the government's aim 'to encourage both new and existing general practitioners to relocate to rural areas through a variety of incentive programs'.¹⁴⁴
- 6.145 The only incentive offered to new general practitioners to go to rural areas, of which evidence was given in this Inquiry, is the rural scholarship system pursuant to which Queensland Health pays an allowance to medical undergraduates for a period of time during their studies, in repayment of which the young doctor, after spending a period first in a larger hospital, is required to work for a time in a rural location.¹⁴⁵ There was no evidence of any incentives provided to existing general practitioners to relocate to rural or even provincial

¹⁴⁴ Appendix 1 to Exhibit 36

¹⁴⁵ Chapter 2

centres to work in public hospitals. Given that it was in the context of such incentives having been provided that it was anticipated that areas of need would be determined, in my opinion there can be no genuine area of need decision made unless such incentives are provided, and, notwithstanding those incentives, an Australian trained doctor cannot be persuaded to accept the position.

- 6.146 It is therefore essential that, without delay, incentives be provided to Australian trained doctors to work in hospitals outside metropolitan areas. I have already suggested a number of ways in which those incentives could be provided.¹⁴⁶
- 6.147 Only after those incentives are in place can a realistic area of need decision be made. If, notwithstanding the provision of appropriate incentives, attempts to recruit an Australian doctor to a position have been unsuccessful, the question which should then be considered is whether that medical service can be provided in that area in some other way; that is other than by engaging a person who needs special purpose registration. It may, for example, be capable of being provided by specialists or general practitioners in the area serving on a part-time basis in the hospital. Or it may be capable of provision by outsourcing the service to another nearby public hospital or to a private hospital. These avenues should be explored before a decision can be made that there are insufficient medical practitioners practising in the State, or part of the State, to provide the service at a level that meets the needs of people living in that part of the State.
- 6.148 There was evidence that the task of certifying that an area was an area of need for a medical service would be delegated to the Executive Officer of the Office of the Health Practitioners Registration Board. That is a good thing in one sense, namely that it has been delegated to a body independent of the public hospitals and of Queensland Health. But it is plain from what I have said that two further steps need to be taken urgently. They are:
- (i) Incentives must be provided to Australian trained doctors, established as well as recently graduated, to relocate to provincial areas where further medical staff are required in public hospitals.
 - (ii) Guidelines must be provided to the Board as to how to determine whether an area is an area of need for a medical service.

Determining medical qualification and experience suitable for practising the profession in an area

- 6.149 The implementation of s135(2) must be seen in the light of an aim of the scheme to which it gives effect; 'to attract general practitioners who do not

¹⁴⁶ Chapter 3

require training or supervision whilst undertaking placements in rural and remote areas'.¹⁴⁷ It can be seen from what has been said so far that the scheme, as presently administered, is no longer achieving that aim. A very high proportion of applicants for positions in areas of need are from developing countries with educational facilities and hospital systems less developed than ours. These are doctors who are most in need of training and supervision. Yet they are being placed in positions where it is likely that they will receive neither. As already mentioned, this has been a major cause of the inadequacies in patient care and safety revealed at public hospitals, especially those in non-metropolitan areas.

- 6.150 In order to ensure adequate patient care and safety, it is essential that those persons who are placed in areas of need where adequate supervision may not be readily available are those who can function adequately and safely without further training or supervision. This requires two pre-conditions. The first is a process of adequate assessment of the suitability of an applicant to practise in the designated area of need. And the second is, as a result of that assessment a determination of the extent to which the applicant may need further training and supervision, and consequently whether, and if so, where that person may be placed for employment.
- 6.151 A comprehensive assessment process was advanced by Dr Lennox in Exhibit 55 but never adopted. There is no point now in considering whose fault that was. But it is likely that, at bottom, the problem was an insufficiency of funds to establish an adequate training and assessment facility.
- 6.152 Dr Lennox suggested that assessment of an applicant would need to be made in four areas:
- (1) English language competence and capability in the Australian context;
 - (2) Cultural safety – Australian culture generally, rural and indigenous cultures specifically;
 - (3) Clinical competence and capability – in diagnosis and management of illness and injury, preventive health and public health management;
 - (4) Understanding of the Australian and Queensland health care settings.¹⁴⁸
- I agree with that.
- 6.153 It may be that the assessment of clinical competence and capability may need to be more specific depending upon the area of need sought. In the case of Dr Krishna and Dr Sharma, for example, the asserted area of need was in the orthopaedic unit at Hervey Bay. Consequently, assessment would need to have been made specifically of orthopaedic skills.

¹⁴⁷ Appendix 1 to Exhibit 36

¹⁴⁸ Exhibit 55, 'management of international medical graduates' at page 9.

- 6.154 Dr Lennox also expressed the view that the assessment should be accredited by a tertiary institution and he suggested perhaps the Skills Development Centre. There was some other evidence before the Commission about the Skills Development Centre¹⁴⁹ but I do not have sufficient information about it to assess its capability to make an adequate assessment of applicants in the above respects. I can say only that such an assessment is necessary and that it should be made by an appropriately qualified and independent body. The Royal Australian College of General Practitioners and the Australian Medical Council would no doubt, be such bodies in most cases. But in cases in which it is intended that the service be within some speciality, it may be more appropriate for it to be a specialist college. But those bodies may not have the means to perform that task; and the cost of that assessment must be borne by Government.
- 6.155 Unless the appropriate body certifies that the applicant is capable of operating independently in the proposed position with no or minimal supervision, he or she should not be appointed to an area of need where adequate supervision cannot be guaranteed. Where an applicant is assessed as being capable of performing adequately in a public hospital only subject to supervision, he or she should be appointed only to a hospital where that supervision can be assured. That will generally be only a hospital in a major metropolitan area. As the evidence has shown, that assured supervision did not exist in either Bundaberg or Hervey Bay.
- 6.156 The experiment at Townsville Hospital with respect to Dr Myers might, with appropriate safeguards, provide a useful analogy to assist in any such assessment. And it might also be appropriate, where deemed specialist registration is sought, to assist the specialist college in assessing the specialist suitability of the applicant. The problem with the process in Townsville in that case was that there were insufficient neuro-surgeons to enable Dr Myers to be properly supervised and assessed during his 'locum' period. But the practice of requiring overseas trained doctors to spend a period of probation under the supervision of doctors in a tertiary hospital may assist in making an assessment of the suitability of an applicant in either case.
- 6.157 For registration under s135, except as a deemed specialist, it may be sufficient to require an applicant, as a pre-requisite of registration, to spend a probationary period of, say, six months in a tertiary hospital where his skill and competence to perform in the position for which he has applied may be assessed. To take an example, Dr Krishna and Dr Sharma could have been assessed over such a period by working with specialists in the orthopaedic unit at Royal Brisbane Hospital or Princess Alexandra Hospital, not for the purpose of deemed

¹⁴⁹ See for example, Dr Buckland, Exhibit 336 par 132 and following.

specialist registration, but for the purpose of assessing what, if any orthopaedic surgery they could perform in the orthopaedic surgery unit at Hervey Bay Hospital department and the extent to which that performance would need to be supervised, and consequently conditions imposed on registration under s135. Such a process would not be a substitute for credentialing and privileging which would still be required at a local level. It might, however make the task of credentialing and privileging easier.

- 6.158 The extent to which training facilities should also be provided to equip overseas trained doctors to pass an assessment sufficient to enable them to practise in an area of need is a matter beyond the scope of this report. It could only be determined after balancing the cost of incentives to Australian trained doctors to provide those services and the high desirability that those services should, wherever possible, be provided by Australian trained doctors, against the costs of training overseas trained doctors to provide them.

Imposing and enforcing necessary conditions

- 6.159 Doctors registered under s135 should ordinarily be registered subject to some condition with respect to supervision: see chapter 6.37.
- 6.160 It is essential that overseas trained doctors registered under s135 should, as soon as reasonably practicable, proceed to obtain Australian registration by qualifying either through an Australian College, including the College of General Practitioners or through the Australian Medical Council. A condition has apparently long been imposed, but rarely, if ever, enforced, that this occur within 4 years of special purpose registration. Dr Huxley said that this was now being enforced but there was no evidence of how this was being achieved.
- 6.161 I would question whether a person registered under s.135 should be permitted as long as four years within which to qualify for Australian registration. But there is insufficient evidence upon which to reach a conclusion on this question. What is clear is that, in deciding whether registration, at the end of the first or any subsequent term thereof, should be renewed, consideration should be given to the progress made by the applicant in this respect.

Conclusion with respect to registration under s135

- 6.162 Unless both the letter and the spirit of s135 (3) in respect of area of need certification, and of s135 (2) in respect of the qualification and experience sufficient to show suitability to practise the profession in an area of need, are complied with – and it is plain that they have not been in the past – the serious risk of inadequate care and the consequent risk to patient safety will remain. There is no doubt that the failure to adequately comply with the letter and spirit of these provisions contributed to the tragic circumstances in Bundaberg and to the dangerous situation which developed in Hervey Bay. Until they can be complied with, there should be no further appointments made pursuant to s135.

- 6.163 There has been no evidence before this Commission of applicants for special purpose registration pursuant to s135 being appointed provisionally pursuant to s143. Except possibly for the purpose of permitting probationary registration, only for the purpose of permitting assessment of an applicant's skills and competence by experienced practitioners in a tertiary hospital, pursuant to the proposal canvassed above, in my opinion, s143 should not apply to applicants for special purpose registration pursuant to s135. To be permitted to be so registered is conducive to the dangers to which I have already referred.

Recommendation: amendment of s135

- 6.164 In view of the continued failure over a substantial period of the Minister's delegate to perform the duty implied by s135(3) and of the Medical Board to perform the duty implied by s135(2), the question arises whether the matters required to be taken into account in the performance of each of these duties should be stated specifically in s135. I think that they should.
- 6.165 However, it is not my intention to draft amendments which would achieve that. Indeed, that would be impossible because they cannot be made until certain other things are done first. Examples of these are incentives to be provided to Australian trained doctors to relocate in areas of need, in the case of the first of those duties, and determination of the appropriate body or bodies to assess the suitability of applicants, in the case of the second of those duties. Instead I propose to set out the matters which as appears from what I have said, I think need to be taken into account in making each of those decisions.
- 6.166 In making the decision under s135(3), the Minister's delegate should take into account, amongst other things:
- (1) Whether a service that meets the relevant need can be conveniently provided in some other way; for example, by practitioners in private practise in the same or a nearby area on a part time basis; or by doctors working in another hospital, private or public, in the same or nearby area;
 - (2) What incentives have been provided to Australian trained doctors to relocate in the relevant area;
 - (3) What endeavours have been made to employ Australian trained doctors to perform that service; and
 - (4) The financial and safety consequences of the transfer of patients to other facilities.
- 6.167 In making the decision under s135(2) the Medical Board should take into account, amongst other things:
- (1) The credentials of and experience of the applicant to be assessed in accordance with the guidelines referred to earlier;

- (2) In the case of an application for deemed specialist registration, the suitability of the applicant to perform the service in the designated area as a deemed specialist, after taking into account the assessment in that respect of the relevant specialist college;
- (3) In the case of other applications, the suitability of the applicant, to perform the specified service in the designated area, after taking into account the assessment of an appropriately qualified and independent body capable of assessing that suitability;

In both cases including:-

- the level of competence of the applicant in understanding and communicating in oral and written English, after taking into account the assessment of an independent body appropriately qualified to make such assessment.
- the level of knowledge and understanding of the applicant of the Queensland hospital and medical system

Part D – The absence of any adequate credentialing and privileging and its consequences; the remedy

The critical purpose of credentialing and privileging: the consequent need to fulfil it.

- 6.168 As explained earlier, the process of credentialing and privileging is a formalised process of assessing a doctor's credentials, and his skill and competence to perform the job to which it is proposed he will be appointed; and of assessing the hospital to which he will, if appropriately assessed, be appointed so that any limitations on the capacity of the hospital are reflected in the work which he is permitted to do.¹⁵⁰ What must never be lost sight of and, unfortunately, was lost sight of at Bundaberg and at Hervey Bay, is that the process of credentialing and privileging is no more than that; a means of assessing the clinical capacity of a doctor in the hospital in which it is intended he will work.
- 6.169 Once that is seen, it can also be seen immediately that it is necessary for that assessment to take place before the doctor commences to work in that hospital. To find out, after a doctor has been working in a hospital for some time, that he has been working beyond his capacity or beyond the capacity of the hospital, would be plainly negligent and causative of serious risk to patients' lives and

¹⁵⁰ Chapter 3.165 to 3.172

safety. Unfortunately this occurred at Bundaberg, at Hervey Bay and at Charters Towers.

- 6.170 It can also be seen that what was needed for that process of assessment was a group of persons, appropriately qualified and skilled in the area of medicine in which the applicant intended to practise in the hospital, who would make that assessment. Thus, if the applicant intended to practise surgery, as Dr Patel did, the group, or committee, would include at least some surgeons. And if the doctor intended to practise orthopaedic surgery, as Drs Krishna and Sharma did, the committee would include at least some orthopaedic surgeons. All of this seems self evident.
- 6.171 As appears from what I have said earlier,¹⁵¹ those doctors who were appointed pursuant to the area of need scheme had not satisfied the same criteria for practise as those required of their Australian trained counterparts. Consequently, the need for such a process of assessment by credentialing and privileging, and for that to take place before a doctor commenced work in a hospital, became more acute in public hospitals as more doctors in those hospitals came to be appointed under the scheme.
- 6.172 And that dual need became even more acute as more and more doctors, appointed under that scheme, came from countries with educational, medical and hospital systems less developed than ours. As explained earlier, whereas in the late 1990s most doctors who came here on temporary visas were from the United Kingdom or Ireland, by 2002 that was no longer the case; and the proportion of those who came from developing countries had risen sharply.¹⁵²
- 6.173 Consequently, by 2002 when the matters the subject of this Inquiry first arose, about half of the doctors in public hospitals in Queensland were registered under the Area of Need Registration process; and many of those were in provincial and rural hospitals. And a substantial proportion of those appointed under the area of need scheme were, by then, from less developed countries.
- 6.174 What I have said so far makes all the more surprising the failure ever to implement any such process of assessment in respect of Dr Patel in Bundaberg, Doctors Krishna or Sharma in Hervey Bay or Dr Maree in Charters Towers. Nor was any sensible explanation given by anyone for any of those failures. It is useful to examine more closely, at least what happened at Bundaberg and Hervey Bay, to see if any explanation can be found.

¹⁵¹ Chapter 2.37

¹⁵² Chapter 2.22

Queensland Health's policy and guidelines

- 6.175 By mid 2002, Queensland Health had issued a policy and detailed guidelines for credentialing and privileging doctors.¹⁵³ Unsurprisingly, both the policy and the guidelines emphasised that clinical privileges should be defined before a doctor commenced any admissions or treatment within a hospital; and that overseas candidates for positions had to be informed that any appointment was subject to the successful awarding of privileges.
- 6.176 Equally unsurprisingly, the policy and the guidelines both provided that the process of assessment should be one of review by peers. To that end, the guidelines left to the District Manager considerable discretion in the formation of a credentialing and privileging committee to ensure that it included peers from the discipline of the applicant.¹⁵⁴ And in order to ensure continuity, it was to have a core component consisting of the Director of Medical Services or his nominee, and two medical practitioners nominated by the District Manager. To that core might be added a variable membership which 'where appropriate' might include a representative of the relevant clinical college, of a university, of a body of persons experienced in rural medicine, and such other medical practitioners as would best be able to assess the clinical qualities of the specific applicant, 'as dictated by the principle of peer representation.'
- 6.177 The ultimate aim of this process was 'to ensure safe, high quality care'. And to enhance that, in some cases, the committee might grant limited privileges to an applicant until a satisfactory period of training had been completed. And an applicant from outside Australia might be required to undertake a period of supervised practice.¹⁵⁵
- 6.178 For some time before Dr Keating commenced as Director of Medical Services at Bundaberg Base Hospital in April 2003, indeed from June in 2002, Dr Hanelt and Dr Keating's predecessor, Dr Nydam, had together been attempting to draft a document setting out a local policy for the Fraser Coast Health Service District and the Bundaberg Health Service District for credentialing and privileging doctors in those districts. That document, in what appears to be its final form in June 2003, states that:

The two hospital districts have combined in order to make the process more impartial for those being considered for credentials and clinical privileges and in anticipation of some clinicians being able to practise across the two health service districts.

¹⁵³ Chapter 3.173 and Exhibit 279

¹⁵⁴ Exhibit 279 para 5.3

¹⁵⁵ Exhibit 279 para 6.1

The failure to apply them

- 6.179 Whilst it was no doubt of advantage to both districts to combine their resources in one credentialing and privileging committee, it remains baffling why it was thought necessary to formulate a new local policy with respect to the evaluation of credentials and privileges. The Queensland Health guidelines already conferred considerable discretion on the District Managers to decide whether a credentialing and privileging committee should be confined to one hospital or apply across a district, or apply at across district or even zonal level. Any further policy to give effect to the desire to combine resources or to enable clinicians to practise across the two health districts, was therefore plainly unnecessary.
- 6.180 Even more baffling is the view, expressed by Dr Keating, but apparently shared by Dr Hanelt, that:
- A credentialing and privileging committee is required by Queensland Health guidelines to have a representative of the relevant specialist college attend the meetings where a practitioner of that specialisation is seeking privileges.¹⁵⁶
- 6.181 Under the Queensland Health guidelines, a representative of a relevant college was only one of a number of categories of persons who might be added to such a committee 'where appropriate', 'as dictated by the principle of peer representation.'
- 6.182 It was because both Dr Keating and Dr Hanelt thought that it was necessary to obtain representation from all relevant specialist colleges on credentialing and privileging committees that they spent most of 2003 and 2004, drafting such a policy and then seeking representation on various committees from the relevant specialist colleges.
- 6.183 Astonishingly, at no stage in 2003 or 2004, or in the case of Dr Hanelt, 2002, did it appear to occur to either Dr Hanelt or Dr Keating that, in the interest of the safety of patients, any doctor to be appointed to his hospital should have his clinical competence assessed by some peer body, however constituted, before he was permitted to commence service at that hospital, or, in the case of Dr Keating, that any doctor at his hospital, who had not been credentialed and privileged before April 2003, should be assessed in that way immediately. On the contrary, when Dr Hanelt emailed Dr Keating on 7 May 2003 his concern at the absence of the formalisation of clinical privileges was not about patient safety but that, if clinicians had not been appropriately credentialed and privileged, they might be denied indemnity by Queensland Health.¹⁵⁷

¹⁵⁶ Exhibit 448 para 356. See also DWK 79

¹⁵⁷ See Exhibit 448 - DWK 79

- 6.184 Dr Hanelt acknowledged in his evidence to this Commission that, in hindsight, when he could not get a college representative on a credentialing and privileging committee:

We should have said, 'Yes, I won't worry about the policy. We will simply do it contrary to the policy.'¹⁵⁸

- 6.185 He agreed that that did not occur to him at the time. And even then he appeared to maintain the untenable view that he could not comply with Queensland Health's Policy and Guidelines without having a college representative on a credentialing and privileging committee.
- 6.186 As to Dr Keating, even when Dr FitzGerald suggested to him in February 2005 that he should co-opt a local surgeon to serve on a credentialing and privileging committee, he declined to do so. His evidence about this, set out earlier¹⁵⁹ shows that he was more focused on the form of the process of establishing credentialing and privileging committees than on the purpose of the process; patient safety.
- 6.187 In summary therefore, there seemed to have been three reasons why, in 2003 and thereafter, neither Dr Patel in Bundaberg, nor Dr Krishna nor Dr Sharma in Hervey Bay was credentialed and privileged. The first of these was a misconception, apparently shared by Dr Hanelt and Dr Keating, that, in order to pool resources of Bundaberg and the Fraser Coast Health Service District for the purpose of credentialing and privileging it was necessary to formulate a joint policy.
- 6.188 The second was a misconception, also apparently shared by Dr Hanelt and Dr Keating, that it was necessary to have a representative of the relevant specialist college upon any credentialing and privileging committee which was assessing the credentials and privileges of a person who might be performing work which came within the speciality of that college.
- 6.189 And the third reason was an astonishing shared failure of Dr Hanelt and Dr Keating to grasp that, in order to protect patient safety, any doctor, before commencing practise in a hospital, must have his competence to perform the work which it is proposed that he will perform in that hospital, assessed by a group of peers.
- 6.190 The first two misconceptions arose simply from a misreading of the Queensland Health policy and guidelines which are not difficult to read. On the contrary they seem quite clear. Yet both Dr Hanelt and Dr Keating appeared to misconstrue them in each of the ways I have discussed; or perhaps neither read them, but made assumptions about what they said.

¹⁵⁸ T6724

¹⁵⁹ Chapter 3

- 6.191 The only explanation which I am able to advance for their failure to see why patient safety demanded such an assessment is that both had become so entrenched in a bureaucratic system that they never directed their minds to the importance of such an assessment in ensuring patient safety. As already mentioned, Dr Hanelt was concerned at the absence of credentialing and privileging, but apparently only because of the risk which that absence might have for indemnity of the doctors concerned. And as I have shown elsewhere both were concerned primarily with maintaining budgets. Whatever the explanation, neither appeared to advert to the critical underlying purpose of credentialing and privileging.

Dr Nydam's negligence

- 6.192 There was, however, an additional and perhaps overriding reason why Dr Patel was not credentialed and privileged before he commenced work at Bundaberg Base Hospital. Dr Nydam, who was then the acting Director of Medical Services concluded, plainly wrongly, that Dr Patel did not require credentialing and privileging because he was a 'locum'.¹⁶⁰ It was not only plainly wrong of Dr Nydam to reach that conclusion; it was grossly negligent of him to do so. Dr Patel was not a locum. He was appointed for a period of twelve months. And, in any event, the guidelines, as might be expected, contemplated some form of credentialing and privileging for locums.
- 6.193 Dr Nydam also negligently assumed that Dr Patel 'would operate within the scope of his experience and previous practise as a general surgeon'.¹⁶¹ Both this and the negligent assumption referred to in the previous paragraph were the main reasons why Dr Patel was not credentialed and privileged before he commenced operating at Bundaberg Base Hospital. If he had been, there is a strong possibility that his fraudulent statements to the Medical Board would have been uncovered,¹⁶² or at least his privileges narrowed.¹⁶³

The capacity to comply with the guidelines was there

- 6.194 At all relevant times, in my opinion, it would have been possible to constitute a credentialing and privileging committee in Hervey Bay, in accordance with Queensland Health guidelines, to credential and privilege Dr Krishna and Dr Sharma. There were at all those times three registered orthopaedic surgeons in the area; Dr Mullen and Dr Naidoo at Hervey Bay and Dr Khursandri at Maryborough. Any two of those three, together with Dr Hanelt, would have constituted such a committee in accordance with the guidelines.

¹⁶⁰ Chapter 3

¹⁶¹ Chapter 3

¹⁶² Chapter 3

¹⁶³ Chapter 3

- 6.195 At all relevant times it would have been possible to constitute a credentialing and privileging committee in Bundaberg, in accordance with Queensland Health guidelines, to credential and privilege Dr Patel. At all those times there were three general surgeons practising in Bundaberg; Dr Thiele, Dr Anderson and Dr de Lacy. Any two of those, together with Dr Keating, would have constituted a credentialing and privileging committee in accordance with Queensland Health guidelines.
- 6.196 Moreover, as already indicated, it would have been possible, in either Hervey Bay or Bundaberg, at any time to invite a doctor from the other centre to sit on a credentialing and privileging committee. Nor would that have been likely to impose any major, inconvenience on the doctor concerned. After all, one was only an hour or so drive from the other.

Townsville

- 6.197 Neither Dr Myers nor Mr Berg was credentialed and privileged, notwithstanding the apparent existence of committees appropriate for that purpose. It seems that Dr Myers' appointment has nevertheless been successful despite that absence. As mentioned earlier, he was closely supervised and granted no independent privileges during his probationary period.

Charters Towers

- 6.198 No explanation could be found, in the limited examination by this Commission of Charters Towers, for the failure to credential and privilege Dr Maree. In one serious respect, his appointment as Director of Medical Services paralleled that of Dr Patel as Director of Surgery in Bundaberg. Dr Maree was appointed to a position in which there would be no supervision and little opportunity for peer assessment of his work, in circumstances in which he had not been credentialed and privileged. His appointment also had a disastrous consequence. It seems likely also in this case that if his skill and competence as an anaesthetist had been assessed by registered anaesthetists, his lack of competence would have been revealed.

Conclusions

- 6.199 The clarity of the Queensland Health Guidelines, the ease with which they could have been complied with, in each of the cases discussed, and the importance, in the interest of patient safety, of complying with them, together make it astonishing and alarming that they were not complied with in Bundaberg with respect to Dr Patel, in Hervey Bay with respect to either Dr Krishna or Dr Sharma, or in Charters Towers with respect to Dr Maree. The responsibility for complying with them in each case was upon the District Manager, but in each case he had, understandably, delegated that responsibility to the Director of

Medical Services, who, it might have been thought, because of his medical qualifications, would have understood the need for peer assessment of medical practitioners before they commenced work in a hospital. In each of the cases of Dr Nydam and Dr Keating in Bundaberg, and Dr Hanelt in Hervey Bay, his failure to implement that process was a gross dereliction of duty.

The remedy

6.200 As appears from what I have already said, it is and was at all times simple to apply Queensland Health guidelines which are clear and comprehensive. In applying them four matters should be borne in mind. They are:

- (1) That the process is one of independent peer assessment; consequently an assessment by a group of independent peers is more important than compliance with the letter of the policy or guidelines;
- (2) That whilst college participation in the process is of advantage, it is not essential;
- (3) That it must be applied before the applicant commences to work in hospital;
- (4) That privileges may be limited by the committee, and that, for an area of need applicant, a period of supervised practice may be first required.

Part E – Inadequate monitoring of performance and investigating complaints: inadequate protection for complainants

6.201 Every year in Australia there are a huge number of adverse outcomes which are 'iatrogenic' in origin: that is, the poor outcome for the patient is caused by the health care provider rather than the underlying condition. It is conservatively estimated that around 4,500 preventable deaths occur in hospitals each year as a result of mistakes and inappropriate procedures.¹⁶⁴ Against that background, it is, of course, vitally important that any health care organisation implement early warning systems to identify, and remedy, poor care. Moreover, it is important to acknowledge that the ultimate aim of any health system should be the creation of an environment predisposed to preventing, rather than reacting to, poor care.

¹⁶⁴ Australian Government Productivity Commissioner Annual Report 2003-2004 page 14. I say conservatively because there have been other studies to suggest that the figure may be more than three times higher than this: David Ranson, *How Efficient? How Effective? The Coroners Role in Medical Treatment related Deaths* (1998) 23 *Alternative Law Journal* 284 at 285

To this end, I set out a range of measures aimed at maintaining clinical standards that came to the attention of this Commission.

Maintaining Standards

6.202 There are a number of measures aimed at maintaining clinical standards in hospitals, namely:

- Credentialing and privileging;
- Clinical audit and peer review, including morbidity and mortality meetings;
- The Service Capability Framework;
- The use of College accredited training posts;
- A 'critical mass' of appropriately experienced peers;
- Safe working hours for staff;
- Continuing medical education; and
- Complaints and incident management systems.

6.203 I briefly summarise these measures below and their role in maintaining standards.

6.204 I set out in detail the role played by complaint and incident management systems and their inadequacies as they presently exist below. It suffices at this point to refer to Queensland Health's recognition of complaints and incident management systems as quality control measures, as demonstrated in its own policy:¹⁶⁵

Queensland Health recognises that consumer feedback, both positive and negative, is essential in order to provide quality health care services that meet consumer needs...

Using information gained from consumer complaints enhances organisational performance. Service improvement results from both handling complaints at the individual level and from the collation and analysis of aggregated complaint data...

The following complaints management performance standards must be met by all Queensland Health services.

- 1) Consumer feedback is actively encouraged and promoted.
- 2) Consumer and staff rights are upheld throughout the complaint management process.
- 3) Local process are implemented to support best practice in complaint handling.

¹⁶⁵ Exhibit 292

- 4) Complaints information is integrated into organisational improvement activities.

6.205 Whilst a good deal of attention has been devoted to complaints and incident management systems those systems should not be the sole focus for improvement in the future. Their success depends heavily on a human element. People have to be willing to bring their concerns forward, and people are by nature unwilling to complain. Further, complaints systems tend to be focused on eradicating inadequate treatment, rather than striving for excellence in clinical standards. Moreover, they tend to be reactive in that something has to go wrong or at least appear to go wrong before the system is invoked. Other measures for maintaining standards, such as audit, accredited training posts, and critical mass of doctors, are essential because they provide other means of checking the standard of clinical services. When they are working they provide objective indicia against which persons with concerns can confirm their concerns and overcome some of the hesitancy they may have to complaining. Further, those persons charged with responding to complaints are more likely to respond more swiftly if they have such indicia against which they can measure those complaints.

Credentialing and privileging

- 6.206 As I have set out elsewhere, the fact that a person holds medical qualifications does not automatically entitle them to practise medicine in Queensland public hospitals. In accordance with best practice, Queensland Health policy demands that before a doctor commences providing clinical services they must first be subject to a process of credentialing and privileging. The process involves assessment of a doctor's credentials, skills, and competence in the context of the clinical capabilities of the hospital in which they are to work with a view to determining their scope of practice at the hospital. I have outlined above the sound reasons which underlie this policy.¹⁶⁶
- 6.207 Under Queensland Health policy the credentialing and privileging process can be invoked in respect of its doctors in three instances, being:¹⁶⁷
- a) When a doctor is first employed by Queensland Health and before they commence performing procedures;
 - b) Periodically, every three years a doctor is employed by Queensland Health; and

¹⁶⁶ See Chapter Three – Dr Patel's employment at the Bundaberg Base Hospital – Application of the credentialing and privileging process to Dr Patel

¹⁶⁷ See Chapter Three – Dr Patel's employment at the Bundaberg Base Hospital – Application of the credentialing and privileging process to Dr Patel

- c) On an ad hoc basis when matters are referred to the credentials and privileges committee by officers such as the Director of Medical Services.
- 6.208 Had the policy been faithfully implemented in Bundaberg, there is a good chance Dr Patel's history and shortcomings would have been identified. This is for two reasons. Firstly, if the process had been carried out rigorously, (as seems possible for reasons identified in Chapter Three) they may have had serious doubts about Dr Patel's history. Secondly, if the process had been in place, then when complaints had been received, such as the complaint from Dr Cook about the performance of oesophagectomies at the Base, they could have been referred to a credentials and privileges committee for a surgeon's opinion.

Clinical audit, peer review and morbidity and mortality meetings

- 6.209 A consistent theme from many witnesses was that adverse trends in Dr Patel's performance would have been identified more swiftly if he had been subject to a functioning and effective clinical audit system, including a process of peer review such as morbidity and mortality meetings.¹⁶⁸
- 6.210 Clinical audit involves comparison of actual clinical performance with accepted standards of what that performance should be.¹⁶⁹ The Royal Australasian College of Surgeons identifies three essential elements of clinical audit, being collection and measurement of data on clinical activities and outcomes; analysis and comparison of that data using standards, performance indicators and outcome parameters; and peer review of that data and analysis.¹⁷⁰ Clinical audit can involve collection and analysis of a range of data, including 30 day mortality and morbidity,¹⁷¹ length of hospital stay, unplanned readmission or re-operation rates, and patient satisfaction.¹⁷² It was suggested in evidence by Dr Carter that data from audits conducted by individual departments within a hospital should be reported to the hospital Executive so that, in effect, the right hand of the hospital knows what the left hand is doing.¹⁷³ Dr Woodruff said that all doctors should be periodically assessed, and he drew comparison with the measures adopted by the aviation industry.¹⁷⁴ Regular audit of such doctors' practices might form a critical part of that process. There is a great deal of benefit in documenting data from audits, or even as suggested by one witness, computerising that data so as

¹⁶⁸ See in particular evidence of Drs de Lacy, Woodruff, Young, Strahan, Nankivell, Fitzgerald - T3263, T2873, T3622-3, T4328, T4440; see also concerns expressed by Dr Risson about the abandonment of the Otago audit system in Bundaberg – Exhibit 448, DWK63

¹⁶⁹ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p3

¹⁷⁰ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p3

¹⁷¹ The monthly peer review of morbidities and mortalities is discussed in more detail below

¹⁷² *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p7

¹⁷³ T3985 (Dr Carter)

¹⁷⁴ Exhibit 283 para 35 and 36

to streamline the process of accessing data for the purpose of assessing doctors' performances.

- 6.211 Audit serves the purposes of identifying ways of improving the quality of care provided to patients and assisting in the continuing education of clinicians.¹⁷⁵ The most important purpose that clinical audit serves, in the context of this Commission, is that it provides a sense of perspective and places a doctor's deaths and complications in a meaningful context.

I mean, longitudinal data. I'll give you a simple example. Supposing at our next month's meeting at my hospital someone presents a wound dehiscence, which we've been talking about in the inquiry. What does that mean? Absolutely nothing. You will only know the meaning if you analyse that doctor's data over a period of time, because over the years everybody will get every complication, if you know what I'm trying to say. I mean, we all get complications. That's part of being a surgeon. What you have to do is look for a percentage because...we know what the acceptable, if you like, benchmarks are for, say, a wound dehiscence.¹⁷⁶

- 6.212 Morbidity and mortality meetings should comprise an aspect of peer review as part of the clinical audit process. They are held monthly by each clinical department in a hospital such as surgery.¹⁷⁷ Deaths and significant illnesses are presented, usually by junior doctors, and then discussed and analysed by the attendees openly in a non-judgmental way with the aim of improving the service for the future.¹⁷⁸ Cases are selected by the Chair of the meeting or the person they delegate that responsibility to.¹⁷⁹ Ideally, they should be attended by all clinical staff, not just the doctors.¹⁸⁰ It was Dr Woodruff's view that Directors of Medical Services should attend all morbidity and mortality meetings that occur in a hospital.¹⁸¹ Anyone can attend the meetings, including doctors from outside the hospital and Visiting Medical Officers.¹⁸² If the meetings are to be part of the clinical audit process then they should be documented.¹⁸³ Dr Woodruff testified that where a death involves multiple departments then all those departments should attend the meeting.¹⁸⁴
- 6.213 In order to achieve their aim, discussions at these meetings are frank and open, and sometimes robust.¹⁸⁵ Patients' cases are brought forward and attendees suggest other approaches to the treatment of those patients than were in fact

¹⁷⁵ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p3

¹⁷⁶ T2984 (Dr Nankivell)

¹⁷⁷ Exhibit 283 para 33

¹⁷⁸ T3620 (Dr de Lacy)

¹⁷⁹ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p14

¹⁸⁰ Exhibit 283 para 33

¹⁸¹ Exhibit 283 para 33

¹⁸² T3620 line 1 (Dr de Lacy)

¹⁸³ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 page 11; Exhibit 283 para 33

¹⁸⁴ Exhibit 283 para 33

¹⁸⁵ T3620 (Dr de Lacy)

adopted.¹⁸⁶ Topics of discussion at the meetings might include wound infection and dehiscence rates¹⁸⁷ and rates of anastomotic leak.¹⁸⁸

- 6.214 It is essential for vibrant morbidity and mortality meetings that doctors be encouraged as much as possible to attend and actively participate. Doctors will often face difficulty in attending because they have running operating lists. Morbidity and mortality meetings should be 'quarantined' so that no other business interrupts them.¹⁸⁹ Consideration should be given to setting aside a specific part of day which is wholly devoted to morbidity and mortality.¹⁹⁰ Further, it is desirable that doctors frankly and honestly discuss their patient deaths and adverse outcomes.¹⁹¹
- 6.215 It is important that morbidity and mortality meetings and other forms of audit should not be confused with complaints and incident management systems. They are complementary and not mutually exclusive. Dr Jeannette Young, Executive Director of Medical Services of the Princess Alexandra Hospital, testified that properly functioning morbidity and mortality meetings often uncover particular issues with doctors' competence which are usually raised with her by those present.¹⁹² Further, morbidity and mortality meetings can provide a transparent forum for review of decisions about reporting incidents, such as decisions about reporting deaths to the Coroner.¹⁹³ Documented audit and peer review uncovers problems and provides people with the opportunity to test the validity of concerns they hold. Moreover, the process provides a means of communicating concerns about clinicians throughout a hospital. If the process is documented and attended by the Director of Medical Services that officer is in a better informed position to assess complaints brought to his or her attention and how to act in response.
- 6.216 Similarly, audit and peer review can potentially provide invaluable data for the process of periodic review of clinical credentials and privileges.
- 6.217 For reasons set out above, the clinical audit/morbidity and mortality system in Bundaberg failed during Dr Patel's period there. Rather than being frank and robust discussions aimed at improving the quality of service, they were subverted by Dr Patel so that they were conducted as teaching sessions where he could demonstrate his medical knowledge to the junior students.¹⁹⁴ I am

¹⁸⁶ Exhibit 283 para 33, T3620 (Dr de Lacy)

¹⁸⁷ T3840 (Dr Boyd)

¹⁸⁸ T3833 (Dr Boyd)

¹⁸⁹ Exhibit 283 para 33

¹⁹⁰ T2984 (Dr Nankivell), T3962 (Dr O'Loughlin)

¹⁹¹ Exhibit 283 para 33

¹⁹² Presumably, the issues are initially canvassed with the doctor concerned and then raised with that doctor's superiors if the problems persist - T2847 (Dr Young)

¹⁹³ T3628 (Dr de Lacy), T5164-T5165 (Dr North)

¹⁹⁴ Dr de Lacy said the only resemblance the meetings bore to morbidity and mortality meetings was they shared the same name and that was all. He commented that the complications he subsequently saw during his review were not presented at the meetings – T3620

satisfied that had there been an effective process of clinical audit operating at Bundaberg at the relevant time it is more than likely that the following would have been uncovered and verified:

- 1) That Dr Patel's rates of complications and deaths were significantly higher than is to be expected from a reasonably competent general surgeon;
- 2) That the quality of care rendered by Dr Patel in individual cases was so inadequate that it would have been reasonable to seriously doubt his competence generally;¹⁹⁵ and
- 3) That the judgment he brought to treatment was seriously impaired.

6.218 The experience of Bundaberg shows that the process of audit and morbidity and mortality meetings relies on independence and transparency for its success. As much as possible there must be independent monitoring of collection and presentation of data. Dr Jeannette Young, for example, gave evidence that the Princess Alexandra Hospital takes steps to ensure that data on deaths and complications is collected and monitored independently of the doctors involved.¹⁹⁶ Most importantly, it is the role of the Director of Medical Services to oversee the whole process and ensure it is transparent and operating as it should.¹⁹⁷

6.219 Clinical audit and peer review is not only designed to discover rogues and underperformers. The process is an invaluable clinical tool that helps identify systemic issues affecting patient care. Where patterns or trends emerge, that can provide impetus for doctors to modify their practice.¹⁹⁸ For example, audit can identify problems with the use of a particular treatment in particular patients. On that basis practice can be altered to address that and improve service.

6.220 Further, clinical audit and peer review should not be seen as a check on the quality of care of only overseas trained doctors such as Dr Patel. Dr Woodruff testified that he knew of a couple of occasions when the performances of well regarded Fellows of the College dropped below an acceptable level requiring remedial action to be taken to correct them.¹⁹⁹ Dips in a competent surgeon's performance can happen for a number of reasons, including change of environment, age related loss of motor skills or dementia, and illnesses or

¹⁹⁵ Particularly pertinent in this context are the cases that Dr O'Loughlin reviewed that led him to question Dr Patel's proficiency at performing laparoscopic surgery and therefore question his competence as a general surgeon. I particularly note the case where Dr O'Loughlin said that if one of his registrars had rendered the same level of care rendered by Dr Patel in that case, he would probably suggest to that registrar that they consider a career other than surgery.

¹⁹⁶ T2848-9 (Dr Young)

¹⁹⁷ Exhibit 283 para 33

¹⁹⁸ T3967 (Dr O'Loughlin), T5132 (Dr North)

¹⁹⁹ T4337 (Dr Woodruff)

injuries.²⁰⁰ When such dips occur clinical audit provides an essential element of the systems that identify them so that remedial action can be taken.²⁰¹

- 6.221 I am of the opinion that all hospitals should have an effective clinical audit system. As a minimum this system should include monthly audit of all mortalities and significant morbidities.

Service Capability Framework

- 6.222 Not all hospitals are created equal. Some hospitals have access to more staff, expertise, infrastructure and facilities than others. There is an obvious distinction, for example, between tertiary referral hospitals and Base hospitals. The effect of this is that some hospitals have the capability to provide certain services safely whilst others do not. In this context, Queensland Health has developed a policy framework aimed at marking out the boundaries that limit the services that its hospitals can provide.
- 6.223 Prior to July 2004, there existed separate policy regimes for defining the limitations of health services that may be provided in public and private hospitals. The *Guide to the Role Delineation of Health Services* applied to public hospitals whilst *Guidelines for Clinical Services in Private Health Facilities* applied to private hospitals. For uniformity between the public and private sector a single policy applying to both sectors was released in July 2004 known as the Service Capability Framework.²⁰²
- 6.224 The Service Capability Framework is designed to 'outline the minimum support services, staffing, safety standards and other requirements required in both public and private health facilities to ensure safe and appropriately supported clinical services'.²⁰³ The framework rates each health facility's ability to deliver a range of clinical services according to a number of factors, including service complexity, patient characteristics, and support service availability and capability. A rating of either primary, Level 1, Level 2, Level 3, or Super-Specialist is then attributed to each service.²⁰⁴ The framework serves two purposes, namely to aid in planning of health services and to provide a broad framework for setting out the minimum knowledge, skills and services that should be available to a facility in order to safely provide a service.²⁰⁵ For example, the document is designed to ensure that hospitals are not performing surgery at a level of complexity beyond their capabilities.²⁰⁶ The framework

²⁰⁰ T4337 (Dr Woodruff); *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review* 2005, viewed at www.surgeons.org on 11 November 2005 page 21

²⁰¹ T2847 (Dr Young)

²⁰² Exhibit 231; T3147 and T3224 (Dr FitzGerald)

²⁰³ Exhibit 231 *Service Capability Framework* p(iii)

²⁰⁴ Exhibit 231 *Service Capability Framework* p8

²⁰⁵ Exhibit 231 *Service Capability Framework* pp2 and 3, T3343-4

²⁰⁶ T3221 (Dr FitzGerald)

should form an integral part of the credentialing process so that privileges are awarded to doctors according to the facilities available to the hospitals in which they practise.²⁰⁷

- 6.225 Bundaberg is an example of a situation where the absence of clearly defined boundaries rendered the Base vulnerable to a doctor who would perform procedures clearly beyond the capabilities of that hospital (oesophagectomies and whipples procedures). So is Hervey Bay where complex elective orthopaedic surgery should never have taken place.

Critical mass of appropriately experienced peers

- 6.226 As I have set out elsewhere in this report, Dr Patel operated in ‘splendid isolation’ from his peers and thereby avoided a level of oversight which could have revealed his inadequacies as a surgeon sooner.²⁰⁸ In large measure this was the result of the fact that the Base at the relevant time had on staff only two surgeons – Drs Patel and Gaffield, that Dr Patel was the Director of Surgery, and that Dr Gaffield had significantly less experience in general surgery. The only other doctors in the surgery department were very junior and were not in a position to assess Dr Patel’s work.
- 6.227 Hospitals should aim to engage a ‘critical mass’ of doctors. By maintaining a breadth of expertise within a hospital, no one doctor can become isolated, either by choice or accidentally, and thereby arbitrarily determine what is adequate care. Moreover, it seems that staffing shortages are threatening public health services’ abilities to meet demand, particularly in rural and regional areas where for reasons discussed above public hospitals struggle to recruit a critical mass of staff specialists.
- 6.228 I deal in more detail with the challenges facing rural and regional hospitals below. However, at this point it is convenient to set out a proposal that might go some way to addressing the practical difficulties public hospitals face in trying to develop critical mass.
- 6.229 Dr Woodruff proposed a strategy he described as ‘hub and spoke’. In essence, he proposed that all regional hospitals (spokes) be attached to tertiary referral hospitals (hubs). Hubs can contribute expertise and resources to spokes’ credentialing, audit, training, assessment and other processes. The use of technology such as teleconferencing and video link can aid in this process.²⁰⁹ Drs Woodruff and O’Loughlin both noted that Dr Patel seemed to practise in isolation and, in particular, did not confer with his colleagues in the tertiary

²⁰⁷ T3244 (Dr FitzGerald)

²⁰⁸ See Chapter Three – “Splendid Isolation”

²⁰⁹ Exhibit 283 para 32

referral hospitals.²¹⁰ Dr Woodruff inferred that Dr Patel, and many other overseas trained doctors, lacked the clinical networks developed with their colleagues after years of training and practice in Australia.²¹¹

- 6.230 Aiding overseas trained doctors to develop those networks is essential in the Queensland Health system which increasingly relies on them; first, because, as Dr O'Loughlin said, medicine is a multidisciplinary exercise and the best care is provided when doctors can draw on as much expertise as possible; and secondly, because the Queensland public hospital system is one where the vast bulk of resources and funding is concentrated in the tertiary referral hospitals. In a sense there needs to be a symbiosis between those hospitals and the rural and regional hospitals to improve the care provided in the regions.²¹²

Accredited training posts

- 6.231 I have identified elsewhere in this report the benefits which College accreditation for training of registrars bring to hospitals. In summary, those benefits are:²¹³

- (a) Higher level of competence of staff;
- (b) Registrars contribute to the breadth of expertise available for the process of informal audit of staff;
- (c) Because registrars possess a higher degree of competence than more junior doctors they take some of the pressure off those doctors and the senior doctors;
- (d) Potential for retention of Fellows following completion of registrars' specialty training;
- (e) A continuing culture of professional development amongst medical staff; and
- (f) The existence of a collegiate educational culture within hospitals which is an incentive for recruitment of specialists, including Visiting Medical Officers.

- 6.232 Further, increasing the number of accredited training posts is necessary so that the increased numbers of graduates from medical schools in Queensland are not lost.²¹⁴ The good work in overcoming the shortage of doctors in this state by increasing the intake of medical students will effectively be undone if those graduates cannot find training positions.

²¹⁰ See Chapter Three – Competency of Dr Patel

²¹¹ T4291 and T4338 (Dr Woodruff)

²¹² I note the efforts of Townsville in this regard. See Chapter Five and in particular reference to the assistance Townsville Hospital provides for credentialing and privileging in smaller hospitals in the Northern Zone

²¹³ See Chapter Three – History of the Hospital and Chapter Five – Rockhampton Hospital; see also T1824

²¹⁴ See the discussion in Chapter Two on steps taken to increase the number of places for medical students

Safe working hours

- 6.233 A consistent theme that ran throughout the evidence before this Commission was the impact of unsafe working hours on clinical standards and patient safety.
- 6.234 Drs Nankivell, Baker, Jelliffe and others consistently gave evidence that they were required to work impossible hours at the Base.²¹⁵ Both Drs Jelliffe and Nankivell gave evidence that the effect on a doctor's ability to provide medical care who is suffering from tiredness is similar to a doctor who is under the influence of alcohol.²¹⁶ In particular, Dr Jelliffe referred to studies that have shown the ability of a doctor who has been working for ten consecutive hours is impaired to an extent equivalent to a doctor whose blood alcohol level is 0.05, and the effect gets worse as the number of hours rises.²¹⁷ Doctors at the Base were regularly required to work well over ten consecutive hours at a time.²¹⁸
- 6.235 Not only do safe working hours enhance patient safety, they are conducive to the retention of quality staff. I am satisfied that the diaspora of 'wounded soldiers' from the Bundaberg Base Hospital was in part precipitated by the work loads to which they were subject. Dr Jelliffe recalled the condition of Dr Nankivell at the time he left the Base following a period in which the only other staff surgeon there, Dr Baker, had been away on leave:²¹⁹
- He had been broken on the wheel at the hospital. He looked grey and old. He was...doing a one-in-one (on call roster). He really had no choice. I think he had to leave for his health. You can't keep up that sort of punishing roster.
- 6.236 That Bundaberg lost a Fellow of the College of the calibre of Dr Nankivell is a tragedy, given what eventually transpired there. When he turned to the Medical Board for direction on safe working hours he was informed that it was not the Board's role to define safe working hours, and that he should instead consult with the Australian Medical Association, his employer (Queensland Health) or the Department of Industrial Relations.²²⁰ I do not doubt the Board's assertion in that regard. However, unfortunately for Dr Nankivell, he is not a member of the Australian Medical Association.²²¹

Continuing medical education

- 6.237 Fellows of the relevant Colleges are subject to obligations that they must engage in continuing medical education, re-accreditation courses and other educational and quality assurance activities.²²² This process of continuing education adds to

²¹⁵ See Chapter Three

²¹⁶ T2971 (Dr Nankivell); T6656 (Dr Jelliffe)

²¹⁷ T6656 (Dr Jelliffe)

²¹⁸ See Chapter Three

²¹⁹ T6652 (Dr Jelliffe)

²²⁰ Exhibit 215

²²¹ T3003 (Dr Nankivell)

²²² See Chapter Three – The Competency of Dr Patel; T776

the quality of delivery of medical care through the ongoing maintenance of clinicians' currency of practice and competency.

Rural and regional challenges

6.238 Largely because of isolation and lack of resources, rural and regional hospitals face substantial challenges in implementing measures aimed at maintaining clinical standards, namely:

- (a) Difficulties in funding, attracting and retaining a critical mass of doctors, which means:
 - As in Bundaberg, the morbidity and mortality process is vulnerable to subversion because there are insufficient doctors involved in the process to ensure that it is independent and transparent;
 - Rural and regional hospitals do not have sufficient doctors to ensure their doctors are not overworked; and
 - Because of insufficient staff rural and regional hospitals struggle to meet the demands for services placed upon them;
- (b) Difficulties in gaining accreditation for College training posts; and
- (c) Difficulties in attracting training registrars, because of isolation and the obvious disparities between the tertiary hospitals and regional hospitals in terms of the variety of expertise that can be devoted to the educational experience.

6.239 Potentially, if the model for the delivery of public health services is not adapted to accommodate these peculiar challenges, a two-tiered health system in Queensland may perpetuate. That is, a system where the quality of care delivered in the cities is superior to the quality of care delivered in the regions.

6.240 I do not accept that the challenges facing rural and regional hospitals should inevitably lead to a two-tiered health system. Standards in rural and regional hospitals should be made a priority.

6.241 The principal step that must be taken is that rural and regional public hospitals must engage the private sector. The experience of Bundaberg provides a particularly salient illustration of the following statement:

The public and private systems may be able to run in parallel in the metropolitan areas, but in provincial areas, for health services to be optimised it has to be done jointly between the private and the public sector because that's the way in which you will have the broadest range of clinical services available.²²³

6.242 The best means of engaging the private sector is through increased use of Visiting Medical Officers. I do not suggest that either Staff Specialists or Visiting Medical Officers are necessarily superior to the other. Each serves a particular

²²³ T1826 (Dr Thiele)

purpose.²²⁴ However, it is vital that rural and regional hospitals draw on the private sector by way of Visiting Medical Officers. Bundaberg had a wealth of surgical experience in the private sector during Dr Patel's tenure as Director of Surgery at the Base. That experience could be an invaluable resource to draw on to ensure patient safety. I say this for the following reasons:

- Visiting Medical Officers with Staff Specialists could provide the necessary critical mass of expertise to ensure the effectiveness of the audit and peer review process;
- Offering more Visiting Medical Officer positions to new specialists rural and regional hospitals can increase the depth of talent available in their areas;²²⁵
- Visiting Medical Officers supplement the staff available to public hospitals so as to ensure Staff Specialists are not overworked;²²⁶
- Visiting Medical Officers increase staff available to rural and regional hospitals to meet demand for their services; and
- Visiting Medical Officers help provide the level of supervision required for College training accreditation.²²⁷

6.243 With respect to morbidity and mortality meetings more generally, rural and regional hospitals should consider the following steps so as to ensure the process is vibrant, effective, independent and transparent:

- a) Involving outsiders; outsiders chair the meetings;²²⁸ indeed, perhaps chairs can rotate on a monthly basis;²²⁹
- b) Holding multidisciplinary meetings between general practitioners and other specialist disciplines;²³⁰
- c) Holding meetings which combine doctors from a number of districts, for example Bundaberg and the Fraser Coast;²³¹ and
- d) Involving outsider doctors from metropolitan areas in morbidity and mortality meetings through regular visits and the use of teleconferencing facilities, online chat groups or discussion forums.²³²

6.244 To an extent the ability of rural and regional hospitals to secure College accreditation for training depends on the resources available to them. For

²²⁴ T2856 (Dr Young)

²²⁵ The option of becoming a Visiting Medical Officer is quite attractive to new private specialists. It provides them with a base income while they establish their private practice - T1826 (Dr Thiele)

²²⁶ Dr Nankivell testified that the presence of a few Visiting Medical Officers at the Base during his time there would have made his roster acceptable - T2935

²²⁷ Chapter Three – History of the Hospital

²²⁸ T3622-T3623 (Dr de Lacy)

²²⁹ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p12

²³⁰ T4560

²³¹ T4560; *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p12

²³² *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p12

example, one of the essential requirements imposed by the Royal Australasian College of Surgeons for accreditation is that registrars be supervised by one of its fellows.²³³ However, many of the measures required for accreditation, such as safe working hours, risk management, credentialing, audit and peer review,²³⁴ represent measures aimed at maintaining standards and ensuring patient safety. Hospitals should be implementing these measures in any event, quite apart from the aim to gain accreditation.

- 6.245 In addition to accreditation, hospitals should strive to attract trainees, which as I have said elsewhere require an environment where those trainees can be assured of an attractive educational experience. Measures such as regular weekly clinical meetings, visits from Brisbane specialists, teaching ward rounds, and regular educational presentations all contribute to this experience.²³⁵

Recommendations

- 6.246 All hospitals must have effective clinical audit systems. As a minimum these systems should include monthly audit of all mortalities and significant morbidities. Hospitals must ensure that their clinical audit systems are independent and transparent. Whilst it is not my function to determine what steps they should employ to ensure this, rural and regional hospitals in particular, should consider the measures aimed at that purpose that I have outlined above and others.
- 6.247 Rural and regional hospitals must engage the private sector as much as possible, such as by the use of Visiting Medical Officers.
- 6.248 All primary referral hospitals should aim to gain accredited training status with the relevant Colleges. Adequate resources and funding should be allocated to those hospitals for this purpose. Steps should be taken to encourage trainees to fill training posts.

Complaints and incidents management

- 6.249 In the course of his evidence before the Commission, Dr Molloy, the President of the Australian Medical Association, acknowledged complaints against doctors – even if they take the form of litigious claims - can be an important tool in

²³³ *Accreditation of Hospitals and Posts for Surgical Training: Process and Criteria for Accreditation*, viewed at www.surgeons.org on 11 November 2005 p4

²³⁴ *Accreditation of Hospitals and Posts for Surgical Training: Process and Criteria for Accreditation*, viewed at www.surgeons.org on 11 November 2005

²³⁵ See Chapter Three – History of the Hospital

maintaining professional standards.²³⁶ Dr Nydam from Bundaberg Base Hospital gave evidence that, even when he was the Assistant Director of Medical Services, he would personally prepare medico-legal reports for lawyers because it presented a ‘fantastic opportunity for clinical audit...as an educator, I need to work out where things can be improved, and writing these letters, after a consideration of clinical notes, provided a very, very fertile ground...’.²³⁷ The importance of recording, and acting upon, complaints was further emphasised in evidence when it was realised that, of the many complaints received during Dr Patel’s term, almost all of them were subsequently vindicated by Drs de Lacy, O’Loughlin or Woodruff.²³⁸

- 6.250 Those matters above underline what is perhaps self evident. However, many Queenslanders are reticent to make complaints. When they do, it will often be a very good indicator that they have received poor care or, at the very least, that there has been poor communication. This will be all the more so where complaints are made by medical staff because, first, there is no reason to suspect any over-readiness on their part to make complaints about colleagues²³⁹ and, secondly, they will have a technical understanding of treatment which is rarely available to patients and relatives.
- 6.251 An organisation which welcomes and addresses complaints frankly is likely to achieve more just outcomes, and it is likely in turn to minimise litigation. Furthermore, if the organisation responds properly to complaints, it is likely to function at a much higher level in the future. For those reasons, the issues addressed in this chapter are critical to confidence and clinical standards in our public hospitals.

The multiple avenues for complaints about medical treatment

- 6.252 If a patient, a patient’s relative or a member of staff wishes to complain about treatment received, or to raise an issue about conditions, in a public hospital there are various authorities to whom they might turn. The choice of the appropriate authority can be difficult and confusing, and it is perhaps complicated further by the fact that, at times, the complaint might be received by more than one body. The complaint could be made:
- a) Within the public hospital to an appropriate employee of Queensland Health;
 - b) If the complaint is to be about a medical practitioner, to the Medical Board of Queensland;

²³⁶ T770, T800 (Dr Molloy)

²³⁷ T4108 (Dr Nydam)

²³⁸ See Chapter Three

²³⁹ On the contrary it has been that doctors may tend not to make complaints about the performance of a colleague: eg Shipman Inquiry 3rd Report Chapter 11 available at www.the-shipman-inquiry.org.uk/thirdreport.asp

- c) If the complaint is to be about a nurse, to the Queensland Nursing Council;
- d) If the complaint is to be about an allied health worker, such as a physiotherapist or an occupational therapist, to the relevant registration board. Queensland has twelve other boards²⁴⁰ Each board is established under an Act with the function of registering, suspending or cancelling the registration of practitioners of any kind of health service.
- e) If the matter involves suspected official misconduct, for instance a sexual assault by a medical practitioner, a nurse or an allied health worker employed by Queensland Health, to the Crime and Misconduct Commission;
- f) If the complaint is to be about administrative action, to the Ombudsman;²⁴¹
- g) If the matter involves an unexpected death whilst in hospital, to the Coroner;²⁴²
- h) To the Health Rights Commissioner if the complaint is about the service of any provider of a health service whether the provider be a doctor, nurse or allied health worker;
- i) By litigation or the threat of it.

6.253 People wishing to choose where to take a complaint are faced with further complexity. They will find that different bodies have different investigative powers and remedial powers and that those powers may be curtailed as certain circumstances arise in the course of the investigation.²⁴³

6.254 To demonstrate deficiencies and inefficiency of the current health complaints system in Queensland and the consequential frustration for complainants, I set out some of the history from a recent case study performed by the Ombudsman²⁴⁴ which details the investigation of a complaint made to him. I will refer to it in the chapter as the 'Ombudsman's case study'.

6.255 The Ombudsman's case study is particularly apt to illustrate the complex and confusing nature of the health complaints system in Queensland. The complainants wished to complain about the tragic death of their child at a regional Queensland Hospital on 7 January 2002. The father is a Medical Practitioner, a senior official in Queensland Health and had a good understanding of the relevant systems for making complaints. Few members of

²⁴⁰ The various Registration Boards are in schedule 2 of the *Health Rights Commission Act 1991* and are Chiropractors Board of Queensland; Dental Board of Queensland; Dental Technicians and Dental Prosthetists Board of Queensland; Medical Board of Queensland; Medical Radiation Technologists Board of Queensland; Occupational Therapists Board of Queensland; Optometrists Board of Queensland; Osteopaths Board of Queensland; Pharmacists Board of Queensland; Physiotherapists Board of Queensland; Podiatrists Board of Queensland; Psychologists Board of Queensland; Queensland Nursing Council; Speech Pathologists Board of Queensland.

²⁴¹ see *Ombudsman Act 2001*

²⁴² *Coroners Act 2003* s7

²⁴³ The Health Rights Commission, for instance, cannot continue with an investigation where the complaint is the subject of litigation. Bodies such as the Queensland Nursing Council may choose to defer investigations where a coronial inquest is expected

²⁴⁴ Referred to in the Submission of Ombudsman dated August 2005 (Volume 3 Submissions No 26)

the public would have the advantages which these parents had in selecting the appropriate bodies to whom to make their complaints and in describing the issues for the complaint. Despite the advantages which they had, the fragmented health complaints system in Queensland meant that there were no less than seven separate inquiries into aspects of an adverse incident. There were inquiries by the State Coroner, the Health Rights Commissioner, the Medical Board of Queensland, the Queensland Nursing Council, the Crime and Misconduct Commission and the Queensland Ombudsman. When the Ombudsman made a submission in August this year, it seems that more than 3 years after the parents made their first complaints, some aspects of the process were still incomplete.

6.256 The Ombudsman's case study reveals:

(a) As for Queensland Health:

- On 11 January 2002, the Executive Director of Medical Services of the relevant Health Service District provided a Preliminary Investigation about the incident to Queensland Health's corporate office, concluding that the treatment provided was reasonable;
- In about March/April 2002, the doctor and his wife lodged complaints with Queensland Health, the Health Rights Commission, the Medical Board of Queensland, and the Queensland Nursing Council concerning treatment provided at the hospital;
- They also raised concerns about a 'Preliminary Investigation Report' prepared by the Executive Director of Medical Services for the relevant district;
- Indeed, they sent a 21 page letter to Queensland Health, seeking a full investigation;
- A senior executive within Queensland Health advised that, given that the Health Rights Commission, the Medical Board, the Queensland Nursing Council, and the State Coroner were likely to conduct their own investigations, Queensland Health would postpone its inquiries;
- In December 2003, after the doctor and his wife drew attention to their still unresolved concerns, another senior executive within Queensland Health commissioned a neurologist to review the circumstances the subject of the complaint;
- The neurologist's report was presented to Queensland Health in June 2004;
- The couple maintain that they have not been informed, subsequently, of the actions taken by Queensland Health in respect of the neurologist's findings and recommendations.

(b) As for the Health Rights Commission:

- It informed the couple on 10 May 2002 that their complaint had been accepted for assessment and indicated that, in its view, the complaint raised four key issues;
- On 8 August 2002, the Health Rights Commission indicated that it would investigate the first and fourth issues but, because the second and third concerned nurses and doctors, the Commission had a statutory obligation to consult with the Queensland Nursing Council and the Medical Board respectively to determine whether each of those bodies would accept the complaint for further action;
- The Queensland Nursing Council and the Medical Board agreed subsequently to investigate the second and third issues;
- The Health Rights Commission made inquiries of the relevant District Manager about the first and fourth issues, but whilst there was initially co-operation, a challenge was then made to the Commission's jurisdiction on the fourth issue. After seeking advice from Crown Law, the Health Rights Commission decided it did not have jurisdiction because, as the allegation concerned the Preliminary Investigation Report, it did not relate to an administrative service directly related to a health service. It informed the couple accordingly on 16 July 2003;
- On 4 September 2003, the Health Rights Commission delivered a report but it did not make any recommendations;
- The couple were unhappy about certain aspects of the report and the Commission agreed to conduct a review. That review was not published until 28 June 2004. It found that there were a number of systemic issues that needed to be addressed at the regional hospital: it made recommendations accordingly.

(c) As for the Medical Board:

- it received a complaint on 10 April 2002 and a referral from the Health Rights Commission on 7 August 2002;
- The Board appointed an investigator from the Office of the Health Practitioner Registration Boards on 27 August 2002;
- After repeated complaints about delay, the Office of the Health Practitioner Registration Boards appointed an external investigator on 24 June 2003;
- The Office of the Health Practitioner Registration Boards provided a copy of the investigator's report to the couple on 20 January 2004;

- The Office of the Health Practitioner Registration Boards referred the matter to the Health Practitioners Tribunal and, on 8 November 2004, certain disciplinary action was taken against a doctor.
- (d) As for the Queensland Nurses Council:
- It received a copy of the complaint on 11 April 2002 and it received the referral from the Health Rights Commission in August 2002;
 - The Council agreed to investigate the complaint about one nurse;
 - The investigator completed her report in July 2004;
 - Subsequently, the Queensland Nurses Council sought legal advice and as a result decided not to proceed against a nurse;
 - It is still unclear, nearly 18 months after the completion of the investigators report, whether disciplinary action is to be taken against the first nurse.

On 24 December 2003, the couple referred the matter to the Ombudsman. The Ombudsman has indicated that he is concerned that there were four separate investigations, by four different agencies, acting under different legislation, and that there were considerable delays and dissatisfaction that accompanied the process.

- 6.257 One can see that there is some scope for adopting a more centralised approach to managing complaints in this State. Before considering that option, I address in turn below, several of the avenues currently available for making complaints.

Complaints made within a public hospital

Overview

- 6.258 As already indicated, there were a range of systems through which problems and issues can be reported, detected and analysed in the hospital environment:

- 1) Complaint processes;
- 2) Incident reporting;
- 3) Risk Management;
- 4) Clinical governance committees; and
- 5) Clinical audits and peer review.

To better understand why Dr Patel was able to practise for so long, despite his incompetence, it is necessary to consider what went wrong with those systems. I have already shown how the last of these failed at Bundaberg. So also did the complaints processes, incident reporting and risk management. Their failure shows that having an adequate policy is not sufficient.

6.259 There were three Queensland Health policies applying statewide which, in various versions, applied during the period of Dr Patel's employment for the management of complaints and incidents raised by patients and staff. If properly implemented and followed at Bundaberg, they should have been useful for picking up surgical incompetence. They were:

- (a) the Complaints Management Policy.²⁴⁵ This policy was effective from 31 August 2002 and governs the management of complaints made by or on behalf of patients;
- (b) the Integrated Risk Management Policy. Two versions of this policy existed during the relevant period. It prescribes how staff should respond to risks which arise in the hospital. The earlier version effective from February 2002 was replaced by another version²⁴⁶ in June 2004; and
- (c) the Incident Management Policy²⁴⁷ which governed treatment of clinical issues raised by hospital staff and was effective from June 2004.

6.260 In addition to these Queensland Health policies, the Bundaberg Base Hospital developed local policies which also dealt with practical application of the matters the subject of the Queensland Health policies.

6.261 The following chronology details when the relevant Queensland Health and Bundaberg policies relating to patient and staff complaints and risk analysis were introduced:

Feb 2002	Queensland Health Integrated Risk Management Policy ²⁴⁸
May 2002 ²⁴⁹	Bundaberg Complaints Management System ²⁵⁰
July 2002	Queensland Health Complaints Management Policy ²⁵¹
Dec 2002	Bundaberg Risk Management Process ²⁵²
Feb 2004 ²⁵³	Bundaberg Adverse Events Management Policy ²⁵⁴
June 2004	Queensland Health Integrated Risk Management Policy (replaced policy of February 2002) ²⁵⁵
June 2004	Queensland Health Incident Management Policy ²⁵⁶

²⁴⁵ Exhibit 292

²⁴⁶ Exhibit 293

²⁴⁷ Exhibit 290A JGW6 Statement Wakefield

²⁴⁸ Exhibit 293

²⁴⁹ Exhibit 162 para 11 Statement Raven

²⁵⁰ Exhibit 162 LTR2 Statement Raven

²⁵¹ Exhibit 292

²⁵² Exhibit 162 LTR3 Statement Raven

²⁵³ Exhibit 162 para 21 Statement Raven

²⁵⁴ Exhibit 162 LTR4 Statement Raven

²⁵⁵ Exhibit 293

June 2004	Bundaberg Sentinel Events and Root Cause Analysis Policy ²⁵⁷
Nov 2004	Bundaberg Incident Management – Clinical and Non-Clinical (replaced Bundaberg Adverse Events Management Policy) ²⁵⁸
Nov 2004	Bundaberg Incident Analysis Policy ²⁵⁹
Nov 2004	Bundaberg Sentinel Events and In-depth Analysis Policy (replaced Bundaberg Sentinel Events and Root Cause Analysis Policy) ²⁶⁰
Nov 2004	Bundaberg Risk Management Process (replaced Bundaberg Risk Management Process issued in December 2002) ²⁶¹

Complaints Management Policy

6.262 The Queensland Health Complaints Management Policy²⁶² governs how Queensland Health should deal with complaints by or on behalf of patients. This policy should have been used at the Bundaberg Base Hospital for recording and analysing patient complaints. Patients are referred to by Queensland Health in the policy as ‘consumers’. The policy does not apply to staff complaints.²⁶³ When staff had clinical issues to raise they were dealt with under a different policy, namely the Incident Management Policy.

6.263 It was observed in the Queensland Health Systems Review, Final Report,²⁶⁴ that the ‘policy reflects contemporary best practice’. The Queensland Ombudsman reported to the Director-General of Queensland Health in March 2004 that the policy ‘compares very favourably to those in most other departments and meets nearly all the criteria for good complaints management’.²⁶⁵ However, each of those compliments was based upon the policy but not upon its implementation. The Queensland Health Systems Review, Final Report observed that implementation of the policy throughout the state had been poor. The Ombudsman in March 2004 recommended that Queensland Health improve the awareness of its staff of the patient complaints management system.

6.264 The Queensland Health Complaints Management Policy relevantly provides:

- Health care consumers have the right to receive feedback and have complaints heard and acted upon;²⁶⁶

²⁵⁶ Exhibit 290A JGW6 Statement Wakefield

²⁵⁷ Exhibit 162 LTR6 Statement Raven

²⁵⁸ Exhibit 162 LTR7 Statement Raven

²⁵⁹ Exhibit 162 LTR7 Statement Raven

²⁶⁰ Exhibit 162 LTR7 Statement Raven

²⁶¹ Exhibit 162 LTR7 Statement Raven

²⁶² Exhibit 292

²⁶³ Exhibit 292: Scope and Application

²⁶⁴ Queensland Health Systems Review, Final Report p189 (www.healthreview.com.au)

²⁶⁵ Queensland Ombudsman submission to the Bundaberg Hospital Commission of Inquiry August 2005 page 43

²⁶⁶ Exhibit 292: Policy Statement

- Information from the complaints management process is used to improve quality and safety in health care;²⁶⁷
- All complaints are to be assessed in a manner that reflects the seriousness of the complaint, in categories that can be applied to the risk management framework ie. negligible, minor, moderate, major or extreme;²⁶⁸
- Complaints rated as moderate, major or extreme will be referred to the Complaints Coordinator for action, the Complaints Coordinator will inform the District Manager of major or extreme complaints and the District Manager will inform the General Manager, Health Service of extreme complaints;²⁶⁹
- Staff are encouraged to resolve minor complaints at the point of service; if this is not achieved the matter should be referred to the Complaint Coordinator who will arrange referral to the district executive. An investigator should undertake an in-depth and or root cause analysis of complaint matters;²⁷⁰
- All parties involved in a complaint are advised of the outcome of the complaint;²⁷¹
- Local processes should be put in place to support best practice in complaint handling;²⁷²
- Organisation wide improvements should result from both aggregated and individual complaint information;²⁷³ and
- A complaints management procedure and register will be in place in each District.²⁷⁴

6.265 From May 2002 a local policy also applied In the Bundaberg Health Service District. Relevantly, the Bundaberg Complaints Management System²⁷⁵ provided:

- Complaints that cannot be resolved at the point of service should be referred to the relevant Executive Director;

²⁶⁷ Exhibit 292: Policy Statement

²⁶⁸ Exhibit 292: Seriousness Categories

²⁶⁹ Exhibit 292: Reporting

²⁷⁰ Exhibit 292: Appendix 1 Complaint Handling Model

²⁷¹ Exhibit 292: Appendix 2 Performance Standards and Criteria

²⁷² Exhibit 292: Appendix 2 Performance Standards and Criteria

²⁷³ Exhibit 292: Appendix 2 Performance Standards and Criteria

²⁷⁴ Exhibit 292: Instruction, Implementation Process

²⁷⁵ Exhibit 162 LTR2 Statement Raven

- The investigation should be coordinated by the line manager or executive member and all quality improvement activities are to be registered with the Quality Management Unit and Improving Performance Committee;
- When the complaint is resolved all relevant documents are to be sent to the Complaints Coordinator for inclusion on the Complaints Register; and
- The Complaints Coordinator will provide a bimonthly report to the Leadership and Management Committee.²⁷⁶

Incident Management Policy

6.266 The Queensland Health Incident Management Policy²⁷⁷ covers all incidents, clinical and non-clinical, defined in the policy as ‘an event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person or the organisation, and/or a complaint, loss or damage’.²⁷⁸ Events with a very high and extreme risk rating and sentinel events must be reported to the District Manager, State Manager and relevant Corporate Office Branch Executive. All incidents must be reported on an incident report form and each district is to maintain a comprehensive register.²⁷⁹

The Queensland Health Incident Management policy is supplemented by three local policies In the Bundaberg Health Service District:

- Incident Management Policy;²⁸⁰
- Incident Analysis Policy;²⁸¹ and
- Sentinel Events and In-depth Analysis Policy.²⁸²

Integrated Risk Management Policy

6.267 The Queensland Health Integrated Risk Management Policy²⁸³ focuses on establishing an organisational philosophy and culture that ensures risk management is an integral part of decision making activities. This policy also applied during the period of Dr Patel's employment. The Policy provides an ‘Integrated Risk Management Analysis Matrix’ for the risk rating of incidents. The Policy details specific requirements for reporting risks, including:

²⁷⁶ Exhibit 162 LTR2 Statement Raven

²⁷⁷ Exhibit 290A JGW6 Statement Wakefield

²⁷⁸ Exhibit 290A JGW6 Statement Wakefield: Incident Categories

²⁷⁹ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording

²⁸⁰ Exhibit 162 LTR7 Statement Raven. This policy was issued in November 2004 replacing the Adverse Events Management Policy Exhibit 162 LTR4 Statement Raven

²⁸¹ Exhibit 162 LTR7 Statement Raven

²⁸² Exhibit 162 LTR7 Statement Raven. This policy was issued in November 2004 replacing the Sentinel Events and Root Cause Analysis Policy Exhibit 162 LTR6 Statement of Raven

²⁸³ Exhibit 293

- Each district will report very high and extreme risks to their appropriate line management; and
- Each district will provide to the Risk Management Coordinator, a quarterly download of the Risk Register and details of risks that have a rating of very high or extreme.

6.268 The Queensland Health Integrated Risk Management Policy sets out principles and leaves much of the practical detail to local policy, the Bundaberg Risk Management Process.²⁸⁴ The local policy which applied throughout Dr Patel's employment requires that risks are systematically identified in each Clinical Service Forum. The Improving Performance Committee is to maintain a Central Risk Register. The Improving Performance Committee may delegate responsibility for the treatment of risks to the relevant committee. The Risk Register must be provided to the Queensland Health Integrated Risk Management Coordinator on a quarterly basis.

What went wrong in Bundaberg?

6.269 Throughout the course of the Commission it became apparent that there had been a steady stream of complaints and clinically significant incidents involving Dr Patel which commenced shortly after his arrival in Bundaberg. There were informal concerns. There were formal ones, by which I mean occasions where patients or staff filled in forms referring to clinical incidents relating to Dr Patel or formally brought issues relating to Dr Patel to the attention of the executive or a committee. If one excludes Dr Patel's holidays, his activities resulted in about one formal patient complaint or formal staff report for each month he actually worked. Despite this, the cumulative significance of the informal and the formal complaints and reports went either undetected or unaddressed for almost two years. A number of factors contributed to this:

- Many adverse incidents which occurred were not made the subject of a complaint nor of an incident report;
- Many complaints and incidents which were formalised were not dealt with as they should have been if the policies had been complied with;
- There was inadequate investigation of complaints;
- There was inadequate risk rating and referral;
- There was inadequate response and resolution;
- There was inadequate management and use of data; and

²⁸⁴ Risk Management Process (December 2002) and Risk Management Process (November 2004) Exhibit 162 LTR3 and LTR7 Statement Raven

- Implementation of systems was hindered by inadequate money, staff and time.

Many adverse incidents were not made the subject of a complaint nor of an incident report

6.270 In the two year period of Dr Patel's employment at the Bundaberg Hospital there were 22²⁸⁵ incidents or issues that were formally reported in one form or another. They can be broken down as follows:

- 7 patient complaints;
- 7 incidents reported to a member of the executive (with no formal incident report form);
- 3 incidents reported with an Incident Report only;
- 2 reported to a member of the executive and an Incident Report was completed;
- 1 incident reported to a member of the executive and a committee;
- 1 incident reported to a committee only;
- 1 incident reported by a patient complaint, Incident Report and to a member of the executive.

6.271 When the issues surrounding Dr Patel came to light, Queensland Health arranged reviews for patients who had received treatment from Dr Patel. The review conducted by Dr Peter Woodruff involved a review of charts but not of patients. It was not a random selection of charts. Dr Woodruff was confined to reviewing charts of a particular kind. The terms of reference for the cases which were to be reviewed by Dr Woodruff was relatively general. The team appointed on 18 April 2005 were to 'review the clinical cases of Dr Patel where there has been an identified adverse outcome, or where issues related to his clinical practice have been raised'.²⁸⁶

6.272 One would expect that the reviewers ought to have been able to identify those cases from the two registers that should have been established pursuant to the Queensland Health Complaints Management and Incident Management policies. They were the Complaints Register which recorded complaints made by and on behalf of patients²⁸⁷ and the Adverse Event Register which recorded incidents raised by staff.²⁸⁸

²⁸⁵ See discussion in Chapter Three: Dr Patel Works at the Base

²⁸⁶ Exhibit 102 p20

²⁸⁷ Exhibit 166

²⁸⁸ Exhibit 167

- 6.273 When one bears in mind the extraordinary findings of Dr de Lacy,²⁸⁹ Dr O'Loughlin²⁹⁰ and Dr Woodruff,²⁹¹ as to the number of procedures performed incompetently by Dr Patel with adverse results, one would expect both registers to be filled with the name Patel.
- 6.274 When the Quality Coordinator was first asked to identify complaints and incidents about Dr Patel, a review of the Complaints and Adverse Incidents registers revealed only three complaints²⁹² and five adverse events.²⁹³ There were in fact other entries on each register which related to Dr Patel that were not picked up because the medical practitioner's name was not, as a rule, put on the registers.
- 6.275 In the months after the Patel issue became public, the Quality Coordinator at the Base was able to find another five records of adverse events relating to Dr Patel's care that had been reported by staff. The extra five had not appeared on the register because they occurred before the Adverse Events Register was commenced in February 2004.²⁹⁴
- 6.276 The failure of the Base to record the names of the medical practitioners about whose treatment complaints were made or issues were raised, is explained by a desire to promote better reporting by promoting the notion of a blame free culture. It did not promote adequate reporting. Reporting was lamentable. The failure to record Dr Patel's name must have helped to conceal his dangerous incompetence.
- 6.277 Dr Woodruff did not content himself with an investigation of the three patients whose complaints identified Dr Patel on the Complaints Register and the five patients about whom entries appeared on the Adverse Events Register. Dr Woodruff was forced to look wider. He chose to look at the patients who died, those who were transferred to other institutions and at those identified as having adverse outcomes which were brought to the attention of the Review Team.²⁹⁵
- 6.278 Dr Woodruff gave evidence that, of the patients' charts he reviewed, 22²⁹⁶ showed to him that Dr Patel contributed to an adverse outcome and a further 24²⁹⁷ showed that Dr Patel may have contributed to an adverse outcome. Of the 46 adverse outcomes identified by Dr Woodruff, only seven appear on the

²⁸⁹ Para 3.416 herein

²⁹⁰ Para 3.417 herein

²⁹¹ Para 3.418 herein

²⁹² Exhibit 162 para 29

²⁹³ Exhibit 162 para 33

²⁹⁴ Exhibit 162 paras 54-60

²⁹⁵ Exhibit 102 p47

²⁹⁶ Exhibit 102, p120-125

²⁹⁷ Exhibit 102, p126-130

Adverse Events Register²⁹⁸ and only six appear on the Complaints Register^{299 300}.

- 6.279 With respect to patient complaints, it is probably the case that many would not have been aware that their problems were the result of clinical deficiencies. Many would have assumed, or may have been informed, that any ongoing problems were normal or to be expected, hence no complaint was made.
- 6.280 The reasons why incidents were not more frequently reported by clinical staff are not so easily explained. Under the Queensland Health Incident Management Policy, which came into effect in June 2004, all incidents must be reported.³⁰¹ For the purposes of the policy, the term incident is defined as ‘an event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person ..., and/or a complaint, loss or damage’.³⁰² The local policies, one of which was in operation from February 2004³⁰³ had similar reporting requirements.
- 6.281 It is worth reiterating. The doctors and nurses at the Base were obliged by the policies in effect from February 2004 to report even incidents which could have led to unintended harm to a patient. It obviously was not honored by staff or sufficiently encouraged by the executive.

Unhealthy culture for staff to complain and report incidents

- 6.282 For any complaints systems to function properly it is vital that people are willing to come forward and ‘speak up’ about concerns that they have.
- 6.283 Whilst Toni Hoffmann campaigned (quite consistently and courageously) over quite some time to bring her concerns about Dr Patel’s practices to light, many other staff at the Base were less than forthcoming in their concerns. A significant number of reportable incidents occurred in Bundaberg but were not reported.
- 6.284 In the aftermath of the Bramich incident, Dr Strahan indicated to Ms Hoffmann that there were a number of other people who had concerns about Dr Patel but were not willing to ‘stick their necks out’.³⁰⁴ Whilst Dr Miach communicated his concerns about Dr Patel’s incompetence in the insertion of catheters, he did not tell his line superiors, Dr Keating or Mr Leck that he had given instructions that his patients were not to be touched by Dr Patel. Indeed, he asked that Ms

²⁹⁸ Exhibit 167

²⁹⁹ Exhibit 166

³⁰⁰ These figures are with respect to the surgery or adverse outcomes referred to by Dr Woodruff. Instances where the patient appears on the register for a distinct adverse event (eg. a fall or system error) have not been included. The register was checked for complaints made prior to April 2005

³⁰¹ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording

³⁰² Exhibit 290A JGW6 Statement Wakefield: Incident categories

³⁰³ Exhibit 162 LTR4 Statement Raven

³⁰⁴ T1490 (Ms Hoffman)

Pollock not minute that direction at an ASPIC meeting.³⁰⁵ There are a number of reasons for staff reluctance to report safety issues.

- 6.285 First, some would have felt unwilling to tell of their concerns and effectively challenge Dr Patel, who was known to intimidate staff and effect some retribution upon those who challenged him. Consistent with this impression was the collective understanding propagated among the staff who worked with Dr Patel that because Dr Patel generated a large amount of revenue for the hospital by his capacity to perform elective surgery he had the unwavering support of management. Dr Strahan testified that he and others felt that if they complained against Dr Patel they would not only be challenging him, they would be challenging management.³⁰⁶
- 6.286 Secondly, Dr Strahan testified that the reason why he and others were less willing to come forward was that they did not believe that the information they had available to them was sufficient to warrant challenging Dr Patel. He effectively said that whilst, to an individual, information did not seem to justify a complaint, that information comprised a larger picture that was beyond any individual's knowledge. Had that information been combined so that the gravity of the situation was known to all those who held the separate pieces of it then he said that more people might have been willing to come forward.³⁰⁷
- 6.287 Thirdly, people who had concerns could only be confident about those things within their expertise and would be less willing to challenge Dr Patel on matters outside it. This problem is multiplied by the increased level of specialisation which characterises modern medical practice. The effect of this is that a specialist may not be willing or able to suggest incompetence in another practitioner who practises outside the specialist's scope of expertise. An eminent nephrologist, for example, may be less willing to claim that a surgeon is incompetent because surgery is not within his expertise nor within the expertise of the hospital's executive who would have to consider the claim.
- 6.288 Fourthly, because Dr Patel was the only general surgeon at the Base, (Dr Gaffield was a plastic surgeon whose general surgical experience was not so extensive as Dr Patel's), there was effectively no-one there observing Dr Patel's work, who could identify failings in Dr Patel as a surgeon with any confidence or significant credibility. Patients are often unable to identify inadequate care and for that reason are more likely to accept than challenge it by way of complaint. Further, a patient's credibility with those to whom they complain is hampered by limited or non-existent clinical knowledge.

³⁰⁵ Exhibit 70 para 21

³⁰⁶ T3282 (Dr Strahan)

³⁰⁷ T3282-3 (Dr Strahan)

- 6.289 Fifthly, the process of formally complaining is quite alien to most people, including clinicians.³⁰⁸
- 6.290 Sixthly, there were some, it seems, who were tired of complaining with no result and because of 'complaint fatigue' were unwilling to complain again.³⁰⁹
- 6.291 The Queensland Health Review team which went to Bundaberg reported³¹⁰ that numerous staff at Bundaberg reported barriers to reporting clinical incidents and summarised those barriers as follows:
- Little point reporting as nothing changed;
 - Leadership not actively encouraging reporting for 'learning';
 - Lack of feedback of outcome to reporting person/unit;
 - Culture of blame and history of punitive approach to reporter;
 - Fear of reprisal;
 - Seen as nursing business; and
 - Multiple forms.
- 6.292 By the time Dr Patel began work at the Base in 2003, the relationship between clinical staff and administrators was marked by a dysfunctional approach to complaints about clinical standards. Management was accustomed to rejecting legitimate demands because management had inadequate funds. Management was accustomed to providing an unsatisfactory service to patients about which the clinicians continued to complain. The inadequate budgets were a constant problem for the District Manager.
- 6.293 There had been some quite vehement earlier complaints about staff working unsafe hours and the need for more staff and equipment. Dr Nankivell and Dr Baker, each surgeons, had complained about their workloads. Dr Jeliffe and Dr Carter, Anaesthetists, had complained about the workloads for anaesthetic staff. When Dr Baker resigned in 2002 he said that he did not wish to continue to provide a third world surgical service. Dr Jeliffe had cancelled elective surgery during the Easter period in 2002 because he was concerned about the risks to patient safety caused by his workload. Dr Nankivell was hospitalised for exhaustion.
- 6.294 The District Manager, Mr Leck, thought that there were staff working too many hours but felt that he had to condone this because he had little practical alternative. He believed that the recommendations of Australian Colleges as to proper numbers of specialists were universally ignored in Queensland Health.³¹¹

³⁰⁸ T3268-T3269 (Dr Strahan)

³⁰⁹ T3283; T4006 (Dr Strahan)

³¹⁰ Exhibit 102 p80

³¹¹ T7187 line 49 (Mr Leck)

- 6.295 If a complaint or a suggestion required further funds, it was likely to lead to nothing but frustration. That frustration could be increased by lack of feed back. A sensible request by a clinician might have to pass through several layers of administration before a decision could be made on the request and it might take several months before the original clinician received an answer. If the request was rejected, it was possible that the clinician would be left wondering as to why it was rejected. Dr Thiele, who had been a Director of Medical Services at the Base, regarded it as 'a fundamental system failure'.³¹²
- 6.296 A general concern was expressed that a complaint about another clinician would result in reprisal or retribution.³¹³ Evidence was given of actual or perceived threats by administrators to suppress complaints. Dr Miach, Staff Physician, formed the impression that he was being threatened by the Director of Medical Services. When the Patel issue arose in the media Dr Keating came to Dr Miach's office, which was most unusual, and observed 'you know what goes around comes around'. Prior to the Patel controversy Dr Jelliffe, then a Staff Anaesthetist, was uncharacteristically summoned to the office of Mr Leck, District Manager. It was after Dr Jelliffe had cancelled elective surgery during the Easter period out of his concern for patient safety caused by the working hours for which he would be rostered. He interpreted the interview as threatening when Mr Leck asked him about the status of his visa.
- 6.297 Dr Nankivell gave evidence that 'the feeling amongst all nurses is that if you complain you'll be sacked or discriminated against', and said that nurses were terrified of the Code of Conduct.
- 6.298 It was alarming that, even after an independent internal investigation had been undertaken by Dr FitzGerald in February 2005 and it was clear to Mr Leck that legitimate concerns had been raised about Dr Patel's clinical competence, he considered taking an adversarial approach to those staff who had felt they had had no alternative but to raise their concerns with their local member. On 7 April 2005 he wrote to the Zonal Manager 'Perhaps we have the Audit Team come up and deliver some training sessions around the Code of Conduct and deliver some firm and scary messages?'

Lack of response to complaints:

Dr Miach's experience

- 6.299 Dr Miach, the Director of Medicine at the Bundaberg Hospital and an eminent physician and nephrologist, found management unresponsive to his serious concerns.

³¹² T1835 line 25 (Dr Thiele)

³¹³ T2251 line 25 (Ms Raven), Exhibit 102 p80

- 6.300 Shortly after Dr Keating's arrival at the hospital, he changed the system of on-call rostering without any staff consultation. Dr Miach advised Dr Keating that the rostering of the most junior staff to the Accident and Emergency Department after hours, instead of the most senior, was bad practice.³¹⁴ Dr FitzGerald whose expertise included emergency medicine confirmed in evidence that Dr Miach's concerns were appropriate.³¹⁵ The bad practice was maintained.
- 6.301 Another incident concerning Dr Miach was the creation of the catheter audit which so damned Dr Patel's competence in surgery to place peritoneal catheters and, arguably, his judgment in performing the procedure. I have referred to the efforts to bring this information forcefully to Dr Keating's attention in Chapter Three. Dr Keating's failure to question the significance of the catheter audit and his failure to become involved with the nurses' concerns about the complications must have left Dr Miach and the nurses perplexed.
- 6.302 Dr Miach also raised issues about vascular access in the hospital with Dr Keating. He wrote a letter to Dr Keating with an example of a young patient who had suffered immensely because vascular access was not performed locally and he was too ill to travel to Brisbane. He suggested that Dr Thiele, a vascular surgeon in town with a long association with the Base, be engaged as a Visiting Medical Officer to perform vascular access locally. Dr Miach received no response to that letter and had to take up the matter with the Zonal Manager.³¹⁶

Oesophagectomy complaints

- 6.303 The circumstances of the first two oesophagectomies performed by Dr Patel at the Base led to a conflict of evidence as to what notice was given to Dr Keating of concerns by Ms Hoffman, Dr Joiner and Dr Cook. Some matters remain beyond doubt. Dr Joiner advised Dr Keating that the Base was not doing sufficient oesophagectomies to maintain competency. This was correct. Dr Joiner advised that the Intensive Care Unit did not have the necessary resources for post-operative support. This, too, was correct. Ms Hoffman wrote by e-mail on 19 June 2003 that she had continuing concern over the lack of sufficient Intensive Care Unit backup to care for a patient who has undergone such extensive surgery. Dr Cook, the most senior intensivist at the Mater Hospital in Brisbane wrote to Dr Keating and spoke to him by telephone because of his concern that a surgeon at the Base would be embarking on such a complicated operation as an oesophagectomy. Dr Keating did not return to Dr Cook to inform him that he was prepared to permit such procedures to continue to be performed at the hospital nor did he respond to the email from Ms Hoffman. The decision by Dr Keating to allow the procedures to continue in the

³¹⁴ Exhibit 21 para 110

³¹⁵ T3158 (Dr FitzGerald)

³¹⁶ Exhibit 21 para 119-126

future was plainly inconsistent with the requirement to apply risk management practices.³¹⁷

- 6.304 It took two more oesophagectomies to close this chapter. It ended with the inappropriate and unnecessary oesophagectomy performed upon Mr Kemp which killed him in December 2004. The circumstances of the incident and the staff concerns raised appear in Chapter Three. The anaesthetist, Dr Berens, brought to Dr Keating his and the theatre staff's concerns about Dr Patel's conduct. Dr Berens was so concerned he expressed the view that perhaps the matter should be referred to the Coroner.
- 6.305 None of the staff involved with Dr Patel during the surgery, nor Dr Carter to whom Dr Berens first went, nor Dr Keating filled in the 'Adverse Event Report Form' consistent with the Adverse Events Management Policy requirements at Bundaberg since February 2004. It meant the event was not sent to the District Quality and Decision Support Unit for registering and risk rating. More significantly, Mr Kemp's death from elective surgery was a 'Sentinel Event' under the Sentinel Events and In-depth Analysis policy because it was an unexpected death. That policy required that the incident be given special treatment. Mr Keating was required to report it to Mr Leck immediately. Mr Leck learned of it immediately. Mr Leck was required to notify the Director-General of Queensland Health immediately. A team independent of the incident were to analyse it within 7 days. A root cause analysis investigation tool was to be used. There was no notice to the Director-General, nor an investigation. Within a month, Mr Leck and Dr Keating extracted a promise from Dr Patel that he would not carry out any further oesophagectomies at the Base.

Reported complaints and incidents not dealt with under the policy framework

- 6.306 Of the 22 incidents or issues that were reported, 15 of those were complaints or issues raised by staff. Of that 15, nine were reported informally, without the use of an Accident/Incident Report or as it was later known, an Adverse Event Report Form.
- 6.307 It meant that nine incidents reported to the executive in this informal way were not dealt with under the policy framework.³¹⁸ The effect of this is that:
- Incidents were not risk rated according to the severity of consequences and likelihood of reoccurrence;
 - Potential or actual incidents with a very high or extreme risk rating were not reported to the District Manager;

³¹⁷ As required at the time by the Risk Management Process Exhibit 162 LTR3 and the Queensland Health Integrated Risk Management Policy Exhibit 293

³¹⁸ Incident Management Policy, Exhibit 293; Adverse Events Management Policy, Exhibit 162 LTR4 Statement Raven; Incident Management Clinical and Non-Clinical Exhibit 162 LTR7 Statement Raven

- Incidents were not recorded on the Adverse Events Register, meaning that trends could not be picked up and this data would not be included in the quarterly trends reports provided to various committees;
- Incidents were not investigated under the comprehensive requirements of the policy,
- Corrective action plans and reports were not produced;
- Feedback about actions taken was not provided to those involved in the incident;
- Risks were not reported on the local Risk Register.

6.308 Similarly, there are examples where patient concerns became known to the executive; however, because they were not the subject of a formal complaint they were not dealt with under the policy framework.

6.309 Recall the case of Ms Lester,³¹⁹ who applied for a travel subsidy to avoid Dr Patel. The patient had seen Dr Patel on an earlier occasion to have packings from a previous procedure removed. The experience had been particularly traumatic as the procedure took place before the anaesthetic had taken effect.³²⁰ After experiencing ongoing pain, the patient sought the opinion of a different doctor. An ultrasound revealed that a foreign body was still within her.³²¹

6.310 Despite what appears to be gross carelessness on the part of Dr Patel, Dr Keating gave evidence that he did not consider it necessary to investigate the clinical aspects of this incident³²² and merely put it down to a difference of opinion between doctors.³²³ The matter was considered purely as a travel application.³²⁴

6.311 There was no record of a complaint, no record of an adverse incident, no risk assessment, no investigation of the treatment that led to the foreign body being missed. This was less than 10 days after Dr Keating counselled Dr Patel about his attitude to Mr Smith and failure to anaesthetise adequately. Ms Lester raised this same issue.

6.312 The policies support the idea that issues are addressed even if they are not raised as complaints. The Queensland Health Complaints Management Policy defines a complaint as 'any expression of dissatisfaction or concern, by or on behalf of a consumer...'. The Queensland Health Incident Management Policy

³¹⁹ Paras 3.253 - 3.255 herein

³²⁰ Exhibit 176 para 14 Statement Lester

³²¹ Exhibit 176 para 16 Statement Lester

³²² T6954 line 35 (Dr Keating)

³²³ T6955 line 17 (Dr Keating)

³²⁴ T6954 line 50 (Dr Keating)

provides that incidents can be identified in many ways, including from patient complaints.

Non-Compliance with the Complaints Management Policy

- 6.313 The Queensland Health Complaints Management Policy affirms and supports the right of patients to feedback and to have complaints heard and acted upon. The implementation of the complaints management process strives for consumer satisfaction in the way the complaint is handled, and to provide reliable and accurate information which is used to improve quality and safety in health care.³²⁵
- 6.314 A review of the Complaints Register for the period July 2002 to April 2005 paints a superficially positive picture of complaints management at the Bundaberg Hospital. During this period 675 complaints were registered, 533 were resolved within 28 days and all but four eventually resolved.
- 6.315 However, a closer analysis of individual cases paints a different picture. The Commission heard evidence that complaints were not always thoroughly investigated and resolved to the satisfaction of the patient. Further, there is evidence of disparities between the patient's recollections and perceptions and the Hospital's records of the complaint outcome.

The Fleming complaint

- 6.316 Mr Fleming's relevant medical history is more fully set out in Chapter Three. Five months after surgery by Dr Patel Mr Fleming was extremely concerned about his health because of pain and internal bleeding and was concerned about delays in having the hospital investigate it. He complained by telephone and a staff member filled in for him a Complaint Registration Form.³²⁶ The staff member chose not to classify the complaint as about 'treatment' or 'professional conduct' but as about 'access to service'. And so, when the complaint could so easily have been categorised as one raising an issue about whether the original treatment was adequate, it was categorised, instead, as a concern about delay – delay in obtaining an investigation to determine the need for remedial treatment from the hospital. When the complaint appeared on the Complaints Register³²⁷ a reader of the document would have assumed that Mr Fleming's major concern was about obtaining access to a specialist. The register gave the impression that the complaint was 'resolved' in two days by 'explanation given'. If it had been classified as a complaint about treatment it would have been more difficult to classify it as 'resolved' and to close the book on it. It would have required a consideration of the adequacy of the initial treatment and a consideration of the

³²⁵ Exhibit 292 QH Complaints Management Policy: Policy Statement

³²⁶ Exhibit 114 IGF3

³²⁷ Exhibit 166

accuracy of the patient's belief that he had internal bleeding and the need for remedial treatment. The complaint was classified as resolved two or three weeks before Mr Fleming was able to see the specialist he was so desperate to have review him.

The Smith complaint

- 6.317 On 27 February 2004 Geoff Smith made a oral complaint to Dr Keating regarding the treatment he received from Dr Patel.³²⁸ Mr Smith had a melanoma on his shoulder. Mr Smith advised Dr Patel that local anaesthetic was not effective for him and questioned him regarding alternatives. Dr Patel dismissed Mr Smith's concerns and proceeded to excise the melanoma without anaesthetising him properly.
- 6.318 Dr Keating met with Mr Smith to discuss the complaint. Dr Keating then met with Dr Patel and explained to him that the patient's complaint appeared to be legitimate and the attitude displayed to Mr Smith seemed to be inappropriate.³²⁹ After the meeting Dr Keating sent a letter to Mr Smith in which he apologised for the distress and unhappiness that had been experienced and advised that Dr Patel had given an undertaking to review his interactions with patients in such circumstances.³³⁰
- 6.319 An alert was also placed on the cover of Mr Smith's medical file stating 'local anaesthetics alone are ineffective alternative methods of pain relief are required'.³³¹
- 6.320 The complaint was registered on the Complaints Register as a 'Treatment' issue that was resolved within 12 days. The resolution is noted as 'explanation given'.³³²

P131 complaint

- 6.321 On 2 July 2004 P131 made a telephone complaint about Dr Patel which was referred to Dr Keating.³³³ P131 complained that she had attended at BreastScreen complaining of an itchy nipple. BreastScreen wrote to Dr Patel requesting that a biopsy be performed to exclude Paget's disease. When she presented for the biopsy on 1 July 2003 she was informed by Dr Patel that she only had eczema and was given cortisone cream.
- 6.322 In October 2003, she was attending the hospital for another matter and informed staff that she still had the itchy nipple and that the cream Dr Patel had given her

³²⁸ Exhibit 174 Statement Smith

³²⁹ T6953 line 20-30 (Dr Keating)

³³⁰ Exhibit 174 GS1 Statement Smith

³³¹ Exhibit 190, there is some contention as to when this alert was placed on the file see T2679-2681 (Mr Smith)

³³² Exhibit 166

³³³ Exhibit 225 GR19 Statement Fitzgerald

had not worked.³³⁴ She was referred to Dr Gaffield for review who recommended that she undergo a punch biopsy.³³⁵ P131 underwent the biopsy in March 2004, some eight months after the first scheduled biopsy that never took place. The biopsy revealed the she did in fact have Paget's disease. The patient elected to undergo a bilateral mastectomy.³³⁶

6.323 On receiving the complaint, Dr Keating took this up with Dr Patel. Dr Patel advised that he intended to review the patient after three months and if there was no improvement a biopsy would be conducted then. He explained that Paget's disease and Eczema are very hard to differentiate. Dr Patel claims that the patient did not return for her review appointment on 23 September 2003.³³⁷ It appears that the patient was not aware of a review appointment.

6.324 Dr Keating accepted Dr Patel's explanation and responded to P131 that:

Eczema and Paget's Disease (early cancer) can be very hard to differentiate and based upon your normal breast examination and mammogram, conservative treatment was begun with a review due in three months. This course of management was appropriate; unfortunately a lack of thoroughness at initial review appointment prolonged the time until definitive diagnosis and treatment in 2004.³³⁸

6.325 The complaint was registered on the Complaints Register as a 'Treatment' issue that was resolved within 31 days. The resolution is noted as 'explanation given'.³³⁹ The complaint was not given a seriousness category or risk rated.

What should have happened under the Complaints Management Policy

6.326 Under the statewide Complaints Management Policy³⁴⁰ any moderate, major, extreme and unresolved complaints are to be referred to the Complaints Coordinator. The Complaints Coordinator is to review resolved complaints and ensure comprehensive assessment or investigation of moderate, major, extreme and unresolved complaints. Under the Bundaberg policy, members of the health service executive are responsible for coordinating the investigation of a complaint in their area of authority.

6.327 In the examples above, the complaints were made directly to Dr Keating or referred to him. He attempted to resolve issues before referring them to the Complaints Coordinator.

6.328 Once the complaints were received by the Complaints Coordinator, the complaint information was put into the Complaints Register. The complaints

³³⁴ Exhibit 294 para 52 Statement Gaffield

³³⁵ Exhibit 294 para 54 Statement Gaffield

³³⁶ Exhibit 294 para 60 Statement Gaffield

³³⁷ Exhibit 225 GR19 Statement Fitzgerald

³³⁸ Exhibit 225 GR19 Statement Fitzgerald

³³⁹ Exhibit 166

³⁴⁰ Exhibit 292

were not classed according to seriousness. The complaints of Ms Lester (a foreign body left within her), Mr Fleming (continued internal bleeding and wound infection), P131 (failure to perform a biopsy to exclude Paget's disease leading to a double mastectomy) and possibly Mr Smith's (failure to give anaesthetic) should have been classed, at least, as moderate and should have been referred for investigation. None of the complaint examples received a comprehensive assessment or investigation as required by the Policy.

- 6.329 The Policy requires an in-depth and/or root cause analysis of complaint matter. The Policy defines investigation as:

A systematic process of collecting relevant evidence, followed by an assessment of the evidence that leads to a logical and reasonable determination or conclusion. Investigations are undertaken when a decision needs to be made and the material/evidence before the decision maker is insufficient and/or needing clarification and/or only an allegation which needs a response or collection of further evidence from another party/parties and/or conflicting and cannot be reasonably assessed without further evidence.

- 6.330 The Policy sets out the following responsibilities of investigators:

- Investigating complaints objectively, fairly, confidentially and in a timely manner;
- Establishing the facts associated with a complaint;
- Compiling a report on the investigation findings;
- Forwarding reports to the person who appointed them to conduct the investigation; and
- Ensuring the principles of natural justice and procedural fairness are upheld throughout the investigative process.

- 6.331 In each of the complaint examples, with the exception of Lester, Dr Keating discussed the incident with Dr Patel. Dr Patel's comments were accepted for the Fleming and P131 complaints and no further medical opinion was sought. With respect to the Smith complaint, Dr Keating advised Dr Patel that the complaint seemed to be legitimate and the attitude displayed to Mr Smith seemed to be inappropriate. The issues raised by Ms Lester were not investigated at all.

- 6.332 Dr Keating's inquiries fall significantly short of the investigation process described in the policy. At the very least, he should have sought a medical opinion from a doctor independent of the event and talked with staff who may have first hand knowledge of an incident.

- 6.333 With respect to the four examples, there were no investigations to establish the facts associated with the complaint. For example, Mr Fleming advised Dr Keating that there was a dispute between Dr Patel and the nurses about the treatment of his wound. It would have been a simple exercise to talk to the nurses involved.

- 6.334 Also of concern is Dr Keating's willingness to accept Dr Patel's explanations. The complaints of Mr Fleming, Mr Smith and Ms Lester occurred in relatively close succession. Dr Keating investigated Mr Fleming's complaint in October 2003. In February 2004, Dr Keating counselled Dr Patel with respect to Ms Smith's complaint. Less than one week later, Ms Lester's problems became known to Dr Keating. All three complaints involved allegations of a failure by Dr Patel to anaesthetise properly and a callous disregard for the patient. In light of the emerging pattern, one might think it essential to conduct investigations beyond obtaining Dr Patel's opinion.
- 6.335 The Policy requires that a report be compiled on the investigation findings and sent to the person who requested the investigation. In each of the four examples, no comprehensive report was produced.
- 6.336 The District Manager has a responsibility to ensure that all patient complaints with a seriousness category of Extreme are reported to the General Manager, Health Services.³⁴¹ In Bundaberg from February 2003 complaints were not categorised and, presumably, then could not be reported to the General Manager, Health Services.
- 6.337 The District Manager is also responsible for ensuring that concerns arising from complaints that relate to the health, competence or conduct of a registered professional are referred to the appropriate registration body.³⁴² This did not occur with complaints about Dr Patel.
- 6.338 Under the Bundaberg policy, following the investigation of a complaint, the line manager should identify the cause of the complaint, isolate contributing factors and identify opportunities for improvement that prevent the circumstances of the complaint recurring. All quality improvement activities should then have been referred to the Quality Management Unit and the Improving Performance Committee.³⁴³ It is not clear from the evidence or the minutes of the Improving Performance Committee whether this ever occurred.

Non-compliance with the Incident Management Policy

- 6.339 In addition to the patient complaints about Dr Patel, there was also a steady stream of concerns expressed by staff within Queensland Health. As discussed above, many were reported informally and were not dealt with under policy requirements. Of those that were reported through an Adverse Incident Form or a Sentinel Event Report Form, the policy was not strictly complied with.

³⁴¹ Exhibit 292: Compliance and Responsibilities

³⁴² Exhibit 292: Compliance and Responsibilities

³⁴³ Exhibit 162 LTR2 Statement Raven

Desmond Bramich (A Sentinel Event³⁴⁴)

6.340 Mr Bramich was admitted to the Bundaberg Hospital on 25 July 2004 suffering an injury to the chest after being trapped under a caravan. Mr Bramich appeared to stabilise but then deteriorated suddenly, he passed away on 28 July 2004. This matter is more fully discussed in Chapter Three.

6.341 Dr Keating received a number of staff complaints with respect to the care of Mr Bramich:

- Dr Carter approached Dr Keating shortly after the death of Mr Bramich suggesting that the management of the patient be audited;³⁴⁵
- Karen Fox, a registered nurse in the Intensive Care Unit lodged an Adverse Event Report Form reporting an absence of water in the underwater seal drainage unit. The unit is used to drain fluid or air from the lungs;³⁴⁶ and
- Ms Hoffman lodged a Sentinel Event Report Form. The form was accompanied by a two page letter detailing the problems the Intensive Care Unit was having with Dr Patel.³⁴⁷

Dr Keating received the Adverse Event Report Form and the Sentinel Event Report Form on 2 August 2004.³⁴⁸

6.342 Dr Keating undertook the following activities in response to the complaints:

- On 29 July 2004, he wrote to Dr Carter and Dr Patel requesting an audit of the total management of Mr Bramich within two weeks;
- On 26 August 2004, he received Dr Patel's report;³⁴⁹
- On 31 August 2004, he obtained a copy of the autopsy report from the Coroner;
- On 13 September 2004, he received Dr Carter's report;³⁵⁰
- On 14 September 2004, he received a report from Dr Gaffield;³⁵¹
- On 25 October 2004, he received a report from Dr Carter to be provided to the Coroner;³⁵²
- On 27 September 2004, he received advice from Dr Younis who was critical of Dr Patel's management;³⁵³

³⁴⁴ A sentinel event is an event that signals that something serious or sentinel has occurred and warrants in depth investigation – Exhibit 290A JGW6 Statement Wakefield

³⁴⁵ Exhibit 448 para 133 Statement Keating

³⁴⁶ Exhibit 162 LTR9 Statement Raven

³⁴⁷ Exhibit 162 LTR9 Statement Raven

³⁴⁸ Exhibit 448 para 135 Statement Keating

³⁴⁹ Dr Patel's report appears at Exhibit 448 DWK40 Statement Keating

³⁵⁰ Dr Carter's report appears at Exhibit 448 TH19 Statement Hoffman

³⁵¹ Dr Gaffield's report appears at Exhibit 448 DWK42 Statement Keating

³⁵² Dr Carter's report for the Coroner appears at Exhibit 448 DWK43 Statement Keating

³⁵³ File note of Dr Younis's advice appears at Exhibit 448 DWK44 Statement Keating

- On 19 October 2004 he discussed the case with Dr Rodd Brockett, an intensive care specialist at Logan Hospital and obtained the names of three intensive care specialists who could review the case;³⁵⁴
 - He provided Dr Patel with a copy of Ms Hoffman's Sentinel Event Report Form and statement and requested him to respond;
 - Dr Patel responded to Ms Hoffman's report and statement;³⁵⁵
 - He reviewed the medical records and various reports;³⁵⁶ and
 - He kept Ms Mulligan and Mr Leck informed of the investigation.³⁵⁷
- 6.343 On 20 October 2004, Ms Hoffman met with Ms Mulligan to raise issues of Dr Patel's clinical competence. Later that day, there was a meeting between Mr Leck, Ms Mulligan and Ms Hoffman in which these issues were discussed further. Ms Hoffman advised that a number of nursing staff had been to see Dr Keating with issues regarding Dr Patel and were not happy with the way he had investigated or managed the complaints. Mr Leck requested Dr Keating to stop investigating the Bramich case.³⁵⁸
- 6.344 After the meeting, Ms Hoffman documented her concerns in a letter to Mr Leck dated 22 October 2004.³⁵⁹ The letter was provided to Ms Mulligan and Dr Keating.³⁶⁰
- 6.345 In order to corroborate the allegations, Mr Leck and Dr Keating met with some of the doctors named by Ms Hoffman. After this Mr Leck concluded that there were some clinical issues in relation to Dr Patel that needed investigation.³⁶¹
- 6.346 On 5 November 2004, Mr Leck met with Dr Keating to discuss what action should be taken in relation to Dr Patel. Mr Leck gave evidence that Dr Keating was reluctant to agree to a review because he considered that the allegations related to a personality conflict and lacked substance.³⁶²
- 6.347 Mr Leck and Dr Keating began to make enquires at various hospitals to find a suitable person to conduct the enquiry. On 16 December 2004, Mr Leck contacted the Audit and Operational Review Branch for advice about the review.³⁶³ They advised that he should contact Dr Gerry FitzGerald, the Chief Health Officer.³⁶⁴
- 6.348 On 17 December 2004, Mr Leck contacted Dr FitzGerald's office and was advised that Dr FitzGerald was about to depart for annual leave but was aware

³⁵⁴ File note of Dr Brockett's advice appears at Exhibit 448 DWK45 Statement Keating

³⁵⁵ Dr Patel's response appears at Exhibit 448 DWK46 Statement Keating

³⁵⁶ File note of Dr Keating's investigations appears at Exhibit 448 DWK47 Statement Keating

³⁵⁷ Exhibit 448 Statement Keating

³⁵⁸ Exhibit 463 paras 42-47 Statement Leck

³⁵⁹ Exhibit 4 TH37 Statement Hoffman

³⁶⁰ Exhibit 463 para 48 Statement Leck

³⁶¹ Exhibit 463 para 51 Statement Leck

³⁶² Exhibit 463 para 52 Statement Leck

³⁶³ Exhibit 463 para 55 Statement Leck

³⁶⁴ Exhibit 463 para 56 Statement Leck

of the situation and could assist with the review. Dr FitzGerald and Mr Leck did not talk until 17 January 2005 when he returned.³⁶⁵

- 6.349 On 14 February 2005, some six months after Ms Hoffman submitted the Sentinel Event Report Form, Dr FitzGerald came to Bundaberg to interview the relevant staff.³⁶⁶
- 6.350 Having not received any feedback from Dr FitzGerald or management regarding the outcomes of investigations into Dr Patel, Ms Hoffman was somewhat comforted by the fact that Dr Patel's contract was due to expire in early 2005. When Dr Patel announced that his contract had been extended Ms Hoffman decided that she needed to do something desperate. On 18 March 2005, Ms Hoffman took her concerns to Rob Messenger, the Member for Burnett.
- 6.351 As at March 2005, Ms Hoffman had received no feedback regarding the outcomes of investigations into the sentinel event report she had lodged in August 2004.

What should have happened under the Incident Management Policy

- 6.352 The adverse and sentinel events with respect to Mr Bramich were reported in August 2004. At this time the Bundaberg Health Service District had a local Adverse Events Management Policy³⁶⁷ and a Sentinel Events and Root Cause Analysis Policy.³⁶⁸ The Queensland Health Incident Management Policy³⁶⁹ was issued on 10 June 2004. The policies of the Bundaberg Health Service District were reviewed in light of the new statewide policy and revised policies³⁷⁰ were issued in November 2004.
- 6.353 The timing of the policies is relevant because under the Queensland Health policy, sentinel events must be reported to the Director-General. This was not a requirement under the earlier policies of the Bundaberg Health Service District. The earlier Bundaberg policy requires the immediate handling of the event including, liaison and notification of the Central Zone Management Unit and Corporate Office Queensland Health.³⁷¹
- 6.354 All District Managers were informed of the new policy by memorandum from the Deputy Director-General dated 30 June 2004.³⁷² The memorandum states that all sentinel events are to be reported to the Director-General immediately.

³⁶⁵ Exhibit 463 para 57-62 Statement Leck

³⁶⁶ Exhibit 463 para 63 Statement Leck

³⁶⁷ Exhibit 162 LTR4 Statement Raven

³⁶⁸ Exhibit 162 LTR6 Statement Raven

³⁶⁹ Exhibit 290A JGW6 Statement Wakefield

³⁷⁰ Exhibit 162 LTR7 Statement Raven

³⁷¹ Exhibit 162 LTR6 Statement Raven

³⁷² Exhibit 448 DWK49 Statement Keating

- 6.355 The Queensland Health Incident Management Policy³⁷³ describes a sentinel event as an event that signals that something serious or sentinel has occurred and warrants in depth investigation. The policy provides a list of certain incidents that are deemed to be sentinel events. The list is not stated to be exhaustive. Under the policy an unexpected death of a patient is deemed to be a sentinel event.
- 6.356 The Policy sets out an Incident Management Model³⁷⁴ with nine elements:
- Prevention
 - Incident Identification
 - Classification/prioritisation
 - Reporting and recording
 - Patient and staff care/management
 - Analysis/investigation
 - Action
 - Feedback
 - Communication
- 6.357 Incidents should be prioritised according to their risk rating. The policy provides a Risk Matrix which assists in categorising the seriousness of adverse events. The event should be risk rated by the person who reports the event and again during the investigation phase. There is no evidence that the sentinel event was ever risk rated.³⁷⁵
- 6.358 The Policy requires that the line manager must report all sentinel events to the District Manager. The District Manager must report all sentinel events to the Director-General.³⁷⁶
- 6.359 One month after Ms Hoffman lodged the Sentinel Event Report Form, she heard that it had been downgraded, that it was deemed not to be a sentinel event.³⁷⁷
- 6.360 Leonie Raven, the Quality Coordinator, gave evidence that Ms Hoffman contacted her around October 2004 enquiring as to the status of the sentinel event. Ms Raven could not locate the report on the Adverse Incidents Register and contacted Dr Keating to see if he was aware of the sentinel event. Dr Keating advised that he was and that an analysis of the event had been undertaken. Ms Raven was of the understanding that Dr Keating would report back to the clinicians involved. Ms Raven stated that she believed the sentinel

³⁷³ Exhibit 290A JGW6 Statement Wakefield

³⁷⁴ Exhibit 290A JGW6 Statement Wakefield: Incident Management Model p6

³⁷⁵ Exhibit 290A JGW6 Statement Wakefield: Prevention p6

³⁷⁶ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording p8

³⁷⁷ Exhibit 4 para 89 Statement Hoffman

event was actioned appropriately and in accordance with the Hospital policy which was current at the time; it was not downgraded. The reason it did not appear on the Register was purely an administrative error.³⁷⁸

- 6.361 Dr Keating gave evidence that at no stage was Mr Bramich's death downgraded or deemed by him not to be a sentinel event.³⁷⁹ However, he did not believe the incident had to be reported to the Director-General because, although it occurred after the introduction of the Queensland Health policy, which requires that all sentinel events are reported to the Director-General, it occurred prior to the implementation of that policy in Bundaberg.³⁸⁰ I do not accept this argument.
- 6.362 Mr Leck gave evidence that he receives copies of Sentinel Event Report Forms because he is required to send a copy to corporate office within a certain timeframe. When he received Ms Hoffman's Sentinel Event Report Form, he said that he contacted the Quality Coordinator and was told that this case did not constitute a sentinel event within the terms of the specific criteria set out in the Queensland Health Incident Management Policy. On this advice, Mr Leck did not report the sentinel event to corporate office.³⁸¹
- 6.363 Each District Manager was supposed to maintain a comprehensive register of all reported incidents in their accountability area. In Bundaberg, the Adverse Incidents Register is maintained by the District Quality and Decision Support Unit.
- 6.364 Due to an administrative error, the sentinel event was never recorded on the Adverse Incidents Register. Of particular concern is that this was brought to the attention of Ms Raven, the Quality Coordinator from the District Quality and Decision Support Unit in October 2004 and the Register provided to the Commission which includes entries up to May 2005 still has no record of the sentinel event reported by Ms Hoffman.
- 6.365 Under the Queensland Health policy, the investigation of sentinel events involves the following mandatory requirements:³⁸²
- Use of a team independent of the incident;
 - Analysis, commencing seven working days after the incident;
 - The root cause analysis tool must be used;
 - Teams should be commissioned by the District Manager;
 - At least one member of the team must be trained in using the root cause analysis tool and process; and

³⁷⁸ Exhibit 162 para 37-39 Statement Raven

³⁷⁹ Exhibit 448 para 157 Statement Keating

³⁸⁰ Exhibit 448 para 159 Statement Keating

³⁸¹ Exhibit 463 paras 33-35 Statement Leck

³⁸² Exhibit 290A JGW6 Statement Wakefield: Incident Analysis/Investigation p10

- A report must be provided to the District Manager within 45 days of commencement of investigation.
- 6.366 Unfortunately, Dr Keating was still operating under the less stringent investigation requirements of the outdated Bundaberg policy³⁸³ and none of the above requirements, with the possible exception of the second requirement, were met.
- 6.367 The Bundaberg Sentinel Events and Root Cause Analysis Policy essentially requires that an investigation be undertaken by a team headed by one of the executives, a root cause analysis to be conducted and a report sent to the Leadership and Management Committee.
- 6.368 The investigation even fell short of the less stringent requirements of this Policy. In the three month period from the date of the sentinel event until the investigation was stopped to focus on wider issues, none of the requirements were met.
- 6.369 Actions are identified through investigating the underlying causes of incidents and are to be documented in a report to the District Manager. The District Manager is to nominate a person, unit or committee to receive investigation reports and authorises and resources this entity to implement actions.³⁸⁴ This did not occur.

General observations with respect to application of complaints and incident management policies

- 6.370 The policy framework for managing complaints and adverse incidents in Queensland Health and the Bundaberg Hospital appears to be adequate with one exception. The requirement of the local policy in Bundaberg that a form be filled in to raise an issue is problematic. The obligation to investigate an issue should not be made dependent upon a complaint in writing. Having an adequate policy solves only part of the problem. The downfall is in the implementation. The effectiveness of the policy framework has been seriously undermined by a number of non-compliant practices that appear to have occurred frequently.

Failure to seek independent medical opinion

- 6.371 A fundamental problem with investigations into complaints about Dr Patel was that the investigation usually consisted only of reference back to Dr Patel and acceptance of his opinion or explanation. With respect to issues of clinical competence, an independent medical opinion should always be obtained.

³⁸³ Exhibit 448 para 159 Statement Keating

³⁸⁴ Exhibit 290A JGW6 Statement Wakefield: Action p11

Failure to check accuracy and corroborate statements

- 6.372 Another deficiency in the investigation of complaints was a failure to check the accuracy of and corroborate statements. This occurred even in circumstances where it would have been a relatively simple exercise to check facts.

Failure to undertake root cause analysis

- 6.373 Where patient complaints are classed as moderate and above, they should receive a comprehensive assessment or investigation. The Investigator is required to undertake an in-depth and/or root cause analysis.³⁸⁵ This did not occur at the Bundaberg Hospital because no one was trained in this process. Dr Keating gave evidence that he was not trained in root cause analysis, nor to his knowledge was any other staff member at Bundaberg Hospital.³⁸⁶

Inadequate risk rating and referral of complaints

- 6.374 The Queensland Health Complaints Management Policy requires that all complaints are categorised in a manner that reflects the seriousness of the complaint. This process enables complaints data to then be applied to the risk management framework³⁸⁷ and for moderate, major, extreme and unresolved complaints to be referred for a comprehensive assessment or investigation.³⁸⁸ The Bundaberg Complaints Management System³⁸⁹ does not have a requirement that complaints be risk rated.
- 6.375 The Bundaberg Hospital Complaints Register³⁹⁰ includes fields for both seriousness category and level of risk. A review of the Register for the period July 2002 to May 2005 reveals that, for the 675 complaints registered, 613 were not risk rated and 610 were not given a seriousness category. After January 2003, no complaints were risk rated.
- 6.376 Ms Raven gave evidence that she identified the level of risk of complaints for a period, purely on speculation but stopped doing this in January 2003.³⁹¹ The fact that complaints were not being risk rated means that they may not have been referred for assessment and investigation in accordance with the policy and the complaints data could not be applied to the risk management framework.

³⁸⁵ Exhibit 292: Appendix 1 Complaint Handling Model

³⁸⁶ Exhibit 448 para 154 Statement Keating

³⁸⁷ Exhibit 292: Seriousness Categories p3

³⁸⁸ Exhibit 292: Appendix 1 Complaints Handling Model p4

³⁸⁹ Exhibit 162 LTR2 Statement Raven

³⁹⁰ Exhibit 166

³⁹¹ T2282 line 53 – T2283 line 2 (Ms Raven)

Inadequate risk rating and referral of incidents

- 6.377 It is also a requirement of the Queensland Health Incident Management Policy that incidents are assessed according to the level of risk.³⁹² Incidents identified as a very high or extreme risk should be reported to the appropriate line manager and District Manager.³⁹³
- 6.378 It appears that, for a period at the Bundaberg Hospital, incidents were not being risk rated nor subsequently referred accurately. Ms Raven gave evidence that there was some discontent surrounding the practice of risk rating ever since the system was introduced. The nurse unit manager and the clinicians who were filling out incident forms felt that they should be risk rating the incident.³⁹⁴ In an email to Mr Leck dated 14 September 2004, Ms Raven wrote that she was not rating anything above medium while there was an unresolved question over whether she should be making those sorts of judgments or decisions. The effect of this was that matters were not being referred to the relevant executive officer for investigation.

Inadequate response

- 6.379 One of the reasons why staff were hesitant to raise issues and report events was the perception that nothing would be done. The perception was reinforced when there was a lack of feedback about a complaint or report. Ms Raven gave evidence that following the implementation of the Adverse Events Management Policy in February 2004, it had been the intention of the District Quality and Decision Support Unit to provide feedback to staff who were reporting adverse events. Due to resourcing issues feedback ceased.³⁹⁵ A fundamental tenet of the policy was ignored.

Inadequate Management and use of data

- 6.380 Complaints and adverse incidents data can potentially serve as a valuable tool for quality improvement and risk management. It is apparent, however, that the data that was being captured during Dr Patel's period at the Hospital was of little value in this respect. Many of the incidents that were reported were not recorded on the registers. For those that were recorded on the registers, it was in insufficient detail to highlight that there was a problem.
- 6.381 It is a requirement under both the Complaints Management Policy³⁹⁶ and the Incident Management Policy³⁹⁷ that each District maintain a comprehensive register of complaints and incident data.

³⁹² Exhibit 290A JGW6 Statement Wakefield: Classification Prioritisation p7

³⁹³ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording p8

³⁹⁴ T2279-2280 (Ms Raven)

³⁹⁵ Exhibit 162 para 25 Statement Raven

³⁹⁶ Exhibit 292: Instruction, Implementation Process, p7

- 6.382 In Bundaberg, a Complaints Register³⁹⁸ was maintained from July 2002 and an Adverse Events Register³⁹⁹ was maintained from February 2004.
- 6.383 The Commission heard evidence from Ms Raven, the Quality Coordinator, that the data on the registers is useful to identify where complaints are coming from, how complaints are received and what complaints are about.⁴⁰⁰ Trends reports were provided to the District Manager and various quality improvement teams and committees.⁴⁰¹
- 6.384 As discussed above, an initial examination of the registers revealed only three complaints and five adverse incidents with respect to Dr Patel's treatment. We now know that 22 incidents or issues were reported in one form or another about Dr Patel. Each of these incidents or complaints should have been readily identifiable from the registers.
- 6.385 One of the reasons why it was difficult to quickly identify all of the incidents involving Dr Patel is that there is no field on either the Adverse Events Register of the Complaints Register to enter the name of the clinician or staff member involved in the incident. Ms Raven's response to this was that the Hospital was trying to introduce a blame free culture.⁴⁰² The problem with this is, that where a surgeon is consistently causing bad patient outcomes, it will not necessarily be picked up through the data registers.
- 6.386 Mr Leck gave evidence that, at the time of Ms Hoffman's complaint in October 2004, there was no information that he had received from the trend information from adverse events that indicated that there was a problem. Mr Leck agreed that if there were serious problems he would expect those sources to have alerted him.⁴⁰³
- 6.387 Another shortfall of the data is that it fails to identify clinical issues in sufficient detail. If this had occurred, it is possible that a number of trends would have been identified with respect to Dr Patel. These included:
- increase in wound infections and dehiscence;
 - inadvertent nicking of organs during surgery;
 - increased complaints about failure to anaesthetise; and
 - increased readmission and corrective surgery.

Implementation of systems was hindered by lack of resources

- 6.388 For complaints handling to operate effectively, those who are responsible must be given sufficient time to devote to it. One of the problems for Bundaberg was

³⁹⁷ Exhibit 290A JGW6 Statement Wakefield: Reporting Requirements – local p9

³⁹⁸ Exhibit 166

³⁹⁹ Exhibit 167

⁴⁰⁰ T2289 line 3-12 (Ms Raven)

⁴⁰¹ T2248 20-30 (Ms Raven)

⁴⁰² T2302 line17 – T2303 line 4 (Ms Raven)

⁴⁰³ T7288 line 20-44 (Mr Leck)

that the responsibilities created in 2002 for the hypothetical Complaints Coordinator were added to an officer's other numerous responsibilities. The role of complaints management fell to the Quality Coordinator, who already had other significant duties including preparation of the ACHS accreditation and maintaining and updating Hospital policies and procedures.⁴⁰⁴

- 6.389 In a large district like the Bundaberg Health Service District, a Complaints Coordinator who has responsibility for resolving complaints in a thorough and timely manner, should be free from other administrative tasks. It would be consistent with the recent recommendation in the Queensland Health Systems Review, Final Report.⁴⁰⁵ Queensland Health's Initial Submission to the Commission stated that the Bundaberg Health Service District has no dedicated Complaint Coordinator. The role of the Complaints Coordinator would need to be promoted in the hospital. I have not heard sufficient evidence to recommend the number of days which the Complaint Coordinator should have to attempt to resolve the complaint locally before referring the matter to the 'one stop shop' which I recommend later in this chapter. Nor have I heard sufficient evidence to recommend the exceptional cases which ought to be referred immediately by the Complaint Coordinator to the 'one stop shop'.

Other systems to capture clinical issues

Clinical governance committees

- 6.390 The Bundaberg Health Service District also had a clinical governance committee structure through which clinical safety and quality issues could be addressed.⁴⁰⁶ At the risk of over-simplifying, various committees throughout the hospital had a responsibility for discussing issues concerned with patient safety, analysing them, suggesting solutions and referring them to the appropriate person or committee to take action.
- 6.391 A review of the clinical governance committee structure in the Bundaberg Health Service District in April 2005 revealed over twenty one committees.⁴⁰⁷ The responsibility for clinical safety and quality issues was shared by a number of committees that were to report directly to the Leadership and Management Committee. A number of sub-committees were to also play a role in considering clinical safety and quality.
- 6.392 During the review of clinical services in April 2005, staff reported that there were too many committees, significant overlap in functions and potential for issues to

⁴⁰⁴ Exhibit 162 para 8 Statement Raven

⁴⁰⁵ Queensland Health Systems Review, Final Report p191 (www.healthreview.com.au)

⁴⁰⁶ Exhibit 102 para 3.4.4

⁴⁰⁷ Exhibit 102, Appendix F. The committee structure has been reviewed since this time resulting in a reduction of major committees

fall through the cracks. Staff reported that, when safety and quality issues were raised, there was rarely any feedback. It was also evident, from reviewing committee minutes, that there was little evidence of any outcomes or decisions made.⁴⁰⁸

Performance management

- 6.393 There was no formal performance management process in place for medical staff at the Base.⁴⁰⁹ Accordingly, no person with the skills to assess Dr Patel was ever called upon to manage or assess him. As I have discussed earlier, the Medical Board of Queensland required an annual assessment from the Hospital, when medical practitioners were registered under the area of need process. The Medical Board of Queensland did not monitor the registrant's performance throughout the year of their registration. However, if an application was made to renew that registration, the Medical Board of Queensland would call upon the employer to certify to a number of performance criteria based upon the registrant's service during the preceding year. Dr Keating, as the Director of Medical Services at the Base, provided such certifications towards the end of Dr Patel's first and second years of service at the Base. Dr Keating did not have qualifications to equip him to assess Dr Patel's skills as a general surgeon by watching Dr Patel's performance. Dr Keating did not watch Dr Patel perform surgery. Dr Keating did not have other general surgeons on his staff or as Visiting Medical Officers during Dr Patel's employment. It meant that he could not have the benefit of the opinion of another general surgeon about Dr Patel's skills.
- 6.394 It has been remarked earlier in this report that Dr Patel was able to practise in splendid isolation. The opportunities to observe and correct his mistakes, which would have existed in a busy metropolitan hospital with numerous general surgeons, did not exist.
- 6.395 Because of this, the importance of adequately recording and investigating complaints and clinical incidents arising as a result of general surgery was all the more acute.

The Health Rights Commission

- 6.396 Aside from complaining directly within the public hospital to Queensland Health, the most popular avenue for complaints is probably to the Health Rights Commission. The Health Rights Commission which accepts complaints about health services provided anywhere within Queensland, in both the public and private health sectors receives approximately 4,500 complaints and enquiries

⁴⁰⁸ Exhibit 102 para 3.4.4

⁴⁰⁹ Exhibit 102 para 3.4.9 (a)

each year.⁴¹⁰ In 2004 the Health Rights Commission's reception received approximately 11,500 telephone enquiries⁴¹¹ although not all became formal complaints.

6.397 The Health Rights Commission is an independent statutory body established under the *Health Rights Commission Act 1991* ('*Health Rights Commission Act*'). At present it has a staff of 26 full time equivalents, and an annual budget of \$3million.

6.398 The statutory functions of the Health Rights Commission are set out in the *Health Rights Commission Act* at s10 which provides:

10 Commissioner's functions

The functions of the commissioner are:

- (a) to identify and review issues arising out of health service complaints;
- (b) to suggest ways of improving health services and of preserving and increasing health rights; and
- (c) to provide information, education and advice in relation to;
 - (i) health rights and responsibilities; and
 - (ii) procedures for resolving health service complaints; and
- (d) to receive, assess and resolve health service complaints; and
- (e) to encourage and assist users to resolve health service complaints directly with providers; and
- (f) to assist providers to develop procedures to effectively resolve health service complaints; and
- (g) to conciliate or investigate health service complaints; and
- (h) to inquire into any matter relating to health services at the Minister's request; and
- (i) to advise and report to the Minister on any matter relating to health services or the administration of this Act; and
- (j) to provide advice to the council; and
- (k) to provide information, advice and reports to registration boards; and
- (l) to perform functions and exercise powers conferred on the commissioner under any Act.

6.399 The main roles of the Health Rights Commissioner are to impartially review and resolve complaints about health services; make suggestions for improvements to health systems and practices by utilising the feedback provided through an analysis of complaints; and to work with health service providers to help them to improve their own complaints management processes. Registration bodies are also required to forward their investigation reports to the Commissioner.

⁴¹⁰ Exhibit 354 para 26

⁴¹¹ Exhibit 354 para 26

- 6.400 Pursuant to ss31 and 32 of the *Health Rights Commission Act*, the Minister may give the Commissioner a written direction to investigate a particular matter or to conduct an Inquiry. However, this Ministerial power is rarely exercised.
- 6.401 Approximately 11,000 complaints have been received by the Health Rights Commission since its inception in 1991 concerning health services in Queensland. Just over 45 % of these complaints have resulted in outcomes that the Health Rights Commissioner has described as favourable or satisfactory to the complainant. The resolutions might include an apology or acknowledgment that a health service should have been performed better; access to treatment that had been unreasonably denied; a remedial procedure; refund of fees; an *ex gratia* payment; or financial settlement of a claim for medical negligence.
- 6.402 The Health Rights Commissioner may not take action on a complaint if the patient has commenced a civil proceeding for redress for the matter of the complaint and a court has begun to hear the matter. A patient who wishes to complain the Health Rights Commissioner is not obliged to forfeit the right to commence a civil proceeding. Presumably, if a patient complains and participates in a conciliation arranged by the Health Rights Commissioner it will be a matter considered by the patient and any other party to the conciliation whether a term of a settlement agreement will be an agreement to compromise civil proceedings.
- 6.403 The Commissioner regarded it as a significant limitation on his powers that he can only respond to complaints the Commissioner actually receives. Even if the Commissioner becomes aware of apparently serious health issues by means such as media reports, the Commissioner has no power to intervene unless the Commissioner actually receives a complaint from someone involved with the particular health service – for example, a patient or a member of staff at the health service concerned. The Commissioner has no power to investigate health care issues of the Commissioner's own initiative, even though the matter may involve important issues of public interest, significant systemic issues or serious concerns about a practitioner's competence.
- 6.404 There are two further significant practical limitations on the Commissioner's powers. Though the Commissioner may have assessed the matter about which a complaint was made, though he may understand the facts thoroughly and though the parties may be before him, the Commissioner cannot adjudicate on the complaint. He cannot determine whether a complaint is unreasonable or justified. He cannot order a restriction or a condition on the right of practice of the doctor, nurse or allied health professional whose conduct led to the complaint.
- 6.405 Section 57 of the *Health Rights Commission Act* provides the types of complaints which may be made to the Commissioner. Among the various types of complaints provided for in s57 the following would allow for complaints

relating to Dr Patel's actions and the hospital's failure to take timely action.
Complaints:

- that a provider has acted unreasonably in the way of providing a health service for a user;
- that a provider has acted unreasonably in providing a health service for a user;
- that a registered provider acted in a way that would provide a ground for disciplinary action against the provider under the Health Practitioners (Professional Standards) Act 1999;⁴¹²
- that a public body that provides a health service has acted unreasonably by:-
 - not properly investigating; or
 - not taking proper action in relation to:

a complaint made to the body by a user about a provider's action of a kind mentioned above.

- 6.406 It follows that a complaint about Dr Patel's decision to perform complex surgery or his manner of performing surgery would each be appropriate for referral to the Health Rights Commission. A complaint that he was unfit for registration would not.
- 6.407 The Health Rights Commission is not responsible for matters relating to the registration of individual health providers. Decisions as to whether a medical practitioner is entitled to be or to remain registered in Queensland are for the Medical Board of Queensland. The *Health Rights Commission Act* recognises this fact by requiring the Commissioner, in specified circumstances, to refer certain health services complaints to the appropriate registered provider's registration board.⁴¹³ In relation to the issue of registration and monitoring of overseas trained medical practitioners, the Health Rights Commission has no role, nor any powers, and absent a complaint, no responsibility in respect of their ongoing assessment and monitoring.
- 6.408 Section 71 of the *Health Rights Commission Act* provides that, before accepting a health service complaint for action, the Commissioner must first be satisfied that the complainant has made a reasonable attempt to resolve the matter with the health service provider⁴¹⁴, unless it is clearly impracticable to do so.⁴¹⁵ Three telephone enquiries were received by the Health Rights Commission from patients of Dr Patel. In each case the patients were referred to the Bundaberg

⁴¹² The Commission's interaction with registration boards is discussed in more detail below. While there are some synergies between the respective bodies, there are also areas where the statutory responsibilities of the Health Rights Commission and registration boards are quite distinct.

⁴¹³ See s68 of the *Health Rights Commission Act* 1991

⁴¹⁴ This is discussed in s71(2)(a) of the *Health Rights Commission Act* 1991

⁴¹⁵ Instances where the Commissioner would generally regard it as impracticable include where allegations are made of serious breaches of professional conduct (such as sexual misconduct), or where there is a clear evidence of a threat to public safety. The Commission's policy is also to accept complaints in the first instance where the complainant may, for language or cultural reasons, find it difficult to take up their concerns with the provider on their own behalf.

Base Hospital and advised of their right to come back to the Health Rights Commission if they wanted to take the matter further. Presumably these three referrals were to satisfy s71(1)(a) of the *Health Rights Commission Act*.

- 6.409 Before accepting a complaint for statutory action, the Commissioner is required to consult the provider's registration board about the complaint.⁴¹⁶ The Health Rights Commission must not take any action with respect to the complaint until the relevant registration board provides comments, advises that it does not intend to comment, or a specified period of time has passed.⁴¹⁷
- 6.410 Section 77 of the *Health Rights Commission Act* provides that if the Commissioner receives a health service complaint about a registered provider, believes that the provider poses an imminent threat to public safety and therefore, considers that immediate suspension of the provider's registration may be necessary, the Commissioner must then immediately refer the complaint to the provider's registration board.
- 6.411 Some clinical staff at Bundaberg Base Hospital had become concerned about Dr Patel well before issues relating to his competence became public. No complaints were received by the Health Rights Commission directly from clinical staff. It would have been open to the Health Rights Commissioner to accept such complaints had they been made. Section 59 of the *Health Rights Commission Act* provides that a 'health service complaint' may be made to the 'Commissioner' by a person other than the *user* of the health service or the user's representative, if it is considered by the Commissioner to be in the public interest to do so. The effect of s59(1)(d) is that a staff member of a public hospital wishing to make a complaint to the Health Rights Commissioner has no right to do so. However, if the Commissioner considers that the public interest requires that the staff member make the complaint then the Commissioner will accept it. Accordingly, if Ms Hoffman in her capacity as a Nurse Unit Manager had chosen in October 2004 to report her concerns to the Health Rights Commission she would have had no certainty that the Health Rights Commission would have acted on the complaint. The first hurdle for her would have been to persuade the Commissioner that the public interest required that she be permitted to make her complaint. If Ms Hoffman had tried to do so, it is reasonable to conclude that her complaint would have been rejected and that she would have been referred to the Medical Board of Queensland as this is in effect what happened to Mr Messenger MP.
- 6.412 When Mr Messenger MP contacted the Health Rights Commission on 23 March 2004 raising Ms Hoffman's concerns about Dr Patel, the Health Rights

⁴¹⁶ s71(3) *Health Rights Commission Act* 1991

⁴¹⁷ s71(6) *Health Rights Commission Act* 1991

Commissioner's recommendation to Mr Messenger was that the Medical Board was the most appropriate body to investigate the concerns.⁴¹⁸

- 6.413 If a staff member of the Bundaberg Base Hospital had persuaded the Commissioner that there was a public interest requirement that the complaint be accepted, the end result may well have been a time consuming assessment process and conciliation with little or no benefit for the staff member or the public.
- 6.414 The *Health Rights Commission Act* essentially follows the so-called conciliation approach to complaints resolution that has been adopted by all States and Territories other than in New South Wales. The Health Rights Commission strives to work cooperatively with all parties to a complaint and wherever possible to help preserve the relationship between them. This contrasts with the more prosecutorial approach to complaints resolution that is reflected in the NSW complaints system, whereby the Health Care Complaints Commission, in addition to its other functions, retains a prosecutorial role.
- 6.415 It should be noted that the Commissioner has no power to compel parties to respond to a complaint or to provide information during assessment. The Commissioner may invite a response or may request information from the provider against whom the complaint was made, or request advice from a practitioner who subsequently treated (or provided a second opinion to) the complainant.⁴¹⁹
- 6.416 Where the information obtained in assessment supports a claim for compensation or some other significant remedy, the matter would quite likely be moved into conciliation, enabling the complaint to be explored further in a privileged and confidential setting. Under the *Health Rights Commission Act*, the parties can reach a legally binding settlement. Of the complaints conciliated, 21 per cent resulted in an agreement that compensation be paid to the complainant.
- 6.417 For a complaint against a registered provider such as Dr Patel, the only further action that is open to the Commissioner following assessment is to try to resolve the complaint by conciliation, if the Commissioner considers that it can be resolved in that way,⁴²⁰ or to refer the matter to the provider's registration board. The Commissioner's power to conduct investigations of individual registrants, was removed by the *Health Practitioners (Professional Standards) Act 1999*.

⁴¹⁸ Exhibit 354 para 48, Statement Kerslake

⁴¹⁹ A 'third party'

⁴²⁰ *Health Rights Commission Act 1991* s71(4)

Only a registration board has the power to formally investigate issues relating to a registered provider.⁴²¹

- 6.418 For a complaint against an individual such as Dr Patel, the actions available to the Commissioner are limited to assessing the complaint, conciliating it or referring it to the provider's registration board.⁴²² The Health Rights Commissioner, Mr Kerslake, explained that, as Commissioner he had no power to punish or sanction.⁴²³ While the Commissioner had power to assess all complaints, he did not have power to investigate a complaint about Dr Patel but did have power to investigate a complaint about Bundaberg Base Hospital.⁴²⁴
- 6.419 Where the Commissioner and a registration board agree that a matter should be referred to the registration board, the Commissioner must generally defer conciliating the complaint until the registration board completes its own investigation.⁴²⁵
- 6.420 The Health Rights Commissioner may not take action on a health service complaint if the matter of complaint arose more than a year before the complaint was made to the Commissioner.⁴²⁶ Such a limitation could affect the treatment by the Health Rights Commissioner of a complaint by a concerned person such as Ms Hoffman if the complaint were based upon a series of clinical misadventures which commenced more than a year before the complaint was made. This is noteworthy because it is similar to the situation which arose in respect of Dr Patel. Ms Hoffman wrote to the District Manager on 22 October 2004⁴²⁷ listing a number of matters of concern to her extending back as far as June 2003.
- 6.421 In summary, while the Health Rights Commissioner performs many useful functions, he was not empowered to provide a practical solution in a case like Patel's where a member of hospital staff held the opinion that several patients had been harmed by a medical practitioner who was likely to harm further patients. No single patient was likely to be aware of the numerous complaints relating to Dr Patel. No patient was likely to complain to the Commissioner of more than an isolated event. A patient's complaint may have led to a conciliation about the patient's individual concern. A member of staff was in a better position to perceive that Dr Patel had harmed several patients and was likely to continue to do so. But a member of staff had no right to force the

⁴²¹ The Commissioner's sole power to require the provision of information falls within the category of 'non-registered' providers (such as a hospital), when undertaking a formal investigation under Part 7 of the Act

⁴²² This can result in quite convoluted with overlapping processes and enquiries in certain circumstances, such as where a complaint is made about a health service performed by an individual doctor in a hospital setting

⁴²³ T5633 line 15 (Kerslake)

⁴²⁴ T5634 line 13 (Kerslake)

⁴²⁵ *Health Rights Commission Act 1991* s75

⁴²⁶ *Health Rights Commission Act 1991* s79(5)

⁴²⁷ Exhibit 4 TH37

Health Rights Commissioner to accept the complaint unless the Commissioner could be persuaded that it was in the public interest. If the Commissioner accepted the complaint, the Commissioner had no power to investigate Dr Patel, no power to sanction Dr Patel and no power to terminate his registration. The Commissioner's power was to conciliate. The most practical thing the Health Rights Commissioner could do if a staff member raised allegations that a medical practitioner had caused harm to numerous patients was to refer the matter to the Medical Board of Queensland. If the Health Rights Commissioner heard of the issue in the media or from a person who was not making a complaint, the Commissioner had no power to act.

Health Rights Commission's response to Bundaberg complaints

- 6.422 As at March 2005 the name of Dr Patel had attracted no significance, nor any level of recognition within Health Rights Commission. A review of the Health Rights Commission's complaints and enquiries database indicated to the Health Rights Commissioner that during the two year period from 1 April 2003 to 31 March 2005, the Health Rights Commission had received six written complaints concerning the provision of health services at Bundaberg Base Hospital. This was not a high level of complaints for that period of time from a provider of the size of Bundaberg Base Hospital. None of these complaints concerned services provided by Dr Patel. There were three telephone enquiries about Bundaberg Base Hospital received over the same period where Dr Patel was named as the treating doctor. In each instance the callers were happy to take their concerns up directly with Bundaberg Base Hospital. The Health Rights Commission advised them of their right to come back to the Health Rights Commission if they wished to take the matter further but none did so prior to April 2005.
- 6.423 On 23 March 2005 the Health Rights Commission received a copy of Mr Rob Messenger MP's letter to the Minister for Health dated 22 March 2005 raising concerns about Dr Patel. Following receipt of this letter the Commissioner spoke with Mr Messenger's office to advise that as the letter primarily raised competency issues concerning a registrant, the Medical Board was the most appropriate body to investigate the concerns, and the Commissioner would confirm with the Medical Board that it would be addressing the matter.
- 6.424 On 8 April 2005 *The Courier-Mail* newspaper reported that the Chief Health Officer of Queensland Health had carried out an investigation into the competency of a surgeon at the Bundaberg Base Hospital who had been linked to the death of at least 14 patients and that the surgeon in question had since 'fled the country'. Upon it becoming apparent that there would be a larger number of complaints and a broader range of issues to be addressed, the Commissioner contacted Mr Messenger and advised that the Health Rights Commission would clearly need to be involved in the assessment and investigation of the complaints, and asked that he refer any additional matters of

which he became aware to the Health Rights Commission. Mr Messenger continued to do this.

- 6.425 The Health Rights Commission sent a senior officer to Bundaberg to liaise with potential complainants and the Health Rights Commission Complaints Manager attended Bundaberg for this purpose for the week of 18 April - 22 April 2005. Over 70 formal complaints or enquiries were received in the course of that week. A priority in this initial period was to ensure that patients in need of medical treatment could receive it. The Commissioner engaged in liaison with Queensland Health. The Health Rights Commission agreed a protocol with Queensland Health that it would advise patients seen by its liaison officers in Bundaberg of their right to complain to the Health Rights Commission, and that the Health Rights Commission would inform complainants who were potentially in need of treatment of the opportunity to make contact with a Queensland Health liaison officer. While in Bundaberg the Health Rights Commission's Complaints Manager arranged for the urgent review of some complainants' immediate health needs. The Health Rights Commission did not initially refer its complaints about Dr Patel to the Medical Board as the Medical Board advised that Dr Patel's registration had expired and they had declined to renew his registration.
- 6.426 As at 5 August 2005, the number of formal complaints received by Health Rights Commission concerning health services provided by Bundaberg Base Hospital had grown to 97 and the Health Rights Commission had notified the Medical Board of Queensland of these complaints and was keeping the Medical Board informed of developments.
- 6.427 Although no formal findings had been reached by the time the Commissioner gave evidence, assessment of these complaints by the Health Rights Commission was well advanced. The Commissioner advised in oral evidence on 20 September 2005 that he had appointed an independent expert to assist with this process being a surgeon from Melbourne, Dr Allsop. A considerable number of cases had already been reviewed, which reviews had identified a range of significant inadequacies in the standard of care provided to patients of Dr Patel. It was then impractical to call Dr Allsop. The results of the reviews were to be made available to the Medical Board of Queensland to assist in its deliberations. The Health Rights Commission had put in place arrangements with Queensland Health to facilitate the prompt assessment, and where appropriate, resolution of these complaints, including the payment of compensation.

6.428 The Health Rights Commission also has an investigative function,⁴²⁸ although that function is limited.⁴²⁹ Mr Kerslake described the Health Rights Commission's investigative functions as invoked:

where a complaint raises serious systemic issues that might warrant detailed examination or result in formal recommendations for change.⁴³⁰

In this ability to investigate systemic issues the Health Rights Commission has the advantage over the Medical Board which has no equivalent investigative power. Yet, if there emerged an obvious need to investigate a doctor, the Health Rights Commissioner would be unable to investigate but the Medical Board could. The Health Rights Commission may use its powers to investigate only:

- A complaint about a health service provider such as a hospital or nursing home;
- An unsuccessful conciliation; or
- A complaint where the Commissioner has elected to end a conciliation.⁴³¹

It could not investigate an individual practitioner such as Dr Patel.

6.429 Through the Australian Health Care Agreements ('the Agreements') the provision of health funding by the Commonwealth is conditional in part on all States and Territories maintaining independent health complaints commissions. Under the Agreements, each of these bodies must:

- be independent of the State's Hospitals and the State's Department of Health;
- be given powers that would enable it to investigate, conciliate and/or adjudicate upon complaints received by it; and
- be given the power to recommend improvements in the delivery of public hospital services.

In the agreements between the Commonwealth and Queensland and the Commonwealth and New South Wales, it is agreed that the:

Powers of the complaints body will not interfere with or override the operation of registration boards or disciplinary boards...and that the exercise of powers by the complaints body will not affect the rights that a person may have under common law or statute law.⁴³²

6.430 The Health Rights Commissioner, Mr Kerslake perceived benefits in keeping the conciliation function of the Health Rights Commission separate from the professional standards and disciplinary function of the Medical Board of Queensland. Mr Kerslake's opinion was that the disciplinary function of the

⁴²⁸ *Health Rights Commission Act 1991* Part 7

⁴²⁹ *Health Rights Commission Act 1991* s95

⁴³⁰ Exhibit 354 para 21

⁴³¹ *Health Rights Commission Act 1991* s95

⁴³² See schedule D clause 6 of the Australian Health Care Agreement between the Commonwealth of Australia and the State of Queensland 2003-2008 and of the Australian Health Care Agreement between the Commonwealth of Australia and New South Wales 2003-2008

Medical Board did not 'fit readily together' with the Health Rights Commissions functions of resolution of complaints and recommending systemic improvement of the health sector.⁴³³ Mr Kerslake considered that the New South Wales Health Care Complaints Commission, which performs all three functions, receives significantly less cooperation from the health service providers than is received by the Queensland Health Rights Commission.

The Medical Board of Queensland

6.431 The Medical Board of Queensland is established by the *Medical Practitioners Registration Act* 2001. The objects of that Act are:

- To protect the public by ensuring health care is delivered by registrants in a professional, safe and competent way; and
- To uphold the standards of practice in the profession; and
- To maintain public confidence in the profession.⁴³⁴

6.432 In the year 2003/2004 the Medical Board received 232 complaints,⁴³⁵ including 128 complaints from patients or persons acting on behalf of patients. In that year the Health Rights Commission referred 21 complaints to the Medical Board.⁴³⁶ Of those 232 complaints the Medical Board referred 74 complaints to the Health Rights Commission.⁴³⁷ A further 34 complaints were investigated by the Medical Board, some of which resulted in disciplinary action.⁴³⁸

6.433 The Medical Board may investigate complaints it receives,⁴³⁹ or a complaint referred to it by the Minister⁴⁴⁰ or the Health Rights Commission.⁴⁴¹ The Medical Board may also conduct an investigation on its own motion.⁴⁴² This is an advantage that the Health Rights Commission does not have for it must wait to receive a complaint and then its power is generally limited to assessment but not investigation.

6.434 When the Medical Board of Queensland determines to investigate a complaint it appoints an investigator from the Office of the Health Practitioner Registration Boards to carry out the investigation. On occasion the Medical Board uses a panel of external investigators to conduct investigations.⁴⁴³

⁴³³ T5645 line 4- line 45 (Dr Kerslake)

⁴³⁴ *Medical Practitioners Registration Act* 2001 s7

⁴³⁵ See Medical Board Annual Report available at:

<http://www.medicalboard.qld.gov.au/Publications/Publications.htm>

⁴³⁶ Medical Board Annual Report 2003/04 p11

⁴³⁷ Medical Board Annual Report 2003/04 p12

⁴³⁸ Medical Board Annual Report 2003/04 p12

⁴³⁹ *Health Practitioners (Professional Standards) Act* 1999 s62(d)

⁴⁴⁰ *Health Practitioners (Professional Standards) Act* 1999 s62(a) & (b)

⁴⁴¹ *Health Practitioners (Professional Standards) Act* 1999 s62(c)

⁴⁴² *Health Practitioners (Professional Standards) Act* 1999 s62(f)

⁴⁴³ Medical Board Annual Report 2003/04 p12

6.435 The Medical Board has broad powers when conducting its investigation into a doctor including:

- the power to require a person to provide information, attend before the investigator and answer questions, and to produce documents;⁴⁴⁴
- the power to enter and search premises and seize evidence;⁴⁴⁵
- the power to require a medical practitioner to attend a health assessment.⁴⁴⁶

6.436 If the investigation is related to a complaint, then during the investigation the Medical Board must also keep the Health Rights Commission informed about the progress of that investigation.⁴⁴⁷ It must also send a copy of its report to the Health Rights Commission.⁴⁴⁸ The Health Rights Commission may, within 14 days or such further times as may be agreed by the Medical Board, comment on the report.⁴⁴⁹

6.437 The *Health Practitioners (Professional Standards) Act* 1999 sets out the functions of various boards established under Health Practitioners Registration Acts. It applies to the Medical Board of Queensland. The *Health Practitioners (Professional Standards) Act* 1999 provides at Section 11:

11 Boards' functions under this Act

A board's functions under this Act are the following:

- (a) to receive complaints about its registrants and, if appropriate, refer the complaints to the commissioner;
- (b) to consult and cooperate with the commissioner in investigating and disciplining its registrants and in relation to complaints about impaired registrants;
- (c) to immediately suspend, or impose conditions on, the registration of its registrants if the registrants pose an imminent threat to the wellbeing of vulnerable persons;
- (d) to conduct investigations, whether because of complaints or on its own initiative, about the conduct and practice of its registrants;
- (e) to deal with disciplinary matters relating to its registrants that can be satisfactorily addressed through advising, cautioning and reprimanding;
- (f) to bring disciplinary proceedings relating to its registrants before panels or the tribunal;
- (g) to implement orders of panels or the tribunal relating to the board's registrants;
- (h) to establish health assessment committees to assess the health of registrants who may be impaired and make decisions about impaired registrants;

⁴⁴⁴ *Health Practitioners (Professional Standards) Act* 1999 s78

⁴⁴⁵ *Health Practitioners (Professional Standards) Act* 1999 Pt 5 div 5 subdiv 2,3 & 4

⁴⁴⁶ *Health Practitioners (Professional Standards) Act* 1999 div 5 subdiv 7

⁴⁴⁷ *Health Practitioners (Professional Standards) Act* 1999 s116(2)

⁴⁴⁸ *Health Practitioners (Professional Standards) Act* 1999 s116(3) & (4)

⁴⁴⁹ *Health Practitioners (Professional Standards) Act* 1999 s116(5)

- (i) to monitor its registrants' compliance with conditions imposed or other disciplinary action taken, or undertakings entered into, under this Act;
- (j) to cancel or suspend, or impose conditions on, its registrants' registration as a result of action taken under a foreign law;
- (k) to consult and cooperate with other boards, foreign regulatory authorities and other relevant entities about the investigation and disciplining of its registrants and the management of its registrants who are impaired;
- (l) to exercise other functions given to the board under this Act.

6.438 The *Health Practitioners (Professional Standards) Act 1999* establishes the Health Practitioners Tribunal.⁴⁵⁰ That tribunal may hear disciplinary matters relating to medical practitioners and other health service providers.⁴⁵¹

6.439 Complaints to the Medical Board must be in writing,⁴⁵² and may be made by a patient, an entity acting on behalf of a patient, another registrant, which includes registered medical practitioners, nurses and allied health workers, the Director-General of Queensland Health, the Minister for Health, or a foreign regulatory authority.⁴⁵³

6.440 The way the Medical Board may deal with a complaint about a doctor depends on the person who makes the complaint. Complaints by and on behalf of a patient are dealt with differently from complaints from any other entity. If a doctor or nurse complains to the Medical Board of Queensland about a registered doctor and the complainant is not representing a patient then the Medical Board would deal with the complaint under the protocol in Section 53 of the *Health Practitioners (Professional Standards) Act 1999*. It provides so far as is relevant:

53 Action by board on receipt of complaint made or referred by another entity, or complaint commissioner not authorised to receive

(1) This section applies if:

- (a) a registrant's board receives a complaint about the registrant from an entity, other than a user of a service provided by the registrant or an entity acting on behalf of the user; or
- (b) a complaint about a registrant is referred to the registrant's board by the commissioner under the *Health Rights Commission Act 1991*; or
- (c) a registrant's board receives a complaint about the registrant and
 - (i) the complaint is about a matter that happened before 1 July 1991; and
 - (ii) the complainant was aware of the matter before 1 July 1991.⁴⁵⁴

⁴⁵⁰ *Health Practitioners (Professional Standards) Act 1999* Pt2 div4

⁴⁵¹ *Health Practitioners (Professional Standards) Act 1999* s30

⁴⁵² *Health Practitioners (Professional Standards) Act 1999* s49

⁴⁵³ *Health Practitioners (Professional Standards) Act 1999* s47

⁴⁵⁴ See the *Health Rights Commission Act 1991*, s149

- (2) After considering the complaint, the board must decide to do 1 of the following:
- (a) under the immediate suspension part, to suspend, or impose conditions on, the registrant's registration;
 - (b) investigate the complaint under the investigation part;
 - (c) start disciplinary proceedings under the disciplinary proceedings part;
 - (d) deal with it under the impairment part; 14 See the *Health Rights Commission Act 1991*, section 149 (Transitional for *Health Rights Commission Act 1991* (Act No. 88 of 1991)).
 - (e) deal with the complaint under the inspection part or the health practitioner registration Act under which the board is established and, if appropriate, start proceedings to prosecute the registrant under this Act or the health practitioner registration Act;
 - (f) refer the complaint to another entity that has the function or power under an Act of the State, the Commonwealth or another State to deal with the matter;
 - (g) reject the complaint under section 54.

6.441 But if instead, a complaint is from or on behalf of a patient about a medical practitioner, the Medical Board is obliged to refer that complaint to the Health Rights Commission⁴⁵⁵ unless, certain conditions exist. They are set out in sub-section 51(2) of the *Health Practitioners (Professional Standards) Act 1999*. This is seen from sub section 51(1) and (2):

51 Action by board on receipt of complaint

- (1) This section applies if a registrant's board receives a complaint about the registrant from a user of a service provided by the registrant or an entity acting on behalf of the user.
- (2) The board must refer it to the commissioner unless:
- (a) following consultation between the board and the commissioner, the board and the commissioner agree it is in the public interest for the board to do 1 of the following:
 - (i). *keep the complaint for investigation under the investigation part;*
 - (ii). *keep the complaint and start disciplinary proceedings under the disciplinary proceedings part;*
 - (iii). *keep the complaint and deal with it under the impairment part;*
 - (iv). *keep the complaint and deal with it under the inspection part or the health practitioner registration Act under which the board is established and, if appropriate, start proceedings to prosecute the registrant under this Act or the health practitioner registration Act;*
 - (v). *refer the complaint to another entity that has the function or power under an Act of the State, the Commonwealth or another State to deal with the matter; or*
 - (b) the board keeps the complaint under a standing arrangement entered into between the board and the commissioner and deals with it in a way mentioned in paragraph (a); or
 - (c) the board, under the immediate suspension part, suspends, or imposes conditions on, the registrant's registration; or

⁴⁵⁵ *Heath Practitioners (Professional Standards) Act 1999* s51(2)

- (d) the complaint is about a matter that happened before 1 July 1991 and the complainant was aware of the matter before 1 July 1991.⁴⁵⁶

6.442 Once the Medical Board has referred a complaint to the Health Rights Commission, then the Medical Board may take no further action with respect to the complaint, unless the Health Rights Commission chooses to refer it back to the Medical Board.⁴⁵⁷

6.443 Unlike the Health Rights Commission, the Medical Board also has the power to immediately suspend a registrant, or to impose conditions on the doctor's registration.⁴⁵⁸ This power is given to the Medical Board to effectively respond to threats posed by medical practitioners to the well being of vulnerable persons. In theory, the Medical Board was empowered in October 2004 to receive Ms Hoffman's complaints about Dr Patel and to take action if Ms Hoffman had chosen to complain to the Medical Board.

6.444 If Ms Hoffman had complained about Dr Patel and had done so on her own behalf and not on behalf of a patient, the Medical Board would have had power to suspend Dr Patel immediately or to impose conditions on his registration. But before doing so the Medical Board would have been obliged to form a reasonable belief about two matters. These appear in s59 of the *Health Practitioners (Professional Standards) Act 1999* which provides, so far as is relevant:

59 Immediate suspension or imposition of conditions on registration

- (1) This section applies if a registrant's board reasonably believes at any time, whether on the basis of a complaint or otherwise, that—
 - (a) the registrant poses an imminent threat to the wellbeing of vulnerable persons; and
 - (b) immediate action to suspend, or impose conditions on, the registrant's registration is necessary to protect the vulnerable persons.
- (2) The board may decide to suspend, or impose conditions on, the registrant's registration.
- (3) However, in making its decision under subsection (2), the board must take the action the board considers is the least onerous necessary to protect the vulnerable persons.

6.445 Where a nurse or a doctor complains to the Medical Board of Queensland about a doctor in a way that suggests that patients may be in danger, the Medical Board is faced with two practical choices. Suspend immediately⁴⁵⁹ and then

⁴⁵⁶ The *Health Rights Commission Act 1991*, section 149, provides that the Act does not authorise a complaint to be made to the commissioner about a health service provided before the commencement of the section, if the complaint relates to a matter arising more than 1 year before the commencement and the complainant was aware of the matter of the complaint more than 1 year before the commencement. Section 149 commenced on 1 July 1992.

⁴⁵⁷ *Health Practitioners (Professional Standards) Act 1999* s52

⁴⁵⁸ *Health Practitioners (Professional Standards) Act 1999* Pt 4

⁴⁵⁹ *Health Practitioners (Professional Standards) Act 1999* s53(2)(a)

investigate the doctor⁴⁶⁰ or postpone the decision about suspension and investigate first.⁴⁶¹

- 6.446 The Medical Board can make the choice to immediately suspend a doctor on condition that it has first reasonably formed the belief that the doctor poses an imminent threat to the well being of patients and secondly that immediate action to suspend is necessary to protect them. Dr FitzGerald was a member of the Medical Board at the time he investigated, for Queensland Health, the complaints relating to Dr Patel. Dr FitzGerald did not choose to recommend to Queensland Health either suspension or the imposition of conditions upon Dr Patel's employment. Dr FitzGerald did write to the Medical Board:⁴⁶²

I wish to formally bring to your attention and seek assessment of the performance of Dr Jayant Patel...My investigations to date have not been able to determine if Dr Patel's surgical expertise is deficient, however, I am concerned that the judgment exercised by Dr Patel may have fallen significantly below the standard expected...I would be grateful for the Board's consideration in this matter.

This was not a recommendation from Dr FitzGerald to suspend Dr Patel. It is probable the Medical Board would not have formed the beliefs necessary to suspend Dr Patel if its members had acted on the basis of that letter to the Medical Board 24 March 2005. If Ms Hoffman had made her complaints to the Medical Board by providing it with a copy of her letter to Mr Leck of 22 October 2004⁴⁶³ would the material in it have permitted the Medical Board to reasonably believe that Dr Patel posed an imminent threat to patients? Possibly, at the very least, the letter would have justified the Medical Board in arranging an urgent and prompt investigation to determine the imminence and extent of any threat to patients and whether suspension of Dr Patel or a less onerous⁴⁶⁴ condition was required to protect patients.

- 6.447 Would a complaint to the Medical Board in October 2004 have led to any practical result? In practice it would have been dependent upon the Medical Board's investigators' case backlog and priorities as to whether the Medical Board would have taken any practical action in a timely way. Mr O'Dempsey on behalf of the Medical Board referred to Section 59 of the *Health Practitioners (Professional Standards) Act 1999* and the way it has been interpreted⁴⁶⁵ writing that:⁴⁶⁶

The threshold was a high one for applying section 59 *Health Practitioners (Professional Standards) Act* for a suspension in terms of evidence of 'immediacy of the threat' ... I believe this provision in its current form is inconsistent with one of the

⁴⁶⁰ *Health Practitioners (Professional Standards) Act 1999* s59(4)(a)

⁴⁶¹ *Health Practitioners (Professional Standards) Act 1999* s53(2)(b)

⁴⁶² Exhibit 225 GF13 Letter Dr FitzGerald to Mr Jim O'Dempsey of 24 March 2005

⁴⁶³ Exhibit 4 TH37

⁴⁶⁴ The Health Practitioners Tribunal in *Thurling v the Medical Board of Queensland* [2002] QHPT 004 held that the Medical Board when applying its power under section 59 of the *Health Practitioners (Professional Standards) Act 1999* should determine the least onerous action necessary to protect vulnerable persons from the imminent threat.

⁴⁶⁵ *Thurling OP.CIT.*

⁴⁶⁶ Exhibit 28 para 41

overall objects of the legislation which is the protection of the public by ensuring health care is delivered by registrants in a professional, safe and competent way...

It seems clear from that evidence that the approach from the Medical Board, since the Health Practitioners Tribunal's decision of 2002, has been to require more evidence of danger to the patients before acting to suspend than Mr O'Dempsey regards as appropriate for protection of the public.

- 6.448 It is appropriate that there should be concern for the rights of a doctor or an allied health professional who is accused of endangering patients. This is especially so if the accusation cannot be tested until there has been a thorough investigation of the facts. However, it is undesirable if the concern for the doctor or allied health professional causes the relevant authority to allow a real risk to patients to continue until a thorough investigation has taken place, or worse, until the evidence is tested in a contested hearing. Under the *Nursing Act 1992* there is a provision to allow for the immediate suspension of a nurse's registration or enrolment prior to an investigation. It creates a lower threshold for suspension than the one which appears in Section 59 of the *Health Practitioners (Professional Standards) Act 1999*. The *Nursing Act* relevantly provides:

67 Immediate suspension of registration or enrolment by council

(1) If the council is satisfied that the ability of a nurse to continue to practise nursing is seriously impaired to such an extent that a patient's health or safety could be at risk, whether because of the state of the nurse's condition or the nurse's conduct or practice, the council may by written notice given to the nurse suspend the nurse's registration or enrolment.

- 6.449 The Medical Board of Queensland had determined to investigate the complaint in the Ombudsman's case study on the 27 August 2002. At that time the Medical Board had a backlog of 295 investigations being about 50 for each of its 6 investigators. Eventually, the Medical Board referred the investigation to an external investigator 10 months after the Medical Board first determined to appoint an investigator. The investigation then took 6 months. The Medical Board found evidence to conclude that the doctors' management constituted unsatisfactory professional conduct. The Medical Board then referred the matter to the Health Practitioners Tribunal. Ten months later the Tribunal accepted a guilty plea from the doctor concerned and imposed sanctions upon his registration. So much emerges from the Ombudsman's case study. It reveals also that the period between complaint to the Medical Board and discipline of the doctor by the Tribunal was two years and seven months. It seems unlikely that a complaint made to the Medical Board in October 2004 would have led to limitations being placed upon Dr Patel's clinical practice before his departure in April 2005. Indeed, the facts of the Ombudsman's case study tend to suggest it is reasonable to expect to wait six months for investigation and a further ten

months for a Tribunal hearing. If the case study can be relied upon as a rough guide, even acting upon the assumption that the investigation would be complete in six months after the complaint⁴⁶⁷ and assuming that it then takes a further ten months for a tribunal hearing as it did in the case study, Dr Patel may well have been practising until April 2005 before the investigation was complete and the investigator informed the Medical Board. If the Medical Board failed to suspend Dr Patel until the evidence was tested in the Tribunal then Dr Patel may have practised until February 2006 before the Tribunal made a finding and determination as to whether conditions should have been imposed upon his registration.

Disciplinary action by the Medical Board

6.450 The Medical Board may start disciplinary action against a medical practitioner in four ways. It may take disciplinary proceedings itself⁴⁶⁸ or establish a disciplinary committee to conduct the proceeding.⁴⁶⁹ It may refer the matter for hearing by a professional conduct review panel.⁴⁷⁰ The role of professional conduct review panels is to conduct hearings of routine disciplinary matters in an informal and collaborative manner.⁴⁷¹ Under Part 6, division 5 of the *Health Practitioners (Professional Standards) Act 1999*, a professional conduct review panel has substantial powers and may refer appropriate matters to the Health Practitioners Tribunal if the matter may provide ground for suspending or cancelling a doctor's registration. Fourthly it may refer the matter for hearing before the Health Practitioners Tribunal.⁴⁷²

6.451 There are a number of grounds for disciplinary action against a medical practitioner including:

- Unsatisfactory professional conduct;⁴⁷³
- Failure to comply with a condition of registration.⁴⁷⁴

6.452 Once proceedings have commenced the Medical Board has extensive powers including the power to:

- Conduct hearings;⁴⁷⁵
- Summon witnesses to provide evidence or produce documents;⁴⁷⁶
- Inspect documents or other things;⁴⁷⁷
- Hold persons in contempt of the Medical Board.⁴⁷⁸

⁴⁶⁷ Instead of the 21 months in the Ombudsman's case study

⁴⁶⁸ *Health Practitioners (Professional Standards) Act 1999* s126(1)(a)

⁴⁶⁹ *Health Practitioners (Professional Standards) Act 1999* s126(1)(a)

⁴⁷⁰ *Health Practitioners (Professional Standards) Act 1999* s126(1)(b)

⁴⁷¹ See the Explanatory Notes, *Health Practitioners (Professional Standards) Bill 1999*

⁴⁷² *Health Practitioners (Professional Standards) Act 1999* s126(1)(b)

⁴⁷³ *Health Practitioners (Professional Standards) Act 1999* s124(1)(a)

⁴⁷⁴ *Health Practitioner (Professional Standards) Act 1999* s124(1)(b)

⁴⁷⁵ *Health Practitioners (Professional Standards) Act 1999* s137

⁴⁷⁶ *Health Practitioners (Professional Standards) Act 1999* s143

⁴⁷⁷ *Health Practitioners (Professional Standards) Act 1999* s148

- 6.453 The Health Rights Commission may intervene in proceedings before the Medical Board if it so chooses.⁴⁷⁹
- 6.454 The Health Practitioners Tribunal, established by s.26 of the *Health Practitioners (Professional Standards) Act* 1999, is comprised of the judges of the District Court. The Tribunal's functions include:
- The hearing of disciplinary matters referred to it by health practitioner boards;⁴⁸⁰
 - The hearing of appeals from decisions of health practitioner boards.⁴⁸¹
- 6.455 The Health Rights Commission may choose to intervene in any disciplinary proceedings before the Tribunal.⁴⁸²
- 6.456 The tribunal has broad powers to hear disciplinary matters including power to:
- Conduct public hearings;⁴⁸³
 - Suppress the name of the registrant to whom the disciplinary proceeding relates;⁴⁸⁴
 - Summon witnesses to give evidence or produce documents;⁴⁸⁵
 - Punish for contempt of the tribunal.⁴⁸⁶
- 6.457 The Tribunal has broad powers if it decides to discipline. They vary from a caution to imposing conditions upon registration to cancelling registration and declaring that the doctor must never be registered by the Medical Board of Queensland.⁴⁸⁷
- 6.458 The Medical Board first learned of concerns relating to the clinical practice of Dr Patel at the Bundaberg Base Hospital on 15 February 2005. Mr O'Dempsey met with two representatives of the Queensland Nurses' Union who indicated that their members were concerned about Dr Patel and had been interviewed by Dr FitzGerald. The Medical Board of Queensland did not receive a formal complaint about Dr Patel. Mr O'Dempsey spoke with Dr FitzGerald, ascertained that Dr FitzGerald was finalising a report and that there may have been recommendations or information about Dr Patel to be included in that report and asked Dr FitzGerald to inform the Medical Board's Registration Advisory Committee before the end of May 2005 so that it could consider whether to recommend conditions upon Dr Patel's registration. This was practical in the opinion of Mr O'Dempsey because conditions upon registration would be more easily imposed under the *Medical Practitioner's Registration Act* than under the *Health Practitioners (Professional Standards) Act*.⁴⁸⁸ This is consistent with the

⁴⁷⁸ *Health Practitioners (Professional Standards) Act* 1999 s163
⁴⁷⁹ *Health Practitioners (Professional Standards) Act* 1999 s153(1)
⁴⁸⁰ *Health Practitioners (Professional Standards) Act* 1999 s30
⁴⁸¹ *Health Practitioner (Professional Standards) Act* 1999 s30(2)
⁴⁸² *Health Rights Commission Act* 1991 s130
⁴⁸³ *Health Practitioners (Professional Standards) Act* 1999 s220
⁴⁸⁴ *Health Practitioners (Professional Standards) Act* 1999 s223
⁴⁸⁵ *Health Practitioners (Professional Standards) Act* 1999 s229
⁴⁸⁶ *Health Practitioners (Professional Standards) Act* 1999 s239
⁴⁸⁷ *Health Practitioners (Professional Standards) Act* 1999 s241
⁴⁸⁸ Exhibit 28 para 31

effect of the interpretation of s59 of the *Health Practitioners (Professional Standards) Act 1999*⁴⁸⁹ which has led the Medical Board to the view that before suspending or imposing conditions upon a doctor it was obliged to find evidence to meet a high threshold of proof of 'immediacy of the threat' and that it should determine the least onerous action to protect the patient.⁴⁹⁰

- 6.459 A consequence of the Medical Board's concern for the quality of evidence required to satisfy s59 of the *Health Practitioners (Professional Standards) Act 1999* is that it is more attractive to the Medical Board to allow an Area of Need registrant such as Dr Patel to continue practicing without conditions or suspension until the expiration of the doctor's year of registration and to consider imposing conditions when the doctor applies for a further year's registration. This cannot be in the best interests of patients.

The Queensland Nursing Council

- 6.460 Complaints against the nursing profession are referred to the Queensland Nursing Council.⁴⁹¹ The Queensland Nursing Council has, as one of its functions, the investigation of complaints against members of the nursing profession⁴⁹². In 2003/04 the Queensland Nursing Council received a total of 177 complaints against nurses.⁴⁹³
- 6.461 The Queensland Nursing Council may accept⁴⁹⁴ complaints about a nurse or midwife from any entity.⁴⁹⁵
- 6.462 If the complaint is from a patient, then before the Queensland Nursing Council can investigate a complaint it must first refer the complaint to the Health Rights Commission.⁴⁹⁶ If the complaint is from someone other than a patient then the Queensland Nursing Council may retain and investigate the complaint.⁴⁹⁷
- 6.463 The Queensland Nursing Council has broad powers to investigate complaints and may also immediately suspend a nurse if satisfied that there is a risk to patient safety.⁴⁹⁸
- 6.464 During the investigation, the Queensland Nursing Council is obliged to keep the Health Rights Commissioner informed on the progress of the investigation,⁴⁹⁹

⁴⁸⁹ See *Thurling v the Medical Board of Queensland* [2002] QHPT 004

⁴⁹⁰ Exhibit 28 para 41

⁴⁹¹ Established by the *Nursing Act 1992* s6

⁴⁹² *Nursing Act 1992* s7(g)

⁴⁹³ Queensland Nursing Council, Annual Report 2003 – 2004

⁴⁹⁴ regarding the acceptance of complaints see *Nursing Act 1992* s102A

⁴⁹⁵ *Nursing Act 1992* s102

⁴⁹⁶ *Nursing Act 1992* s102A, although in some circumstances, following consultation with the Health Rights Commissioner, the Queensland Nursing Council may retain the complaint for investigation if that is in the public interest, or in other case: see *Nursing Act 1992* s102A(2)

⁴⁹⁷ *Nursing Act 1992* s102A

⁴⁹⁸ *Nursing Act 1992* s67

⁴⁹⁹ However the council is only obliged to keep the Commissioner informed of the progress of the investigation if the Health Rights Commissioner asks to be kept informed

and is also required to provide to the Health Rights Commission the final report about the investigation.⁵⁰⁰

- 6.465 If satisfied that there are grounds for disciplinary action,⁵⁰¹ then the Queensland Nursing Council may refer the charge to the Nursing Tribunal.⁵⁰²
- 6.466 The Nursing Tribunal is an independent tribunal⁵⁰³ established under the *Nursing Act* 1992. It has no relationship with the Health Practitioners Tribunal established under the *Health Practitioners (Professional Standards) Act* 1999.⁵⁰⁴ It has broad powers and its function is to hear disciplinary charges with respect to nurses, make findings, and take appropriate action in response to disciplinary charges.⁵⁰⁵
- 6.467 The Ombudsman's case study reveals that the complaint about a registered nurse which was made to the Queensland Nursing Council was not immediately investigated by the Council. The investigation was delayed for three and a half months while the Health Rights Commission assessed the complaints, sought submissions and consulted with the Council. The Council accepted the complaint for investigation after that delay. The Council's investigation into the complaint against that registered nurse took a further fourteen months. Despite finding that there were concerns regarding the nurse's competence, the Queensland Nursing Council resolved to await an inquiry by the Coroner to determine what action should be taken. Three years and three months after complaining to the Queensland Nursing Council the complainants were still waiting to learn what disciplinary action, if any, would be taken against the nurse.

Queensland Ombudsman⁵⁰⁶

- 6.468 The Ombudsman can investigate administrative actions of an agency,⁵⁰⁷ including Queensland agencies that provide health services, deal with complaints about the provision of health services, and regulate the health service professions. The Ombudsman can investigate the administrative actions of the Health Rights Commissioner, the Medical Board of Queensland, Queensland Health and the Queensland Nursing Council.

⁵⁰⁰ *Nursing Act* 1992 s103A(2)

⁵⁰¹ *Nursing Act* 1992 s104A

⁵⁰² *Nursing Act* 1992 s104

⁵⁰³ The Nursing Tribunal is established under the *Nursing Act* 1992 Pt 5 Div 1

⁵⁰⁴ The Health Practitioners Tribunal hears matters concerning health practitioners other than nurses

⁵⁰⁵ The actions that the Tribunal can take are contained in the *Nursing Act* 1992 s116

⁵⁰⁶ The Queensland Ombudsman helpfully provided to me a copy of his submission of August 2005 to the Bundaberg Hospital Commission of Inquiry. I have relied upon the submission to describe the role of the Queensland Ombudsman so far as it relates to dealing with complaints about the Health Service and particularly for a case study done by the Queensland Ombudsman of a health related complaint. The case study illustrates well some unsatisfactory consequences which arise from Queensland's system which allots to different authorities different responsibilities for dealing with health complaints.

⁵⁰⁷ As defined in ss8 and 9 of the *Ombudsman Act* 2001

- 6.469 The Ombudsman is expected to liaise with other complaints entities to avoid inappropriate duplication of investigative activity⁵⁰⁸ and would not ordinarily accept an initial complaint about the provision of a health service if the complaint more appropriately fell within the jurisdiction of the Health Rights Commission, the Medical Board of Queensland (or another registration board), or the Queensland Nursing Council.
- 6.470 In most cases, the Ombudsman will not accept a complaint unless the complainant has tried to resolve it with the agency which is the subject of the complaint.
- 6.471 In the 2004/2005 financial year, the Ombudsman's Office received 339 health related complaints. Of those:.
- 156 related to Queensland Health;
 - 50 related to the Health Rights Commission;
 - 33 related to a registration board or the Queensland Nursing Council.
- 6.472 In accordance with the Ombudsman's normal practice in relation to Queensland Health complaints, many of the 256 complaints received (126) were referred to Queensland Health for internal review, while an additional 37 complaints were referred to the Health Rights Commission or to the relevant registration board.
- 6.473 The Ombudsman received no complaints about medical services at Bundaberg Base Hospital or about maladministration by health agencies in dealing with complaints about medical services at Bundaberg Base Hospital.

Recommendations for complaints management

Health Systems Review recommendation for complaints management

- 6.474 The final report of the Queensland Health Systems Review⁵⁰⁹ (the Forster Report) recommends changes to the current system of complaints management within Queensland Health.⁵¹⁰
- 6.475 Some key features of the Forster Report's proposed complaints model are:
- A complaints model be adopted that provides for local resolutions first whilst requiring escalation to an independent complaints body, a Health Commission if the complaint is not resolved in 30 days;⁵¹¹
 - the proposed Health Commission would have powers to investigate

⁵⁰⁸ *Ombudsman Act 2001* s15

⁵⁰⁹ *Queensland Health Systems Review*, Final Report, September 2005

⁵¹⁰ *Queensland Health Systems Review*, Final Report, September 2005 p190-192

⁵¹¹ *Queensland Health Systems Review*, Final Report, recommendation 9.16 at p196

the complaints;⁵¹²

- There should be better coordination of the work of the Health Rights Commission, the Medical Board of Queensland and the other Health Practitioner registration boards, the Crime and Misconduct Commission, the State Coroner and the Queensland Ombudsman;⁵¹³
- A separate and short review needs to be undertaken of the legislation and working arrangements between those external bodies to determine how their work can be better coordinated;⁵¹⁴
- The proposed Health Commission could assume within its functions the role of the current Health Rights Commission;⁵¹⁵
- The proposed Health Commission would adjudicate complaints in a timely way.⁵¹⁶

6.476 The Forster Report did not explain what powers should be given to the proposed Health Commission as part of its role as an adjudicator of complaints. It was not obvious from the report whether the Health Commission would be 'one stop shop' with power to discipline or power to impose conditions upon the right to practice of doctors, nurses or allied health professionals.

Ombudsman's proposals for a new health complaints system

6.477 The submission of the Queensland Ombudsman⁵¹⁷ set out a comprehensive outline of features for a proposed new health complaints system.⁵¹⁸ The Queensland Ombudsman's office initiated a project in March 2003 called the Complaints Management Project and provided a report to the Director-General of Queensland Health on 8 March 2004 concluding that the Queensland Health system of complaint management 'compares very favourably to those in most other departments and meets nearly all the criteria for good complaints management.' However, the Ombudsman's office had recommendations for improvement then. That office has considered the matter since and in particular in light of the experience of the Bundaberg Base Hospital and has set out a comprehensive outline of the health complaints system which the Ombudsman proposes.

6.478 Some features of the Ombudsman's submission relating to a new health complaints system differ from the features I have extracted from the Forster

⁵¹² *Queensland Health Systems Review*, Final Report, p190

⁵¹³ *Queensland Health Systems Review*, Final Report, p198

⁵¹⁴ *Queensland Health Systems Review*, Final Report, recommendation 9.22 p198

⁵¹⁵ *Queensland Health Systems Review*, Final Report, p199

⁵¹⁶ *Queensland Health Systems Review*, Final Report, p191

⁵¹⁷ Submission to Bundaberg Hospital Commission of Inquiry, August 2005, which was resubmitted to this Inquiry

⁵¹⁸ Ombudsman's submission at Section 5.4

Report. The Ombudsman's recommendations included the following features not apparent among the Forster Report's recommendations:

- A new and independent body which could provide complainants with a 'one stop shop' in that it would have jurisdiction to deal with all aspects of complaints in relation to both registered and non-registered providers of health services in both public and private sectors with power to assess and coercive powers to investigate.⁵¹⁹ The Medical Board and the other registration boards would no longer conduct investigations of complaints about their own registrants, except by arrangement with the new body;
- Generally before the new body would accept a complaint the complainant would be required to demonstrate that the complainant had attempted to resolve the matter with the health service provider. In this respect the recommendation of the Ombudsman is somewhat similar to the recommendation of the Forster Report. However, the Ombudsman adds significant practical exceptions:

There should be exceptions to this, for example where there is an immediate risk to the health or safety of a user or consumers, or where a complaint is made by a staff member of the relevant HSP who is fearful of reprisal.⁵²⁰

6.479 On the basis of the evidence and submissions received I am not in a position to recommend, in any detailed way the indicia of a better system. Some deficiencies are obvious. By dividing the jurisdiction to deal with complaints between numerous bodies there is a confusion for the complainants as to which is the best authority or the appropriate one for a practical resolution. Complaints often pass from one body to another and back again with consequential delays. The transfer of matters from one authority to another is dispiriting for complainants. From the Ombudsman's case study, it emerged that the Medical Board and the Nursing Council had no statutory power to investigate the matter for the first few months after receiving the complaints while the Health Rights Commissioner was assessing them. During the same months, while the Health Rights Commissioner was empowered to assess, he lacked the Medical Board's and Nursing Council's powers to investigate and had no power to adjudicate. The same case study reveals that for the next ten months, the backlog of Medical Board investigations prevented an investigation. When the investigation was assigned by the Medical Board to an external investigator it took six months to complete. In total, the time between complaint to the Medical Board and the

⁵¹⁹ Ombudsman's submission to the Bundaberg Hospital Commission of Inquiry August 2005 p74

⁵²⁰ Ombudsman's submission to the Bundaberg Hospital Commission of Inquiry August 2005 p77

disciplining of the doctor about whom the complaint was made was two years and eight months. When, in August of this year, the Ombudsman submitted the case study three years and four months had elapsed since the complaint to the Queensland Nursing Council. The complainants then were still waiting to learn what disciplinary action, if any, would be taken against the registered nurse about whom they first complained.

- 6.480 There are obvious advantages in having one independent body which could act upon complaints from patients and health practitioners or on its own initiative with the powers to assess and to investigate doctors, nurses, allied health professionals, private hospitals and public hospitals and which had the power to conciliate but also to adjudicate, discipline and suspend in cases where there exists a real risk to patients.
- 6.481 On the basis of the complaints made by Ms Hoffman in October 2004 some authority independent of Queensland Health ought to have existed with sufficient investigators to verify in no more than thirty days whether there existed a real risk that patients were in imminent danger and with the willingness and the power to suspend Dr Patel. If necessary, the suspension could be followed by a subsequent, more thorough, prompt investigation into whether the suspension was justified and whether it should continue. Fairness to a doctor or nurse suspended could be offered with a right to appeal and provisions such as those appearing in s92 of the *Public Service Act* 1996. That section provides so far as relevant:

92 Effect of suspension from duty

- (1) An officer suspended from duty under this part is entitled to full remuneration for the period for which the officer is suspended, unless the employing authority otherwise decides.
- (2) If the officer is suspended without full remuneration, the authority cancels the officer's suspension and the officer resumes duty, then, unless the authority otherwise decides, the officer is entitled to be paid the prescribed remuneration to which the officer would have been entitled apart from the suspension, less any amount earned by the officer from additional employment undertaken during the suspension period.

Complaint by litigation

- 6.482 Some significant claims against doctors, nurses and allied health professionals are made without notice to the Health Rights Commissioner or to the relevant registration board. This commission received a copy of an extract from a foreign newspaper that asserted that Dr Patel had been made the subject of several medical malpractice suits in the United States and that those suits had been settled without trial and without public record.

- 6.483 It is common for insurers to require of their insured that the insurer be notified by their insured if a claim for professional negligence is made against them. It would be useful if the insurer of a doctor, nurse or allied health professional gave notice of receipt of claims for professional negligence against its client and, upon resolution of the claim, details of the resolution. Legislation to compel this should be considered. The appropriate body to whom such notice should be given by the insurer is the body which has power to suspend or impose conditions upon the practise of the doctor, nurse or allied health professional, whether that body be the relevant registration board or the proposed 'one stop shop'.
- 6.484 In summary, it seems to me that serious consideration should be given to legislation to oblige insurers to report notice of claims for negligence against health practitioners and to creating a body which:
- Is a 'one stop shop' independent of Queensland Health and the registration boards having sole power to act upon complaints from or on behalf of patients or issues raised by health practitioners or upon notice of claims notified to insurers of health practitioners;
 - Has power to investigate, conciliate and adjudicate;
 - Has the power, where there is a real risk to a patient's health or safety from acts or omissions of a doctor, nurse or allied health professional, to immediately suspend or impose conditions on the doctor, nurse or allied health professional. Patient safety should have a higher priority than fairness to the practitioner. A sensible compromise for the practitioner would be a preliminary assessment of the reality of the risk to patients and, if a suspension or the imposition of a condition upon practise were to be ordered, it would be followed by a prompt investigation into whether the suspension or condition was justified and whether it should continue, a right of appeal, and a fair approach to remuneration for the practitioner for the period of suspension.

Whistleblower protection and reform

- 6.485 The people of Queensland owe a great deal to Ms Toni Hoffman, whose decision to speak to her local member of Parliament about her concerns regarding the activities of Dr Patel and the apparent threat he represented, led to his exposure and this Inquiry. Without her taking that step, the extent of Dr Patel's actions may yet remain unknown. As shown in Chapter Three above, that was not the first time that she had complained about Dr Patel.

6.486 Whether Ms Hoffman realised it or not, her disclosure to Mr Messenger MP was not protected by the *Whistleblowers Protection Act* 1994.⁵²¹ The fact that Ms Hoffman had to reveal her concerns to Mr Messenger MP, to have those concerns dealt with, and that her disclosure was not protected, reveals the failure of the current system of protecting whistleblowers.

The present system of Whistleblower protection

6.487 When introduced in 1994, Queensland's *Whistleblowers Protection Act* was the first of its kind in Australia and indeed one of the first in the common law world.⁵²² Whistleblower protection is an attempt to encourage people to speak out against corruption and poor practices without fear of reprisal as a result of speaking out. The *Whistleblowers Protection Act* recognises and attempt to achieve a balance of competing interests such as:

- The public interest in the exposure, investigation and correction of illegal, improper or dangerous conduct;
- The interests of the whistleblower in being protected from retaliation or reprisal and in ensuring that appropriate action is taken regarding the disclosure;
- The interests of persons against whom false allegations are made, particularly the damage to reputations and the expense and stress of investigations;
- The interests in the organisation affected by the disclosure in ensuring its operations are not disrupted and also in preventing disruptive behavior in the workplace; and
- The need to ensure that whistleblower protection has appropriate safeguards to protect against abuse.⁵²³

6.488 In attempting to strike a balance between these competing considerations the *Whistleblowers Protection Act* permits specified persons to make disclosures to particular entities about specified conduct. As the system presently stands, public officers are entitled to make public interest disclosures afforded the protections in the *Whistleblowers Protection Act* provided that disclosure is to a public sector entity about conduct that amounts to:⁵²⁴

⁵²¹ Under Part 4 Division 2 of the *Whistleblowers Protection Act* 1994, in order to attract the protections of the Act public interest disclosures must be made to a public sector entity. A public sector entity is defined in Schedule 5, section 2 of the Act. That definition does not include disclosures to a member of the legislative assembly.

⁵²² See: 'Three Whistleblower Protection Models: A comparative analysis of Whistleblower Legislation in Australia, the United States and the United Kingdom' a report of the Public Service Commission of Canada available at: www.psc-cfp.gc.ca/research

⁵²³ These points are drawn from the Ombudsman's submissions

⁵²⁴ For the source of this information see the Ombudsman's submission to the Bundaberg Hospital Commission of Inquiry, see also: Sections 15, 16, 17, 18, 19, and 26 *Whistleblowers Protection Act* 1994

- Official Misconduct;
- Maladministration that adversely affects anybody's interests in a substantial and specific way;
- Negligent or improper management involving a substantial waste of public funds; or
- A substantial and specific danger to public health or safety or to the environment.⁵²⁵

6.489 Apart from public officers⁵²⁶ any person⁵²⁷ may make a public interest disclosure about:

- A substantial and specific danger to the health or safety of a person with a disability
- An offence under certain legislation that is or would be a substantial and specific danger to the environment
- A reprisal taken against anybody for making a public interest disclosure

6.490 There are two significant limitations to this system. Firstly, disclosures must be made to an 'appropriate entity'. Secondly, only public officers are permitted to make disclosures about official misconduct, maladministration, waste of public funds, or threats to public health.

Disclosures to an 'appropriate entity'

6.491 Section 26 of the *Whistleblowers Protection Act* provides:

26 Every public sector entity is an appropriate entity for certain things

- (1) Any public sector entity is an appropriate entity to receive a public interest disclosure—
 - (a) *about its own conduct or the conduct of any of its officers; or*
 - (b) *made to it about anything it has a power to investigate or remedy; or*
 - (c) *made to it by anybody who is entitled to make the public interest disclosure and honestly believes it is an appropriate entity to receive the disclosure under paragraph (a) or (b); or*
 - (d) *referred to it by another public sector entity under section 28.4.*
- (2) Subsection (1)(c) does not permit a public sector entity to receive a public interest disclosure if, apart from this section, it would not be able to receive the disclosure because of division 4, 5 or 6.5.

⁵²⁵ Clearly Ms Hoffman's complaint would fall into this category, however her disclosure to Mr Messenger MP was not a disclosure to a 'public sector entity' as defined by the Act.

⁵²⁶ A public officer is an officer of a public sector entity see Schedule 6, *Whistleblowers Protection Act* 1994

⁵²⁷ as opposed to a public officer

- (3) If a person makes a public interest disclosure to an appropriate entity, the person may also make a public interest disclosure to the entity about a reprisal taken against the person for making the disclosure

6.492 The term 'appropriate entity' is defined in the *Whistleblowers Protections Act* 1994 as including bodies such as:

- a committee of the Legislative Assembly;
- the Parliamentary Service;
- a court or tribunal;
- the administrative office of a court or tribunal;
- the Executive Council;
- *a department*;
- a commission, authority, office, corporation or instrumentality established under an Act or under State or local government authorisation for a public, State or local government purpose.

6.493 Section 26 of the *Whistleblowers Protection Act* has the effect that, as far as Queensland Health is concerned, under that section an appropriate entity to receive a public interest disclosure about Queensland Health is itself.⁵²⁸

6.494 There was considerable evidence before this Commission about staff of Queensland Health having little or no faith in Queensland Health in dealing with complaints. In an organisation that actively conceals information and uses Cabinet confidentiality provisions to avoid Freedom of Information laws, it seems unlikely that public interest disclosures by employees would be dealt with any differently.

6.495 In any event, Ms Hoffman's complaint to Mr Leck would amount to a public interest disclosure⁵²⁹ to an appropriate entity under the *Whistleblowers Protection Act*.⁵³⁰ However, Ms Hoffman did not consider that the actions taken by Queensland Health were appropriate to her complaint.

Limitations of persons and entities to whom a protected disclosure can be made

6.496 Noticeably a member of Parliament is not an 'authorised entity' to whom a public interest disclosure can be made under the *Whistleblowers Protection Act*.

⁵²⁸ s26(1) of the *Whistleblowers Protection Act* 1994 states that a public sector entity is the appropriate entity to receive a public interest disclosure about its own conduct or the conduct of any of its officers

⁵²⁹ concerning a threat to the health and safety of patients at the Bundaberg Hospital

⁵³⁰ Queensland health is an appropriate entity to receive a disclosure about the conduct of one of its own officers.

- 6.497 Furthermore, a disclosure to a journalist or a member of the media attracts no protection under the *Whistleblowers Protection Act*. During the course of this Commission of Inquiry, there was at least one instance of a report being provided to *The Courier-Mail* newspaper.⁵³¹ How that document came into the possession of the *The Courier-Mail* before being disclosed to the Commission was not investigated. However, needless to say that disclosure was afforded no protection under the *Whistleblowers Protection Act*.
- 6.498 The findings made in respect of Bundaberg, Rockhampton, and Queensland Health show that Ms Hoffman had no choice but to complain to her local member of Parliament, and that another person felt the need to disclose a confidential report regarding the Rockhampton Emergency Department should be provided to *The Courier-Mail*, in my opinion demonstrates that the protection to whistleblowers in the Queensland public sector needs reform.

Limitations on who can make a protected complaint

- 6.499 As set out in paragraph 6.488 and 6.489 above, it is not just any person who can make a public interest disclosure about maladministration or a threat to public safety. Patients, or their family members, are unable to gain the protections of the *Whistleblowers Protections Act* should they wish to make a public interest disclosure. The categories of persons permitted to make protected disclosures needs expansion.

Lack of central oversight of public interest disclosures

- 6.500 As submitted by the Ombudsman, another failure of the current system is the lack of a central body charged with overseeing and managing public interest disclosures. Under the present system, the Office of Public Service, Merit and Equity is responsible for administering the *Whistleblowers Protection Act*.⁵³² That office has no role in overseeing public interest disclosures, each department being required to develop its own policy and procedures for managing public interest disclosures.⁵³³
- 6.501 Queensland Health has developed a document titled 'Policy and Procedures for the Management of Public Interest Disclosures' that sets out the processes to be used in managing public interest disclosures under the *Whistleblowers Protections Act*.
- 6.502 Broadly, the procedures in place at Queensland Health are as follows:

⁵³¹ Exhibit 129: Rockhampton Emergency Department Review, which was 'leaked' to *The Courier-Mail* prior to being disclosed to the Commission of Inquiry

⁵³² See Administrative Arrangements Order (No 2) of 2005 available at:
http://www.premiers.qld.gov.au/library/pdf/admin_arrangements2_05.pdf

⁵³³ See Ombudsman's submission August 2005

- Public interest disclosures must be brought to the attention of the Director-General to determine appropriate management and investigation of the disclosure.
- The Director-General is also charged with considering the risk of reprisals and with taking steps to ensure that an employee who makes a public interest disclosure is not disadvantaged as a result of making the disclosure.
- The Audit and Operational Review Branch of Queensland Health is obliged to record the public interest disclosure and also record the action taken. This information is collected for publication in the department's annual report.

6.503 At present there is no single body charged with overseeing public interest disclosures within the Queensland Public Sector (save where that public interest disclosure involves official misconduct⁵³⁴). In my opinion this is a serious shortcoming. As the facts revealed in this Inquiry show, it was futile to expect Queensland Health to manage public interest disclosures about itself with no external oversight.⁵³⁵

6.504 The Queensland Ombudsman has provided a helpful submission to the Commission, in which he recommends changes to enhance the protection of whistleblowers in the public sector. The Ombudsman makes the following recommendations regarding changes to the current whistleblowers protection system.

6.505 Firstly the Ombudsman recommends that his office be given a supervisory role over public interest disclosures made under the *Whistleblowers Protection Act* 1994⁵³⁶. That role would be similar to the role which the Crime and Misconduct Commission has in overseeing and investigating complaints about official misconduct. The Ombudsman recommends a model where:

agencies would have an obligation to refer to the ombudsman all public interest disclosures that involve serious maladministration but do not amount to official misconduct.⁵³⁷

6.506 The Ombudsman takes the view that the phrase 'serious maladministration' includes such things as conduct that would amount to a danger to the health and safety of the public or the environment and also negligent or improper management affecting public funds.⁵³⁸

6.507 The Ombudsman recommends that public interest disclosure regarding official misconduct should remain subject to the present arrangements of referral to, and oversight by, the Crime and Misconduct Commission.

⁵³⁴ in that case the complaint must be dealt with in accordance with the *Crime and Misconduct Act* 2001 which obliges notification of the Crime and Misconduct Commission

⁵³⁵ the same can be said for any public sector body

⁵³⁷ See Ombudsmans Submission to the Bundaberg Hospital Commission of Inquiry, August 2004

⁵³⁸ See the *Queensland Ombudsman, Annual Report 2004/2005*

6.508 I adopt those recommendations.

Proposals for reform

6.509 I recommend the following changes to the *Whistleblowers Protection Act* 1994:

Central oversight of public interest disclosures

6.510 Firstly I recommend that the Queensland Ombudsman be given an oversight role with respect to all public interest disclosures save those involving official misconduct. I recommend a system similar to that involving Official Misconduct where all public interest disclosures must be referred to the Ombudsman who may then either investigate the disclosure itself, or refer it back to the relevant department for investigation, subject to monitoring by the Ombudsman.

Increase the class of persons who may make a public interest disclosure

6.511 Secondly, I recommend that the categories of persons who may make a public interest disclosure protected by the *Whistleblowers Protection Act* be expanded in cases involving danger to public health and safety, and negligent or improper management of public funds, to include any person or body.

Expansion of bodies to whom a complaint may be made

6.512 Finally, I recommend a scale of persons or bodies to whom a complaint may be made. Effectively a whistleblower ought to be able to escalate his or her complaint in the event that there is no satisfactory action taken with respect to it. The scale should be as follows:

- (a) A whistleblower should first complain to the relevant department – or public sector entity under Schedule 5 of the *Whistleblowers Protection Act* – subject to the Ombudsman’s monitoring role discussed above. The *Whistleblowers Protection Act* must also provide strict time limits to investigate and resolve the disclosure. A time of 30 days would be appropriate.
- (b) If the matter is not then resolved within the time, to the satisfaction of the Ombudsman, the whistleblower ought to be able to make a public interest disclosure to a member of Parliament.⁵³⁹
- (c) If disclosure to a member of Parliament does not result in resolution, to the satisfaction of the ombudsman, within a further 30 days, then the whistleblower should be entitled to make a further public interest disclosure to a member of the media.

⁵³⁹ It should not be restricted to a local member of Parliament, but should be any member of Parliament, for example an Opposition spokesperson on the relevant matter.

Part F - A culture of concealment and its consequences

The issue

- 6.513 The evidence before this Commission of Inquiry yielded, among other things, examples of persons in stewardship roles in Queensland Health engaging in conduct pertaining to clinical practice and procedure which diminished the prospect of facts being open to proper scrutiny. An occasional concomitant of concealment is reprisal; there was also some evidence of this.
- 6.514 It is one thing to identify isolated instances of concealment. It is quite another if the disposition to conceal existed at a high level throughout the relevant period and was pervasive, encouraging others in leadership positions within hospitals to themselves conceal facts.
- 6.515 Was concealment (and its occasional bedfellow reprisal) endemic within Queensland Health? If it was then that evidenced a culture of concealment within Queensland Health. What I propose to do is discuss this issue by reference to the various levels of Queensland Health management, commencing with the overarching stewardship of that government department by Cabinet. Only then can the practices at hospital level be seen in proper focus.

Cabinet

- 6.516 There are two spheres of relevant conduct to be addressed with reference to Cabinet. First, there is the issue of publication of elective surgery waiting lists. Secondly, there is the issue of the Measured Quality Reports. I will deal with them in turn.

Elective surgery waiting lists

- 6.517 From no later than 1996 there have existed two lists relating to elective surgery at Queensland public hospitals. First, a list of patients who have attended an appointment with a resident or Visiting Medical Officer specialist and placed on a list of persons awaiting surgery. I shall call that 'the surgery list'.
- 6.518 Secondly, there is a list of persons who have been referred by a general practitioner for specialist appointment at a cohort hospital but not yet seen and assessed. I shall call that 'the anterior list'.
- 6.519 The anterior list itself consists of two sub-categories. First, there are patients who have not yet been allocated such an appointment. Secondly, there are patients who have been allocated such an appointment but have not yet been seen.

- 6.520 From about November 1998 to about June 2003 Queensland Health collected and collated data from the 31 reporting hospitals in relation to their surgery and anterior lists.⁵⁴⁰ This data was provided monthly by the hospitals to the Surgical Access Team.⁵⁴¹ From April 1999, this data was in turn provided by the Surgical Access Team on a monthly basis to the General Manager Health Services, the Director-General and the Minister for Health⁵⁴² and on a quarterly basis to Cabinet.⁵⁴³ Unlike the collated surgery list which was published quarterly on its Internet site to the public,⁵⁴⁴ the collated anterior list was never published.⁵⁴⁵
- 6.521 In late 2000, the reporting of the anterior list data was scaled back to a summary on a zonal basis.⁵⁴⁶ In 2003, the Office of the General Manager Health Services instructed the Surgical Access Team to cease the monthly reporting of such data to the General Manager Health Services, the Director-General and the Minister for Health.⁵⁴⁷ Such information remained available and able to be provided if it had been requested. Until January 2005, the outpatients' waiting list data continued to be reported by the hospitals to the Team.⁵⁴⁸ In January 2005, the Team was disbanded. The management of such information devolved back to the zones.⁵⁴⁹
- 6.522 As to the number of patients on the anterior list, a table prepared from the specialist outpatients' waiting list data base⁵⁵⁰ shows, as at 1 July 2001, 1 July 2002, and 1 July 2003, it was 51,876, 54,725 and 55,684, respectively, of which 33,929, 35,945 and 36,165 had been offered an appointment.
- 6.523 An analysis of 1 July 2004 data⁵⁵¹ undertaken by the Commission staff,⁵⁵² solely with respect to surgical disciplines, computed 67,052 persons on the anterior list. Of whom 46,637 were without an appointment. I think this to be correct as at 1 July 2004. Clearly such anterior list was growing.
- 6.524 The Surgical Access Team, however, thought the anterior list data, collected over time, unreliable.⁵⁵³

⁵⁴⁰ Exhibit 326 paras 23-26 (Zanco)

⁵⁴¹ Exhibit 328 para 62 (Walker)

⁵⁴² Exhibit 328 para 70; Edmond T4998

⁵⁴³ Exhibit 326 para 22

⁵⁴⁴ Exhibit 326 para 44; Exhibit 328, para 29

⁵⁴⁵ Exhibit 317 (Scott) para 10.2

⁵⁴⁶ Exhibit 328 para 70

⁵⁴⁷ Exhibit 328 para 72, 74

⁵⁴⁸ Exhibit 328 para 76

⁵⁴⁹ Exhibit 328 para 8

⁵⁵⁰ Exhibit 326 attachment 'MCZ8'

⁵⁵¹ Exhibit 267

⁵⁵² Exhibit 318, T5251, 5252

⁵⁵³ Exhibit 326 para 24; T6183, 6203

6.525 As was rightly conceded by most witnesses;⁵⁵⁴ it would be much more meaningful for the public generally, and certainly patients, to know not just the total number of persons awaiting surgery but also how long it takes to receive appropriate treatment from the time of referral from their general practitioners. Not only would this statistic more accurately represent true waiting times of patients awaiting surgery, but it would allow patients and their general practitioners to better evaluate and plan their care, affairs and priorities. It may be that during earlier stages, the collection of anterior list data was not as standardised or accurate as the surgery list data.⁵⁵⁵ But, as Mr Walker conceded, some information is better than no information.⁵⁵⁶

6.526 The evidence of Dr Stable was instructive in this regard.⁵⁵⁷

You say in paragraph 74 of your statement that you have ... no difficulty '(w)ith transparency of outpatient lists broken down into specialty

which include surgical and non-surgical specialties.'... -- That's correct. I would have preferred it to be the case. It would have supported my

ongoing argument since January 1996 about the underfunding of health in Queensland. In March 1996 the Australian Institute of Health and Welfare reported 16 per cent underfunding in Queensland. To have actually had all that transparent would have been very good for the people of Queensland, but also for the Department.

Your opinion is that if outpatient specialist waiting lists had have been publicised as early as possible, that that would have enhanced the argument to obtain greater funding for Queensland Health?-- Absolutely. This has been an issue since the eighties, I might add, but absolutely.

...

Having regard to your comments earlier about the publication of outpatient specialist waiting lists and the enhancement to the argument for better funding that would ensue from their publication, why is it that the politicians of the day haven't disclosed them?-- In discussions I've had both at state level and nationally, as Chair of the Australian Health Ministers Advisory Council, I don't think politicians have wanted to admit - I'll call it political honesty. Either the funding has to be there or there's a limit on services, or maybe even both, and I think there needs to be quite a serious debate in this country to actually bring that to the fore about what actually can be afforded, or are governments going to put in the necessary funding. That's the issue.

The Queensland system presently, and throughout the entirety of your tenure, was contrasted with interstate analogues in terms of dealing with specialist outpatient patients. Is that not so?-- That's correct, yes.

Just explain to the Commission how that was different? Well, other states were limiting, or in fact stopping outpatient services. We in fact continue to increase them. In fact during the term that I was Director-General, according to the annual reports of Queensland Health, there was a 37 per cent increase in non-inpatient occasions of service, which includes outpatients, all those sort of things. But Queensland, when I discussed it with Ministers over the years, have

⁵⁵⁴ T4885 line 50 T5307 line 20; T5254 line 20, 5255, 5257 line 40 T6183 line 30

⁵⁵⁵ T6181

⁵⁵⁶ T6183 line 20

⁵⁵⁷ T5720 line 50 -T5723 line 10

always said, 'We've got a free hospital system. We intend to keep it.' The Commonwealth Department of Health reported in June last year in its annual report of public hospitals that Queenslanders utilise outpatients 20 per cent above the national average, and that reflects the policy of consecutive governments. But I might add, at the same time we're significantly underfunded, but we have this extra demand on our hospitals.

...Quite apart from the funding - the important funding issue that you've raised, you would agree that there would be other advantages in the publication of specialist outpatient surgical waiting lists?-- Oh, I think there are clear indications. It means, doctors out there in practice can look and say, 'Well, there's a wait at this hospital. I'll refer you to another hospital', or can say to the patient, 'Look, there's a significant wait, a 12 month wait for this procedure in the public system. I can arrange for you to go privately, but of course you're going to have to pay.' But then there can be an informed decision, and of course the public, at each election, can decide whether they want to elect someone who is going to put more money into - and significant and honest more money, not this stuff where it's to cover the labour costs, which just enables us to stand still.

Perhaps if not put more money, perhaps even less money, but restructure the system, and say so?-- Or be honest about, 'We can't provide certain procedure in the public system because we can't afford it.'

What sort of pressure does the non-publication of lists place on the individual hospital?-- Well, because they have to continue to present the public face that they can do everything - and of course there's been periods where hospital superintendents have done a letter to say, 'We can't take this booking', it gets in the media and the politician of the day gets all upset about it. But that's the pressure that hospitals are under.

6.527 I accept this evidence.

6.528 Evidence as to the disposition of Cabinet to surgical waiting lists, in successive governments, was given by Mr Michael Clare.⁵⁵⁸ Mr Clare was an impressive witness and I have no hesitation in accepting his evidence (with one exception, concerning Dr Stable, to which I will come). He worked for Queensland Health for 27 years. From January 1997 to January 2002 he was the Manager, Parliamentary and Ministerial Services and Cabinet Legislation Liaison Officer.

6.529 Part of his duties included the preparation, scheduling and lodgement of Cabinet submissions generated within the department. In July 2002 he was appointed by the then Beattie Government as a member of the Medical Board of Queensland.

6.530 Mr Clare gave evidence that governments of both political persuasions in the period of his tenure from 1997 (initially the Borbidge Coalition Government and then the successive Beattie Labor Governments) abused the Cabinet process in order to avoid information deemed sensitive or politically embarrassing falling into the public arena. This was because s36 of the *Freedom of Information Act* 1992 provided for an exemption from Freedom of Information disclosure of documents which, in effect, were submitted to Cabinet.

⁵⁵⁸ Exhibit 387; T6075-T6088

- 6.531 Mr Clare gave evidence that, during the period of the Borbidge Coalition Government he procured a 'fridge trolley' in order to deliver and retrieve documents associated with Cabinet submissions which collected surgery waiting lists in Queensland public hospitals. In response to a Freedom of Information application which had been lodged seeking hospital waiting list documents.⁵⁵⁹ In this way that Government concealed from the public the surgery list.
- 6.532 Following the election of the Beattie Labor Government in 1998, Mr Clare said the remitting of such waiting lists to Cabinet was continued and formalised by the inclusion of the same on Queensland Health's 'Cabinet Forward Timetable'.
- 6.533 Mr Clare said that, on a number of occasions, his instructions were received, in relation to this issue, from Dr Stable. It was plain that Mr Clare inferred that Dr Stable was responsible for submitting waiting list information to Cabinet.
- 6.534 Dr Stable gave evidence that the decision was a political one made by the Minister and Cabinet of the day in a conscious endeavour to engage the Freedom of Information exemption.⁵⁶⁰ I accept Dr Stable's evidence in this regard.
- 6.535 Below when dealing separately with the conduct of former Minister Edmond, I again address this issue of waiting lists. Her conduct, consisting of a campaign by press release, was plainly undertaken with the full knowledge of Cabinet.
- 6.536 All this reflects poorly on the politicians involved in the stewardship of Queensland Health. There was a bipartisan (in the pejorative sense) approach to concealing from public gaze the full waiting list information. Only the (shorter) surgery list was published from 1998.

Measured quality reports

- 6.537 I turn to the issue of the 'measured quality reports' and Cabinet's disposition of the same. Mr Justin Collins gave evidence to the Commission.⁵⁶¹ I accept the evidence of Mr Collins. He was an impressive witness.
- 6.538 From September 2001 Mr Collins was manager of Measured Quality Service at Queensland Health. Although not involved with the development of Measured Quality Service from its inception he was very knowledgeable about it.
- 6.539 Measured Quality was (and is) a system which routinely measured the quality of services provided at selected Queensland Health hospitals. Data collected through the Measured Quality process was designed to be used to identify variation in performance between comparable hospitals across the State, and areas for potential improvement as well as areas of good practice in the

⁵⁵⁹ T6077

⁵⁶⁰ T5720 lines 40-50

⁵⁶¹ Exhibits 377, 378, Transcript for 26 and 28 September 2005

particular hospital. In turn this information was used by the hospitals to focus their attention on identified areas for detailed analysis.

- 6.540 It is plain from any fair reading of the medical literature referred to by Mr Collins⁵⁶² that concealment of medical and hospital data (excluding individual patient information) is inconsistent with maintenance of high medical standards. One of the articles, published in 2002 in the Medical Journal of Australia,⁵⁶³ said:

We believe that a negative response to public disclosure in Australia would be counterproductive. Greater openness in healthcare is inevitable. Information is freely available about most areas of modern life and many believe that healthcare is one of the last bastions of protectionism. When millions of dollars are spent on healthcare, those who pay have a right to know that the money is being spent effectively, and the publication of comparative data sends a strong message about the willingness of health professionals and organisations to be accountable.

In addition, public disclosure appears to be an effective way of improving quality. There is a growing body of evidence that the current level of quality of care is unacceptable and that quality-improvement initiatives using confidential data have been largely ineffective at changing the behaviour of health professionals. When comparative data are released to the public it appears to remind providers of the issues and refocuses them towards taking action.

Arguments in support of the status quo – that the data are inadequate, the public won't understand them and the media will misuse them – are not sustainable if public disclosure is introduced properly. There are lessons that can be learnt from other countries to guide the process of disclosure in Australia. The United States has nearly 15 years' experience at publishing data in the form of 'single report cards' or 'provider profiles'. The initiative was launched by the Federal Government and the momentum has been maintained by a variety of public, private, commercial and not-for-profit organisations. Consumers and purchasers of healthcare were expected to play a key role by selecting high-performing providers, but recent experience suggests that the providers themselves make greater use of the data than the service uses.

There are some notable examples of improvements in both processes and outcomes of care associated with the publication of performance data. Public reporting in Europe is less well established than in the United States, but hospital 'league tables' have been published in the Netherlands for several years, and the UK Government plans to introduce incentives linked to a range of publicly reported performance criteria.

What can we learn from the initiatives that have been introduced?

- First, a backlash from some doctors, professional groups and institutions (particularly those seen to be performing badly) is predictable. Some criticisms were justified in the early days of report cards but lessons are being learnt. For example, we know that forcing initiatives on reluctant professionals is not the most effective way of changing attitudes, and the introduction of report cards is more likely to be successful if doctors are encouraged to take a lead, particularly in selecting the performance measures. Bringing the media on board at an early stage to ensure fair and balanced coverage also helps. In addition, delaying publication for a short

⁵⁶² Exhibit 378, annexure 'JEC-27'

⁵⁶³ Marshall & Brook MJA 2005-2006 *Public Reporting of Comparative Information About Quality of Health Care*

period to allow providers time to look at and act upon the data is a useful strategy.

- Second, it is important that those who publish the data show a commitment to investing in the process and progressively improving the quality of the data and the validity of comparisons arising from the data. However, it makes little sense to 'wait for better data' – data will always be imperfect and, as one commentator stated, it is important not to let 'perfect be the enemy of good'. Experience suggests that the process of publication can in itself act as a catalyst for data improvement.
- Third, the utility of comparative data comes less from making absolute judgments about performance than from the discussion arising from using the data to benchmark performance. There is therefore a strong educational component to the effect of use of comparative data, and resources are required to facilitate this process.
- Finally, it is important to be cognisant of the risks of publishing comparative data. The danger of institutions refusing to treat certain disadvantaged groups in order to improve their apparent performance is well recognised, although probably overstated, and can be reduced by careful adjustment of risk and casemix. A tendency to focus on what is being measured at the expense of other areas of practice can be minimised by publishing a wide range of quality indicators. The risk of 'short-termism' – an inappropriate focus on annual reporting cycles – can be reduced by ensuring a balance between short-term targets and long-term strategic aims.

A greater degree of public reporting and information about healthcare quality is an inevitable and desirable way forward. Practitioners and policy makers in Australia have an opportunity to ensure that the policy is implemented in the manner that is most likely to produce positive change.

[footnotes omitted]

6.541 I accept this view.

6.542 The Measured Quality Service process was in two parts. First, there was a hospital report prepared for each hospital. I shall call these 'the hospital reports'. Secondly, there was an annual public report. Mr Collins gave evidence that the Measured Quality Service policy, in mid 2002, was never to 'hide' any document.⁵⁶⁴ He explained that the Measured Quality Service was concerned to contribute towards a 'blame free' environment within hospitals.⁵⁶⁵ There was concern⁵⁶⁶ that the hospital reports, if made public, could be 'misleading' because they were based on data collected before the hospitals had an opportunity to investigate the results and analyse them.

6.543 Mr Collins emphasised,⁵⁶⁷ however, that, in his view, clinicians and hospital managers needed to be provided with data which indicated the hospital's performance, together with information about successful strategies which had been adopted within other health service districts.

⁵⁶⁴ Exhibit 378 para 9

⁵⁶⁵ Exhibit 378 para 6

⁵⁶⁶ Exhibit 378 para 7

⁵⁶⁷ Exhibit 378 para 8

- 6.544 Engaging the hospital clinicians, Mr Collins said, was an important aim of the Measured Quality process. He also emphasised that the public needed to be provided with a thorough explanation of what the data meant. Achieving this balance was part of the process.
- 6.545 As Mr Collins explained,⁵⁶⁸ the public report provided 'analysed data comparing the relative quality and safety performance between peer groups at a statewide level and also comparing Queensland Health with the rest of Australia'. The hospital reports identified problems and resources in individual hospitals. But in relation to publication 'it would be left to the relevant Health Service District to determine whether or not to release the hospital reports for their Health Service District publicly', it being 'recognised ... that the hospital reports may have to be released to the media or to the general public through a Freedom of Information ... application and as a result it was decided to develop a strategy to assist Health Services Districts if that occurred'.
- 6.546 This process altered once the politicians' hands came upon it. I canvass below, when dealing with former Minister Edmond, what occurred at and following the presentation by Mr Collins to Minister Edmond and Director-General Stable on 13 August 2002. Shortly prior to that meeting Dr Glenn Cuffe, the Manager of the Procurement Strategy Unit of Queensland Health, and Mr Collins' superior, told Mr Collins⁵⁶⁹ that 'Ms Edmond and/or Dr Stable may ask that the measured quality phase 1 public hospital reports be sent to Cabinet and this would restrict our ability to disseminate the reports to Health Services Districts and effectively kill the measured quality program'. Mr Collins said⁵⁷⁰ that he and Dr Cuffe agreed that 'this was not desirable from the perspective of safety and quality as well as overall improvement within Queensland Health'. The concern was that open discussion of the hospital reports by clinicians and administrators would be prevented.
- 6.547 This comment by Dr Cuffe proved prophetic.
- 6.548 Neither Mr Collins nor any other Queensland Health employee advised nor suggested that the then phase one Measured Quality Service hospital reports (the hospital reports) be sent to Cabinet. He said that this course was raised by Minister Edmond at the 13 August 2002 presentation. I accept the evidence of Mr Collins as being accurate in this (and in all other) respects.
- 6.549 Mr Collins was involved in drafting the Cabinet submission. The submission was considered by Cabinet on 11 November 2002 and went under Minister Edmond's hand. It is worth noting that the submission in question was for the 'information' of Cabinet accompanied by a large wad of documents consisting of

⁵⁶⁸ Exhibit 378, para 9

⁵⁶⁹ Exhibit 378, para 12

⁵⁷⁰ Exhibit 378 para 12

public and hospital reports.⁵⁷¹ This could not sensibly have been done to inform Cabinet but rather to engage the Freedom of Information Cabinet exemption.

6.550 The drafting of the Cabinet submission was a tortuous process. Mr Collins was obliged to consult with representatives of the office of the Department of Premier and Cabinet, Treasury and the Minister's office. By the time the Cabinet submission was drafted the communicated policy therein was that the hospital reports were no longer to be released publicly. Rather, there was to be⁵⁷² confidential distribution of each hospital report to the relevant District Manager and Zonal Manager.

6.551 When asked about when the original promulgated policy about hospital report disclosure (canvassed above) altered, Mr Collins could only say that this alteration occurred 'at some point between the presentation of the Minister and the Director-General and the actual Cabinet submission being finalised' and that 'more than likely' the change occurred at the behest of someone either within the office of the Premier, Cabinet or Treasury because they had 'the most input'.⁵⁷³

6.552 The influence of these other persons or bodies upon the content of the Cabinet submission is underscored by the email exchange between Mr Collins and Mr Smith, Queensland Health's Manager of Parliamentary and Ministerial Services,⁵⁷⁴ who was liaising with Cabinet on behalf of Queensland Health. When speaking of suggestions raised by officers of the Department of Premier and Cabinet Mr Smith observed:⁵⁷⁵

Please incorporate the issues raised This helps ensure that the Premier is happy when the matter is considered in Cabinet in relation to the concerns about retention rates, etc. ...

6.553 On 11 November 2002, Mr Collins received an email from Mr Smith indicating Cabinet's approach to the disposition of the Measured Quality Service reports⁵⁷⁶:

Cabinet will be approving a public release of the report 'Qld hospitals and the 21st century', accordingly the report will be a public document and the copies distributed will have no security attached to them.

The 60 individual hospital reports on the other hand should remain confidential and to help maintain any protection afforded by the FOI document to Cabinet material, any distribution of these reports to District Managers etc should be on a confidential/restricted basis.

6.554 On 12 November 2002, there was distributed, to each of Mr Collins, Director-General Stable, General Manager Health Services Buckland and Dr Cuffe, an

⁵⁷¹ Exhibit 377 attachment 'JEC9'

⁵⁷² Exhibit 377 attachment 'JEC9A' para 16 of submission

⁵⁷³ T5921 lines 10 to 30

⁵⁷⁴ T5949 line 40

⁵⁷⁵ Exhibit 378 attachment 'JEC35'

⁵⁷⁶ Exhibit 378 attachment 'JEC38'

email from Mr Smith communicating Cabinet's view of what was required of the Measured Quality Service in respect of the hospital reports and public reports⁵⁷⁷:

Further to my conversation with you on Monday, 12 November 2002, additional advice has been received from the Department of the Premier and Cabinet that the Premier has given the following directive this morning to the Director-General, Department of the Premier and Cabinet in relation to this matter,

neither the proposed public report which was attached to the Cabinet Submission nor any of the 60 individual Hospital Reports are to be distributed to *anyone*;

Senior Management can be briefed on the outcomes of the quality measurements and the contents of the documents, but they are *not* to be given copies of any of this material.

The Department of the Premier and Cabinet advised that the Premier has emphasised that Cabinet does not want this material released or circulated in any way....

- 6.555 Mr Collins gave evidence that this directive caused considerable delay and difficulty in the implementation of the Measured Quality Service process.⁵⁷⁸ It delayed publication of the public report. Most relevantly, it made it extremely difficult if not impossible to enable clinicians to discuss the hospital reports freely, or even to obtain access to them. I canvass that in more detail below, in particular by reference to the ministerial briefing of 10 March 2003, when dealing with former Minister Edmond.
- 6.556 Notwithstanding his explanation of these difficulties, Mr Collins was directed by Minister Edmond to submit the phase 2 reports (further hospital reports) to Cabinet. That occurred on 10 June 2003.⁵⁷⁹ The Cabinet submission,⁵⁸⁰ like that of 11 November 2002, was for the 'information' of Cabinet and had as attachments a vast wad of public and hospital material.
- 6.557 The result was the same secrecy and concealment as had occurred with the waiting list information canvassed above.
- 6.558 The Measured Quality Service process, fortunately, survived. I find that that was largely due to the involvement of Dr John Scott in his role as General Manager Health Service, in 2004.⁵⁸¹ Whilst I deal with Dr Scott elsewhere in this report concerning Dr Aroney and the North Griblin report, I think it remains correct to say that the termination of Dr Scott's employment by the present Beattie Government was a considerable loss to Queensland Health.

⁵⁷⁷ Exhibit 340

⁵⁷⁸ Exhibit 378, attachment 34; T5942, 5943; T6542 lines 1-10 (Cuffe)

⁵⁷⁹ Exhibit 377, attachment 'JEC15'

⁵⁸⁰ Exhibit 377, attachment 'JEC15'

⁵⁸¹ Exhibit 377 para 37; Exhibit 377; T5247, 5248; T5946 line 30

Conclusions with respect to Cabinet

6.559 The conduct of Cabinet, in successive governments, in the above respect, was inexcusable and an abuse of the *Freedom of Information Act*. It involved a blatant exercise of secreting information from public gaze for no reason other than that the disclosure of the information might be embarrassing to Government. In the case of the Measured Quality Service policy, Cabinet's decision was undertaken in the teeth of a contrary view expressed by Queensland Health and, had any one outside the ranks of Queensland Health bothered to enquire, contemporaneous literature.

6.560 On 28 September 2005⁵⁸² I gave an intimation in respect of findings in relation to elective surgery waiting lists and Measured Quality Service reports. On that occasion I indicated in open hearing the following:

I have given this intimation at this stage to give to any person the opportunity to consider whether to give or tender further evidence upon either of these issues and to permit that consideration to be given before the close of evidence which will possibility occur at the end of next week.

6.561 Apart from the submissions received from relevant participating parties, namely former Minister Nuttall and former Minister Edmond, no politician (past or present) took up this opportunity.

6.562 I received a letter from Premier Beattie on 30 September 2005.⁵⁸³ That spoke prospectively of the current Government's intentions in respect to waiting lists and Measured Quality reports. It said:

I am prepared to act to continue my Government's record of openness and accountability. Therefore, my Government now commits to legislating to ensure that all relevant data about waiting lists and all Measured Quality Reports about individual hospitals will be reported in an annual State of Health Report. That information will be available to be accessed by all Queenslanders.

6.563 The opening sentence of this extract is inconsistent with the facts as I have related them pertaining to elective surgery waiting lists and Measured Quality hospital reports.

Findings against Cabinet

6.564 I make the following findings with respect to elective surgery waiting lists:

- (a) In 1997 and 1998, Cabinet under a Coalition Government decided not to disclose to the public statistics which showed the number of persons on elective surgery waiting lists.
- (b) That decision was contrary to the public interest.

⁵⁸² T6088-6090

⁵⁸³ Exhibit 388

- (c) In 1998 and thereafter until 2005, Cabinet under an Australian Labor Party Government decided to disclose to the public the surgery lists but not the anterior lists and only that disclosure was made.
- (d) To disclose the surgery lists but not the anterior lists was misleading and was contrary to the public interest.

6.565 With respect to Measured Quality Reports I make the following findings:

- (a) These were of two kinds: the first, the public reports, were reports intended for publication to the public about the performance of Queensland hospitals. The second, the hospital reports, which were reports specific to each of the hospitals which were part of the measured quality program, were intended by Queensland Health for publication only to managers and clinicians at those hospitals.
- (b) In late 2002, Cabinet under an Australian Labor Party Government decided to limit publication of the hospital reports to an extent which was contrary to the public interest.
- (c) That decision was made contrary to the advice of officers of Queensland Health.

6.566 Any findings which I make below against current and former employees of Queensland Health, with respect to secrecy and concealment, must be seen in the light of what I have said and found above in this section of this Chapter of my report.

Former Minister Edmond

6.567 The Honourable Wendy Edmond was a member of successive Labor Governments from 1998. She was Minister for Health from June 1998 to February 2004. She retired from Parliament in early 2004.

6.568 In the case of Ms Edmond, there are two matters which I ought to canvass in the context of concealment as I introduced above in this portion of this Chapter. The first is elective surgery waiting lists. The second is the Measured Quality Service issue. Each of these matters I have treated in the preceding section concerning Cabinet.

6.569 A submission is made on behalf of Ms Edmond to the effect that treatment of these matters is outside my terms of reference. I disagree. Ms Edmond, when Minister, was at the pinnacle of leadership of Queensland Health. She undertook a stewardship role in respect of policy and conduct of staff at hospital level in their adoption of clinical practices and procedures. If the conduct of any member of staff of Queensland Health is to be the focus of criticism, then it must be considered in the light of the policy adopted by, and statements made by those in senior leadership positions, including Minister Edmond. It is therefore necessary to make findings about the conduct of Ms Edmond.

Waiting lists

6.570 I deal first with waiting lists. In this regard I adopt what appears in the preceding section of this chapter concerning Cabinet and those lists.

6.571 Ms Edmond's written statement⁵⁸⁴ deals with the issue of waiting lists. Upon assuming office, to her great credit, she immediately caused the publication of the elective surgery waiting lists. However she did not, then or at any time during her approximately six year stewardship as Minister, cause publication of the anterior lists. There can be no doubt, from her early press releases about the issue,⁵⁸⁵ that Minister Edmond knew of the anterior lists and, importantly, by making press releases, was publicly acknowledging her and the Government's knowledge of and intention to deal with them.

6.572 In her 30 July 1998 press release⁵⁸⁶ Minister Edmond expressed:

'However, Ms Edmond said her major concern was that the figures did not represent the whole picture.

'I believe there is an untold story out there about patients who have been given appointments to see out-patient specialists and therefore can't get on a waiting list ...', she said

'I have asked Queensland Health for standardised and improved procedures on this issue and on the collection of data.

'I expect a flurry of appointments and, as a result, the next quarterly elective surgery report may show some politically unattractive jumps in waiting times.

'I am prepared to wear this in the interests of honesty, openness and a better public health service.'

6.573 Apparently there was an investigation conducted within Queensland Health, at the request of Minister Edmond, between 30 July and 16 October 1998 because, on the latter date, a further press release was issued⁵⁸⁷ which contained the following:

'Health Minister Wendy Edmond's investigation into hospital waiting lists has revealed a massive 'unofficial' list of would-be patients who haven't even made the official list.

Ms Edmond said the investigation confirmed her long-held fears but represented a major step towards tackling the issue.

...Ms Edmond said in July that she was concerned about the untold story of the waiting list to get an appointment.

...Ms Edmond said Queensland Health had made some progress on her instruction to develop standardised and improved procedures for allocating appointments and collecting information.

'The downside is that I now know that the waiting list to get into the waiting list for surgery is almost as long as the waiting list for surgery', she said.

⁵⁸⁴ Exhibit 302

⁵⁸⁵ Exhibit 303; Exhibit 302 sole attachment

⁵⁸⁶ Exhibit 303

⁵⁸⁷ Exhibit 302; sole attachment

The upside is that we can now tackle the problem systematically.

Ms Edmond said Queensland Health was collecting appointment waiting list data manually because no computer systems currently were doing this....'

- 6.574 Just over 12 months later, on 11 November 1999,⁵⁸⁸ Minister Edmond issued a press release in response to Opposition criticism of waiting list data:-

Health Minister Wendy Edmond said today that the Opposition's campaign to discredit the waiting list data was desperate and dishonest.

...'There has been no manipulation of waiting list figures. Waiting list data is available to all. The level of transparency is unprecedented.

'The Opposition collected the same data in exactly the same way, the only difference is this Government publishes the data openly and honestly as part of its elective surgery strategy and as part of its commitment to open an accountable Government.

'The pathetic attempts of the Opposition to claim that specialist out-patient appointment waiting times would provide the 'real picture' of elective surgery waiting times shows a complete misunderstanding of the hospital system.

'People waiting for specialist out-patient appointments do not necessarily need surgery.

'Elective surgery coordinators from Queensland Health have developed processes to ensure that once a surgeon completes a surgery booking form for a patient, that patient's name is immediately placed on the Elective Surgery Waiting List.

That is the 'real picture', that is the truth.

'All hospitals have processes in place to ensure that there are no 'hidden' waiting lists at any stage of the process at any facility across the state', Ms Edmond said.

- 6.575 I am left in no doubt that this press release was misleading and, particularly in light of the press releases of approximately a year earlier, which are extracted above, knowingly so on the part of Minister Edmond. Earlier she referred to her investigation revealing a 'waiting list for the waiting list' but, in the last mentioned press release, she told the people of Queensland who might read the press release in the media, and staff, that the data has been published 'openly and honestly', 'waiting list data is available to all' and that 'there are no 'hidden' waiting lists at any stage of the process at any facility across the State.
- 6.576 This was clearly a significant issue for Minister Edmond. The publication of the surgery list, she clearly thought, was a major achievement of her Government. Having accurately identified the anterior list in October 1998, just over a year later she knowingly misrepresented that the published surgery list comprised all of the 'waiting list data'.
- 6.577 Ms Edmond's approach to the matter did not improve with the passage of time after the abovementioned press release of Remembrance Day 1999. From

⁵⁸⁸ Exhibit 304

September 1998 to January 2003 the Minister received monthly reports which dealt with, among other things, the (growing) anterior lists.⁵⁸⁹ It must also have been plain from those documents, as was the fact, that Queensland Health was encountering real difficulty in developing an electronic data base to marshall that anterior list data. Yet press releases were issued from 2000 to 2003 in her name, and one infers with her approval, speaking of the improving surgery lists without hint of a mention of the anterior lists or their growing size.⁵⁹⁰

6.578 As to the marshalling of this anterior list information, I accept that the Surgical Access Team was concerned about the reliability of the information about the anterior lists. Mr Walker of that Team was of the view that he had difficulty with the notion that the anterior list data ought be released, and that if it was to be released he 'would put a rider on it that we need to actually make sure that the data was actually accurate'.⁵⁹¹ Mr Walker also indicated that a lack of funding was stymieing the improvement of this data collection.

6.579 I reject the submission, that to publish the surgery waiting lists, without the anterior lists, was not a misleading course. Whilst general practitioners may have some ability to obtain some information about these matters, such general practitioners and the public, making decisions about personal health funding, ought at least have had the benefit of periodical (say quarterly) information about the state of anterior lists. For Minister Edmond to make statements, as she did, from 1999, which had the effect of misrepresenting the existence, nature and extent of anterior lists, was to mislead and, in my view, was against the public interest.

6.580 Moreover, it set a very poor example for Queensland Health staff in relation to the openness with which they should deal with matters which might be embarrassing to the Government or Queensland Health.

Measured quality reports

6.581 By mid 2003 Minister Edmond had five years experience in her portfolio. There could be no doubt that she knew of the provisions of the *Freedom of Information Act* 1992.

6.582 On 13 August 2002, Mr Justin Collins (to whom I referred earlier) and other Measured Quality Service staff made a presentation⁵⁹² to the Minister and the Director-General in relation to the Measured Quality process.⁵⁹³ One of the matters identified at the presentation (dealt with under a heading 'Communication Objectives', in one of the presentation documents) was

⁵⁸⁹ Exhibit 311

⁵⁹⁰ Exhibit 305

⁵⁹¹ T6181 to T6183

⁵⁹² T5916

⁵⁹³ Exhibit 377, attachment 'JEC8'; Exhibit 378, attachment 'JEC30'

Queensland Health's policy of 'delivering on its commitment to be open and transparent'. Another issue identified was about the likelihood, in relation to hospital reports, that 'journalists will request individual facility reports on local hospitals once they are aware of their existence' and that 'a decision needs to be made on whether access would be granted administratively or only through a Freedom of Information request'.

- 6.583 Mr Collins said that what he was identifying (and this would have been plain to any listener) was whether, in pursuit of Queensland Health policy developed to that point in relation to the Measured Quality process, an individual hospital report ought be the subject of provision by the District Manager of the Hospital upon request, or if not then provision to an applicant under a Freedom of Information application.
- 6.584 Mr Collins said it was Minister Edmond who raised the proposal to take the Measured Quality reports to Cabinet.⁵⁹⁴
- 6.585 Mr Collins sent an email to a former Queensland Health associate, Mr Filby, after the 13 August presentation, namely on 28 August 2002.⁵⁹⁵ Therein one sees a contemporaneous recollection by Mr Collins to the effect that a person or persons in attendance at the presentation expressed that he, she or they were 'very concerned about the media consequences' of the process and that 'as a result it has been decided that the reports should go to Cabinet'.
- 6.586 I accept that Minister Edmond, in part, was motivated to take the Measured Quality process documents to Cabinet with a view to properly informing Cabinet as to those matters. However, in my view, the clear import of the above evidence, and Minister Edmond's experience at that point, meant that she knew, and intended, that in doing so the Freedom of Information Cabinet exemption would be triggered. Nothing seems to have been done by her to address any disadvantages of that course.
- 6.587 Following the directive from Cabinet of 12 November 2002⁵⁹⁶ referred to in the last section of this Chapter, a dissemination strategy was developed within the Measured Quality Service. On 10 March 2003, from within Minister Edmond's office, a request was made for a briefing for the Minister as to the Measured Quality Phase 1 and Phase 2 Hospital reports. That briefing was drafted by Mr Collins.⁵⁹⁷ It described the dissemination strategy development, which essentially involved restricted dissemination to the District Manager, with elimination of all options for printing and distribution, and with documents marked 'Cabinet in Confidence'.

⁵⁹⁴ T5917 line 10

⁵⁹⁵ Exhibit 378, attachment 'JEC31'

⁵⁹⁶ Exhibit 340

⁵⁹⁷ Exhibit 377, attachment 'JEC13'

6.588 The briefing went on to recite, under a heading 'KEY ISSUES', the following:

Due to the restricted distribution of the Measured Quality Hospital reports (District Managers Only), difficulty may be encountered in the dissemination of the results within the Hospital environment. This may impact on the usefulness of the Hospital reports and limit the engagement of clinicians and managers to whom change is to be delivered.

The Phase 1 Hospital reports and Public report were considered by Cabinet on 11 November 2002. It is recommended that the Phase 2 Hospital reports also be considered by Cabinet, as an information submission, to afford it the same consideration for FOI exemption.

6.589 The evidence of Mr Collins was that, in the drafting the document, the second paragraph extracted above was added at the suggestion of Dr Cuffe.⁵⁹⁸ That followed what had transpired from the previous presentation and the eventual submission to Cabinet of the Phase one reports, together with the Cabinet directive extracted in the last section.

6.590 This, in my view, shows the understandable response of Mr Collins and Dr Cuffe to the directive which came from Cabinet and the Ministers, on 12 November 2002, that the hospital reports should be concealed. Employees of Queensland Health, in response, were likely to remind their political masters that Freedom of Information exemption and like practices for concealing documents ought be routinely adopted. Concealment practices of this kind, encouraged by politicians, filtered down to Queensland Health staff and, through them, to administrators in public hospitals.

6.591 Minister Edmond, reading this 10 March briefing at the time, could have been under no illusion, from the first of the paragraphs last extracted above, that Measured Quality Service staff were of the view that, due to the restricted distribution, difficulty would be encountered with the dissemination of the results in the hospital environment, detracting from the usefulness of the report and limiting discussion with and among clinicians.

6.592 In submissions on behalf of Ms Edmond it was contended that the use of the linguistic 'may' in this paragraph represented a softening of the likely impact which ought not have given concern to Minister Edmond. I do not accept that. An experienced Minister (as Minister Edmond was), having sought such a briefing, ought to have immediately seen that the Measured Quality process was being diminished by the restrictions on distribution, and attempted to ameliorate that outcome. Staff within Queensland Health, having made this 'cry for help' in relation to the Measured Quality process, it is plain, were ignored.

6.593 To the credit of Mr Collins, and his fellow staff, the identification of the difficulties presented by the dissemination strategy, particularly in the process caused by the implementation strategy, were the subject of reiteration. Mr Collins made a

⁵⁹⁸ T5934 line 50

further presentation to Minister Edmond and the Director-General, Dr Stable, on 6 May 2003.⁵⁹⁹ He made his presentation from notes in the form of a powerpoint display, which he exhibited to the first of his statements.⁶⁰⁰ From those he was able to say⁶⁰¹ he canvassed the following matters with those present at the presentation:

- In utilising the hospital reports, to obtain the serious attention of clinicians and managers without physically distributing the reports the Measured Quality Service personnel would need to undertake a presentation of approximately two hours.
- To ensure the security of the reports but to still engage clinicians and managers there had to be addressed the uncontrollable nature of the hard copy report.
- Negativity had been expressed, in the interviews undertaken thus far, about the restriction of distribution as staff had shown a great eagerness to discuss ways to improve or identify reasons for good performance.
- Importantly, hospital clinicians were reacting negatively to responding to Mr Collins because they couldn't see the individual hospital report and such clinicians were not satisfied with a response from Mr Collins to the effect that the reason that was done was because Queensland Health wanted to avoid misinterpretation.

6.594 Notwithstanding these matters, no instruction came from any person present to alter the dissemination strategy.⁶⁰² To the contrary, on 10 June 2003 the Phase two Hospital reports and Public Reports were submitted to Cabinet, as an information submission.⁶⁰³

6.595 In the Cabinet submission, which went under the hand of Minister Edmond, the sensitive nature of the hospital reports is identified, and the dissemination strategy outlined, but none of the abovementioned concerns about the disadvantages of that dissemination strategy upon the Measured Quality process is identified. The issue of necessary engagement of clinicians is identified⁶⁰⁴ but unembroidered by the negativity being experienced by Mr Collins in the field.

6.596 Minister Edmond would have known of the impact of the Freedom of Information exemption obtained by taking the Phase two Hospital reports to Cabinet. Indeed, in my view, the Phase two reports were taken to Cabinet for that purpose because that was part of the dissemination strategy developed

⁵⁹⁹ T5940

⁶⁰⁰ Exhibit 377, attachment 'JEC14'

⁶⁰¹ T5942-5944

⁶⁰² T5944 line 10

⁶⁰³ Exhibit 377, attachment 'JEC15'

⁶⁰⁴ Exhibit 377, attachment 'JEC15', paras 14 to 18 of 'Body of Submission'

following restriction imposed by Cabinet on 12 November 2002 (eg, documents marked 'Cabinet-in-confidence').

- 6.597 In my view this conduct was contrary to the public interest. Again, it was only due to the endeavours of Mr Collins and Dr John Scott, in 2004, that the measured quality process managed to survive in an effective way.

Findings against former Minister Edmond

- 6.598 It may be accepted that Minister Edmond was acting under the usual political constraints associated with Government. Nevertheless, the response of Minister Edmond to those matters constituted, at the very least, a poor example to staff of Queensland Health with respect to concealment of facts in dealing with matters at all levels, and principally at the level of hospitals.

- 6.599 I make the following findings in respect of the conduct of Minister Edmond:

- (a) During the period 19 June 1998 to February 2004 when the surgery lists were published at Ms Edmond's behest as Minister, Ms Edmond took no steps to publish the anterior lists, the outcome being misleading and not reflecting the true nature of surgical waiting time in Queensland public hospitals.
- (b) Ms Edmond's press release of 11 November 1999 headed 'Health Minister says Opposition campaign to discredit the waiting lists data is desperate and dishonest, in light of the previous press release of 3 July 1998 entitled 'Health Minister lifts the lid on waiting lists' and a further previous press release of 16 October 1998 entitled 'Labor Plan reveals hidden waiting lists' was misleading in not reflecting the true nature of surgical waiting time in Queensland Public Hospitals.
- (c) With respect to the Measured Quality Program developed by Queensland Health directed to improvement of patient safety and medical standards, following a presentation by Mr Justin Collins of Queensland Health on 13 August 2002, in which Minister Edmond was informed that use and dissemination of hospital reports was proposed to be left to District Managers, Ms Edmond directed that the measured quality program hospital reports be taken to Cabinet for noting;
- (d) Further, with respect to the Measured Quality program, following a ministerial briefing to Ms Edmond dated 10 March 2003, and a presentation to Ms Edmond by Mr Collins on 10 May 2003, in each of which Ms Edmond was informed of the deleterious effect which the Cabinet restriction of 12 November 2002 had on the use of the measured quality hospital reports, Ms Edmond directed the phase two reports be taken to Cabinet for noting and failed to include the aforesaid deleterious effect in the Cabinet Submission;

- (e) As a result of the directions or decisions in (c) and (d) above, Ms Edmond knew or believed that the Measured Quality Reports would not or may not be available to the public, and further that access by hospital staff thereto would be delayed, and use thereof restricted in a manner deleterious to the effective implementation of the policy;
- (f) The directions or decisions in each of paragraph (c) and (d) above and the outcome in paragraph (e) above, were contrary to the public interest.

Former Health Minister Nuttall MP

6.600 The Honourable Gordon Nuttall MP was Minister for Health in the Government from February 2004 to July 2005. The only matter I need canvass in this section concerning Minister Nuttall are those about his emerging knowledge of Dr Patel and the investigation of his conduct at Bundaberg Hospital. I have already canvassed these matters, in part, in Chapter Three.

6.601 On 22 March 2005, the Member for Burnett, Mr Messenger MP, raised issues about the clinical practices and procedures of Dr Patel at Bundaberg Hospital. This led to Minister Nuttall requesting a briefing from Dr FitzGerald, the Chief Health Officer for Queensland Health. Dr FitzGerald sent the Senior Departmental Liaison Officer in Minister Nuttall's office an email at 1.25pm, attaching a suggested response to Parliamentary questions,⁶⁰⁵ which included the following:

The significant issue regarding the competency of Dr Patel appears to relate to his preparedness to take on cases which are beyond the capacity of the Bundaberg Hospital and possibly beyond his personal capacity. There is no evidence that his general surgical skills are inappropriate or incompetent.

However, the fact that he has taken on those cases may reflect significantly poor judgment to a level which may be grounds for disciplinary action by the Medical Board. Thus, the Chief Health Officer has recommended that this matter be referred to the Medical Board for attention.

6.602 It seems that, later in the day, Dr FitzGerald met with the Minister and informed him, in substance, that:⁶⁰⁶

- Dr FitzGerald had conducted an investigation concerning allegations about Dr Patel.
- Such report of the investigation was near completion and would be finalised in the near future because he was awaiting benchmarking data from similar hospitals.
- Dr Patel had performed surgery outside his scope of practice.
- Dr FitzGerald had advised Bundaberg Hospital that Dr Patel was to cease performing surgery outside his scope of practice.

⁶⁰⁵ Exhibit 391

⁶⁰⁶ Exhibit 319 para 27; T5311.30-5312.12; T6134

- 6.603 Dr FitzGerald in fact finalised and produced his audit report on 24 March 2005. I accept the evidence of Mr Nuttall that a copy of that report was not given or shown to him (by any person, even his ministerial staff if they had received it) until some time after 9 April 2005. On this lastmentioned date Minister Nuttall appointed a full inquiry in respect of Bundaberg Hospital and in particular Dr Patel.
- 6.604 Minister Nuttall attended Bundaberg Hospital with Dr Buckland on 7 April 2005. He travelled there by plane via Springsure where he opened a Queensland Health facility. On arriving in Bundaberg, he participated with Dr Buckland in a meeting of staff.
- 6.605 The evidence is unclear as to precisely what Minister Nuttall and Dr Buckland discussed about Bundaberg Hospital issues, on or shortly prior to 7 April between themselves, or with others, prior to commencement of the staff meeting. But I accept that the existence of, and thereby content of, Dr FitzGerald's audit report of 24 March 2005 was not discussed.
- 6.606 I infer there must have been some discussion about the Patel issue because of what was said by Minister Nuttall to the Bundaberg meeting.
- 6.607 I find Minister Nuttall's recollection of the events of the meeting to be quite vague. That is perhaps understandable for a busy minister.
- 6.608 Evidence was given from witnesses Margaret Mears, and Karen Jenner Doherty⁶⁰⁷ of what was said by Minister Nuttall, and also Dr Buckland at the meeting. I have set out in Chapter three some pertinent parts of their recollections of the meeting and I accept that evidence.
- 6.609 An example of conflict between the evidence of these witnesses and Minister Nuttall is of what Ms Mears attributed to Minister Nuttall concerning Mr Messenger:⁶⁰⁸
- During the meeting, Mr Nuttall said that the only way we could stop the rubbish that was going on at Bundaberg Base and in Bundaberg was if we were to vote Mr Messenger out.
- 6.610 Mr Nuttall vehemently denied making such a statement.⁶⁰⁹ I do not accept his evidence in this respect.
- 6.611 Minister Nuttall also informed the meeting that the report contained (or more properly, given his state of knowledge, would contain) confidential patient information. That was untrue. It may be that Minister Nuttall was informed of this by Dr Buckland or a member of his staff. If that is so, I consider it was

⁶⁰⁷ Exhibits 507, 508 and 509, T7374-7404

⁶⁰⁸ T7375 line 35

⁶⁰⁹ T5321 line 40

reasonable for Minister Nuttall, given his state of knowledge, to accept and say that.

6.612 I accept that Minister Nuttall told the meeting that Dr FitzGerald's report was incomplete, and that was his true belief. That was also untrue. It is quite unacceptable, however, that he would not have taken the trouble to make a specific enquiry of Dr FitzGerald or Dr Buckland as to whether, in truth, it had been completed or what lead time was involved in such completion.

6.613 It will be remembered, in this regard, that Minister Nuttall had been told on 22 March, 15 days earlier, that the report was near completion. In expressing his belief as to report non-completion, Minister Nuttall was not corrected, either publicly or privately, by Dr Buckland. I return to this issue below when dealing with Dr Buckland.

6.614 Minister Nuttall also informed the meeting that Dr Patel could not give his version of events to the Chief Health Officer and thereby Dr Patel could not be afforded natural justice. In speaking of matters canvassed at the meeting Minister Nuttall said:⁶¹⁰

I indicated to them that the report wouldn't be able to be released because Dr Patel wouldn't have a chance to respond to the report.

6.615 Minister Nuttall said that what was in his mind was that the audit report was a type of document which ordinarily would not be released, being a clinical audit.⁶¹¹ But that, in my view, was not what was communicated by Minister Nuttall at the meeting (nor by Dr Buckland).

6.616 From what was said by Dr Buckland at the meeting there could have been no doubt in Minister Nuttall's mind that Dr Patel had by then left Australia, probably never to return and most likely unco-operative at a distance.

6.617 Minister Nuttall's choice of language at the meeting was poor. I find it reprehensible that he was prepared to say at the meeting, in effect, that Dr FitzGerald report would remain incomplete because Dr Patel would not have a chance to put his side of the story. If that is what he was told by Dr Buckland, or his staff, then he was at best naive and at worst disingenuous in his asserted acceptance of that advice. To a politician of Minister Nuttall's obvious experience, any such advice would obviously be nonsense.

6.618 Minister Nuttall commissioned a wide ranging review on 9 April 2005. He did so on the advice of Dr Buckland. Minister Nuttall's evidence was to the effect that it was not until some days after 9 April that he came to know of reports of Dr Patel's adverse clinical history in the United States. Dr Buckland says that he

⁶¹⁰ T5319 line 55

⁶¹¹ T5319 line 50

informed Minister Nuttall to this effect on 8 April. I accept Dr Buckland's evidence in this respect.

- 6.619 The statements made by Minister Nuttall at the meeting show a disposition to conceal adverse information. Concealment of Dr FitzGerald's report was not in the public interest.

Findings against former Health Minister Nuttall

- 6.620 My findings in respect of Mr Nuttall are:

- (a) In circumstances where Mr Nuttall had no knowledge, nor made any inquiry whether Dr FitzGerald's investigation or report was complete or could be completed, and Mr Nuttall had not read any report by him in complete or incomplete form, Mr Nuttall attended a meeting at the Bundaberg Base Hospital on 7 April 2005 during which Mr Nuttall advised hospital staff present that:
 - (i) The report being prepared by the Chief Health Officer was incomplete, when Mr Nuttall had made no enquiry as to whether this was true;
 - (ii) Dr Patel had not given his version of events to the Chief Health Officer and, therefore, had not been afforded natural justice; the report, therefore, could not be completed or publicised in incomplete or completed form.
- (b) Such conduct was misleading, unreasonable and careless.

Dr Buckland

- 6.621 There are a number of matters to be canvassed with respect to Dr Buckland:-

- The events on or about and following 24 March 2003 with respect to Dr Patel.
- The meeting in Bundaberg attended by Dr Buckland, with Minister Nuttall, on 7 April 2005.
- The events concerning Mr Berg at Townsville Hospital in 2002.
- The events concerning the North-Giblin report in or about May 2005.
- Earlier events in 2003 concerning an alleged instruction to destroy Queensland Health documents.

- 6.622 As I have already canvassed the North-Giblin report and Berg issues in Chapters Four and Five respectively, I do not propose to repeat those here. I dealt with the 7 April 2005 meeting issues in Chapter Three and earlier in this Part. I need to expand upon that.

Dr Buckland's background

- 6.623 Dr Steve Buckland is a very experienced medical bureaucrat.⁶¹² He has a medical background, graduating from the University of Queensland with a Bachelor of Medicine and a Bachelor of Surgery in 1976. He was registered as a medical practitioner in 1977. He became a Fellow of the Australian College of Occupational Medicine (now the Australasian Faculty of Occupational Medicine of the Royal Australian College of Physicians) in 1985. He obtained specialist registration in the specialty of occupational medicine in 1991.
- 6.624 Dr Buckland obtained a Masters Degree in Health Administration from the University of New South Wales in 1990. He became an Associate Fellow of the College of Health Service Executives in 1990. He became a Member of the Royal Australian College of Medical Administrators in 1999.
- 6.625 Dr Buckland worked⁶¹³ as a medical professional from 1977 until 1999. He was Medical Superintendent of Redcliffe Hospital from December 1989 and District Manager and Medical Superintendent in the Redcliffe-Caboolture Health Service District from 1996.
- 6.626 From August 1999 to July 2002 Dr Buckland was Queensland Health's Southern Zone Manager. From 29 July 2002 to 1 November 2003 he was General Manager Health Services (having acted in that capacity at various times previously). He was Acting Director-General of Queensland Health from 1 November 2003 to 29 April 2004, being appointed permanently to that position on the latter date. He remained in that position until 26 July 2005 upon which date his employment was terminated by the Queensland Government.
- 6.627 From the above recitation of background, and the evidence given by Dr Buckland, it is clear that he is a man of experience and intelligence. He was also far from naïve in matters of medical administration. These comments, however, prove a double-edged sword for Dr Buckland in an endeavour to explain away his conduct by reason of, for example, deference to Minister Nuttall or delegation of responsibility to Chief Health Officer Dr FitzGerald.

Dr Patel

- 6.628 It is convenient to deal first with issues pertaining to Dr Patel. It was on 22 March 2005 that Dr Buckland was first informed of Dr Patel, together with the fact that Dr FitzGerald had been undertaking an investigation into general surgery services at the Bundaberg Hospital.⁶¹⁴ On that day Dr Buckland received an oral briefing from Dr FitzGerald. He was aware that Dr FitzGerald had briefed the Minister orally and in writing the same day. When briefing Dr

⁶¹² Exhibit 335 para 5

⁶¹³ Exhibit 335 para 6

⁶¹⁴ Exhibit 335 para 17

Buckland on 22 March, Dr FitzGerald did not advise Dr Buckland to suspend Dr Patel or to take any action against him, at least at that point.⁶¹⁵

- 6.629 Dr FitzGerald completed his audit report on 24 March 2005 and on that day supplied a copy to Dr Buckland.⁶¹⁶ The same day Dr FitzGerald provided to Dr Buckland what was in effect a covering memorandum to the audit report.⁶¹⁷ He also met with Dr Buckland.
- 6.630 The effect of the evidence of Dr Buckland was that by the conclusion of the briefing of 24 March 2005, he considered that no immediate action was required with respect to Dr Patel,⁶¹⁸ and there was no advice by Dr FitzGerald that any such action was required.⁶¹⁹ Dr Buckland said that he was not informed nor had any sense that there was any major issue with respect to Dr Patel's competence and was satisfied that the matter was being dealt with (adequately) by referral of Dr Patel to the Medical Board of Queensland.⁶²⁰
- 6.631 Dr FitzGerald had advised Dr Buckland that action had been taken to limit the scope of the surgery being performed by Dr Patel and to ensure that critically ill patients were being referred to higher level hospitals.
- 6.632 Dr Buckland gave evidence that Dr FitzGerald informed him, on 24 March 2005, that 'Dr Patel was fundamentally an average surgeon ... he's not as good as some but he's not as bad as others'.⁶²¹
- 6.633 Dr Buckland agreed with Mr Douglas SC, Counsel Assisting the Commission of Inquiry, that the reference of Dr Patel to the Medical Board of Queensland might entail investigation which could take 'possibly months' and that Dr Patel might continue to work at Bundaberg Hospital in the meantime.⁶²² Further, he knew that it was within his power to suspend Dr Patel forthwith from providing clinical (but not other) services at Bundaberg Hospital, and on full pay.⁶²³
- 6.634 Mr Douglas asked this of Dr Buckland in respect of his stewardship of surgeons within Queensland Health as Director-General:⁶²⁴

I am seeking to elicit from you...in the conduct of Queensland Health during your time as Director-General, how bad a surgeon has he to be, working within Queensland Health in order to move the Director-General to cross the Rubicon and suspend that person?-- I would have to be concerned to the point where I felt that the individual was dangerous, that patients were dying unnecessarily, or that there was some other major event in terms of a surgeon's either mental or surgical capacity.

⁶¹⁵ T6138

⁶¹⁶ Exhibit 230

⁶¹⁷ Exhibit 335 attachment SMB3

⁶¹⁸ T5490

⁶¹⁹ T5490 line 10

⁶²⁰ Exhibit 335 paras 20, 22 and 24

⁶²¹ T5489 line 15

⁶²² T5496 line 35

⁶²³ T5496 line 25

⁶²⁴ T5497 lines 40-55

COMMISSIONER: You would have to have proof that they were dying or being injured, would you?—Commissioner, you would need to have significantly more evidence than I had available to me at that time.

6.635 The audit report,⁶²⁵ even though (as I have discussed in Chapter Three and further below) it is more muted in its terms than properly reflects the facts, remains a disturbing document. Although it did not specifically refer to Dr Patel, in the mind of Dr Buckland, it was clearly referable, principally, to the conduct of Dr Patel. I refer to the 'summary' of the document. The judgment of Dr Patel was clearly placed in question. Moreover, reference is made to what appears to be a disturbingly high complication rate in respect of standard procedures (28 times the national average for one common procedure) in Dr Patel's surgical sphere.

6.636 To the extent that the audit report may have been, to some extent muted, the accompanying memorandum certainly was not.⁶²⁶ It is addressed to Dr Buckland from Dr FitzGerald and the subject matter was 'Clinical Audit – General Surgical Services at Bundaberg Hospital'. The document is dated 24 March 2005. The document provides:

In February this year I was asked to undertake a clinical audit of general surgical services at Bundaberg Hospital. As you are aware, the events which triggered this audit have now been the subject of questions in Parliament.

The report of the clinical audit is now complete and I have attached a copy of this memorandum. There are issues which I need to bring to your attention. There is evidence that the Director of Surgery at Bundaberg Hospital has a significantly higher surgical complication rate than the peer group rate (Appendix 1). In addition, he appears to have undertaken types of surgery which, in my view, are beyond the capability of Bundaberg Hospital and possibly beyond his own skills and experience, although his surgical competence has not been examined in detail. I believe his judgement, both in undertaking these procedures and also delaying the transfer of patients to a higher level facility, is below that which is expected by Queensland Health. I would recommend that these matters should be examined by the Medical Board and have written to the Executive Officer – Mr Jim O'Dempsey, bringing the matter to his attention.

The audit report also identifies that there has been a failure of systems at the hospital which has led to a delay in the resolution of these matters. The credentials and clinical privileges committee has not appropriately considered or credentialled the doctor concerned. The executive management team at the hospital does not appear to have responded in a timely or effective manner to the concerns raised by staff, some of which were raised over 12-months ago. While the report makes a number of recommendations for system improvements, I would recommend that some discussion should occur with the hospital management, reminding them of their responsibilities to put such systems in place and ensure they respond appropriately to reasonable clinical quality concerns.

6.637 A number of disturbing features, concerning the competence, judgment and character of Dr Patel, are identified in this document:-

⁶²⁵ Exhibit 230

⁶²⁶ Exhibit 335, Attachment SMB3

- He had undertaken (and thereby, implicitly had a penchant for undertaking) types of surgery which, in Dr FitzGerald's view were beyond the capability of the Bundaberg Hospital and possibly beyond his own skills and experience.
 - He had delayed (and implicitly had a penchant for delaying) the transfer of patients to a higher level facility, at a standard below that expected by Queensland Health.
 - The matters in question were sufficiently serious to be examined by the Medical Board of Queensland.
 - Dr Patel (a surgeon operating on patients by then for almost two years at Bundaberg) had not been credentialed or privileged in accordance with Queensland Health policy.
 - There had been a failure of systems at Bundaberg Hospital which led to a delay in investigating these matters, concerns about these matters first being raised 12 months earlier.
- 6.638 Dr Buckland agreed that the audit report and the 24 March memorandum, to some extent, contradicted each other,⁶²⁷ the latter being more critical of Dr Patel. He agreed that he did not attempt to elicit from Dr FitzGerald the reason for such contradiction.⁶²⁸
- 6.639 Dr Buckland agreed⁶²⁹ that, knowing what he then knew about Dr Patel, he would not have let that doctor perform elective surgery upon him (Dr Buckland), although Dr Buckland did indicate that he had not previously considered that as an issue.
- 6.640 Following the briefing on 24 March 2005, Dr Buckland had a telephone conversation and an email exchange with Mr Peter Leck, the District Manager of Bundaberg.⁶³⁰ Dr Buckland said in evidence that he did not to take up with Mr Leck the issues upon which he had been briefed that day.⁶³¹ Rather he had a conversation with him in an attempt to arrange for Dr Patel to work over the Easter break which would conclude in early April 2005. By that exchange Dr Buckland's clear endeavour was an attempt to maintain the provision of Dr Patel's services at Bundaberg Hospital.
- 6.641 In my view, the conduct of Dr Buckland (and Dr FitzGerald, as I discuss below) in their disposition of the Dr Patel issue, at the latest by the end of 24 March 2005, was wholly unsatisfactory. On any fair or intelligent reading of it, the material canvassed in the audit report, as augmented by the memorandum of that date, was such as to move any person in a senior stewardship role, having

⁶²⁷ T5562 line 20

⁶²⁸ T5562 lines 22-60

⁶²⁹ T549p line 10

⁶³⁰ Exhibit 335 attachment SMB4

⁶³¹ T5500 line 20

regard to the safety and interests of patients, to suspend Dr Patel from providing any further surgical services. At the very least Dr Patel remained uncredentialed and unprivileged. As noted above, he could have been suspended on full pay, permitting him to provide other non-surgical services. Any decision other than suspension, in my view, was negligent. This is so even if, in truth, Dr Patel was soon to depart Bundaberg in any event.

- 6.642 Dr Buckland's attempt to sheet home responsibility to Dr FitzGerald by, in effect, delegating to him the need to advise Dr Buckland that Dr Patel ought to be prevented from providing surgical services until further notice, evidences lack of candour on his part. It may be accepted that Dr FitzGerald was closer to the issues, having undertaken the audit. However the information placed before Dr Buckland by Dr FitzGerald, including the memorandum of 24 March, ought to have left Dr Buckland in no doubt that he was obliged to suspend Dr Patel immediately. He was derelict in his duty in not doing that.
- 6.643 Moreover, when seen in the light of his conduct on 7 April, his conduct on this occasion, in my opinion, was affected, at least in part, by a desire to put an end to any inquiry into Dr Patel's conduct, thereby limiting further public discussion and criticism. The issue of Dr Patel had been raised at a political level, by Mr Messenger in Parliament. Dr Buckland knew that Dr Patel might soon leave Bundaberg.

The 7 April meeting

- 6.644 The events at the 7 April 2005 meeting are canvassed in Chapter Three of this report, and also in the above subsection of this section of the report concerning Minister Nuttall.
- 6.645 Dr Buckland and Minister Nuttall attended a staff meeting in Bundaberg on 7 April 2005. At no time between 24 March and 9 April 2005 did Dr Buckland ask Minister Nuttall whether he had received or read the audit report.⁶³² Nor did he at any time discuss the content of it with him. In evidence he said that:⁶³³

I made an assumption, and maybe that's an incorrect assumption, that because the Minister was dealing directly with Dr FitzGerald on this case and because of the nature of the case, that in fact a report may well have been made available to him or his staff.

- 6.646 Dr Buckland said that he did not even take a copy of the report with him to Bundaberg for the meeting.⁶³⁴ Some briefing of Minister Nuttall by Dr Buckland must have taken place but it is difficult to know precisely what that was. What was said by each at the meeting in the presence of the other was, in the above circumstances, surprising and inexplicable.

⁶³² T5503 line 5

⁶³³ T5503 line 20

⁶³⁴ T5503 line 55

6.647 Minister Nuttall told the meeting the FitzGerald Report was incomplete. Dr Buckland did not correct the Minister. Dr Buckland acknowledged that he told the staff meeting that:

As Dr Patel had left the country, the audit process being conducted by Dr FitzGerald in relation to Dr Patel would be difficult to finalise as natural justice had not been afforded to him (Dr Patel).⁶³⁵

6.648 Yet, as already mentioned, he had a copy of Dr FitzGerald's completed report.

6.649 Ms Mears, a staff member present at the 7 April meeting said Dr Buckland also said at the meeting (necessarily referring to Dr Patel and any replacement):⁶³⁶

How are we going to get him back from America now?

...

No decent doctor would want to come to Bundaberg to work in these circumstances.

6.650 Dr Buckland agreed it was 'probable' he made each of these remarks.⁶³⁷

6.651 Dr Buckland acknowledged that he had conducted matters at the meeting rather poorly in implying that the audit process had not been completed.⁶³⁸ To explain his abovementioned statement, he said that he intended to communicate the true position, namely that Dr FitzGerald's audit report was only the start of the process:⁶³⁹

The whole process is not a process of accusation, the process is a process of improvement, and trying to do that in a no-blame situation, so there may well have been, as I said earlier, plausible or understandable, or even clinically correct explanations for certain sets of outcomes. So, these sorts of things have to be fully investigated ... that was my belief at the time, that it would be very difficult because Dr Patel was not there to be able to inform the whole process. I mean, sure we have grabbed the data, we could have looked at that, and Dr FitzGerald had done some of that in relation to infection, but not to the whole patient cohort

6.652 I put the following to Dr Buckland:⁶⁴⁰

If Dr Patel had left the country and wasn't coming back, you would never be able to accord natural justice to him in the way you have described it? .. That's probably – that is probably true, Commissioner, yes.

You would have known that at the time and, therefore, you were going to close the whole inquiry down? -- No, that's not true. That wasn't the intention at all. We gave a very clear indication, both the Minister and myself, that Dr FitzGerald would be returning to Bundaberg to meet with staff to talk about his findings and to meet with the District Executive to be able to follow through with what he had.

⁶³⁵ T5505 line 30

⁶³⁶ Exhibit 507 para 15

⁶³⁷ T5567 line 5-25

⁶³⁸ T5507 line 5

⁶³⁹ T5505-5506

⁶⁴⁰ T5506 lines 40 to 60

- 6.653 This, in my view, comprised Dr Buckland's stance in respect of Dr Patel. That is, the audit report was the end of the investigation by Queensland Health of Dr Patel and the complaints made about him. It would not be released. Dr FitzGerald would return to Bundaberg only for the purposes of placating staff who had complained about Dr Patel and to follow through with the District Executive, presumably in terms of future management. Dr Patel was gone. That dispensed with the trouble of further investigation. Yet Dr Buckland must have known that Dr Patel's absence did not prevent, nor impede, a full investigation of his conduct, as subsequently occurred.
- 6.654 As is recorded in Chapter Three of this report, shortly following the 7 April meeting, Dr Keating took Dr Buckland aside and told him of the outcome of his (Keating's) 'Google' search in respect of Dr Patel's disturbing US history. Dr Buckland did not inform the Minister of that because he wished to undertake his own search that evening. He did so, and advised Minister Nuttall the following day. Only then did he recommend to the Minister the undertaking of a detailed inquiry.
- 6.655 What stymied Dr Buckland's intention was this 'Google' search. Once he found that information was on the net Dr Buckland must have known that it would be discovered by others. That is why, in my opinion, he recommended a detailed Queensland Health inquiry. This was announced on 9 April 2005.

The surgical access team's 30 July 2003 submission

- 6.656 The Surgical Access Team of Queensland Health made an unsolicited submission to Dr Buckland, who was then General Manager of Health Services, in a document dated 30 July 2003. The concern of the submission was that a number of hospitals were engaged in reclassification of patients from emergency patients to elective surgery patients and thereby illicitly gaining additional funding.
- 6.657 There was a clear disagreement about this issue between the Team and Health Service Districts which it is not necessary for me to resolve. I should indicate, however, that Dr Buckland's view is probably the preferred one, namely that whilst one or two hospitals may have been illicitly reclassifying patients, the then surgical funding rules were vague. In stating this I imply no criticism of Mr Walker and his fellow Team members. They were diligent staff members seeking to ensure proper expenditure of departmental funds.
- 6.658 Of greater importance, in the context of any culture of concealment within Queensland Health, is the evidence that there was a direction that the 30 July submission be destroyed.
- 6.659 Whilst, as noted below, there is no question that ultimately a direction was communicated to the Surgical Access Team that original and electronic copies of the document be destroyed, a hard copy of the document was retained within

the office of the General Manager Health Services, and, in addition, information technology analysis also revealed that an electronic copy had not been ultimately deleted from the Queensland Health network.⁶⁴¹

- 6.660 There is no direct evidence to the effect that Dr Buckland gave any person an instruction that the 30 July submission be destroyed.
- 6.661 Dr Glenn Cuffe was Manager, Procurement Strategy Unit, of Queensland Health, from 1999 to 2004. He is now the Director, Analysis & Evaluation Unit, Innovation Branch, Innovation and Workforce Reform Directorate in Queensland Health. Dr Cuffe was an impressive witness. I accept him as a truthful and reliable witness. However that acceptance does not necessarily resolve this issue against Dr Buckland.
- 6.662 Dr Cuffe gave evidence⁶⁴² that shortly after a meeting of 15 August 2003, attended by representatives of the Surgical Access Team, Dr Buckland, Dr Cuffe and Ms Deborah Miller, he received a telephone call from Ms Cheryl Brennan, the Executive Secretary to Dr Buckland.
- 6.663 Dr Cuffe knew Ms Brennan very well. He said that he did not recall exactly what Ms Brennan said; however 'she communicated a direction that hard copies of the 30 July 2003 submission held in the SAS were to be destroyed and that the copies on the network were to be deleted'.⁶⁴³
- 6.664 Dr Cuffe said⁶⁴⁴ that Ms Brennan, to his recollection, did not mention Dr Buckland or any other persons name as the person who gave the direction but he assumed it came with Dr Buckland's knowledge. Upon receiving the direction he spoke to Mr Walker and Mr Roberts of the Surgical Access Team and passed on the direction.
- 6.665 Dr Buckland⁶⁴⁵ and Ms Miller⁶⁴⁶ deny having given or knowing of any such instruction given to Ms Brennan. Ms Brennan has no recollection one way or the other of having received or given such direction.⁶⁴⁷ Ms Brennan was quite distressed and did not give oral evidence but gave a written statement to that effect.
- 6.666 In early 2004 Dr Buckland had a conversation with Dr Cuffe. One of the issues raised was to the effect that Dr Buckland had been informed by one of his staff members that such staff member had seen a copy of the 3 July submission in the Surgical Access Service work area team. It seems clear that Dr Cuffe could not recall the exact words used. He expanded upon this in examination.

⁶⁴¹ Exhibit 495 paras 21, 22; T6197, T6222

⁶⁴² Exhibit 426

⁶⁴³ Exhibit 426 para 11

⁶⁴⁴ T6554 line 55

⁶⁴⁵ Exhibit 459 para 20

⁶⁴⁶ Exhibit 416 para 31

⁶⁴⁷ Exhibit 425 paras 15 to 17

To Mr Douglas SC⁶⁴⁸ and to Mr Applegarth SC,⁶⁴⁹ Dr Cuffe related the following:-

How certain are you that in this conversation you had with Dr Buckland that he was in fact referring to the 30 July submission, ... as opposed to any other submission that may have preceded it or followed it? -- Well, he – his words were, if I can recall to the best of my ability, the document that was asked to be destroyed had been seen on the officer's desk, which was a 30 July submission.

...Dr Buckland wasn't specific about the document? -- No, he – my recollection is that he said that the document that he had asked – or that had asked to be destroyed was – had been seen on the desk in the Surgical Access Service.

- 6.667 Dr Cuffe, and the witnesses from the Surgical Access Team, say that they remember the events because it was the first time in the history of their long employment with Queensland Health that any had been asked to destroy a document. I accept that Dr Cuffe received such a direction. But the apparent uncertainty of Dr Cuffe's exact recollection of the conversation, the substance of which he relates in the previous paragraph, has caused me to have some doubt that the direction came from or was ratified by Dr Buckland. Whilst I reiterate that I found Dr Cuffe a thoroughly reliable, and indeed engaging witness, to make a finding of such seriousness against Dr Buckland on the basis of the above evidence, in my view, would be improper.
- 6.668 Before leaving this issue I should advert to the evidence of Ms Miller in respect of the discrete issue of the removal of the 30 July submission from RecFind, a document management system maintained by Queensland Health. RecFind is an index, not a data storage system, upon which the document itself is contained.⁶⁵⁰ The removal of the reference to the document on RecFind is not to delete the document from the computer server upon which it is stored.
- 6.669 Ms Miller⁶⁵¹ was a Principal Project Officer attached to Dr Buckland's office. She was, in effect a senior liaison officer. She possessed tertiary qualification in nursing and business administration. She had worked for Dr Buckland's predecessor, Dr Youngman, in the same capacity, for two years.
- 6.670 Ms Miller gave evidence to the effect that, as she had done on other occasions with different documents, she instructed that the 30 July submission be removed from RecFind because, in effect, her understanding was that until a submission to the General Manager Health Services was approved, it remained a draft.⁶⁵²
- 6.671 This approach to the disposition of documents, in my opinion, is fanciful. A submission, even if misconceived in content, remains just that. The approach

⁶⁴⁸ T6557 line 25

⁶⁴⁹ T6579 line 55

⁶⁵⁰ see T6548 (Cuffe); T6407 (Miller)

⁶⁵¹ Exhibit 416

⁶⁵² Exhibit 416 paras 20,21; T6413

certainly did not accord with the Executive Services Guidelines.⁶⁵³ Such a practice would involve a submission to the Minister or Senior Service being more difficult to locate, for example upon a *Freedom of Information Act* search in that if one was looking for a submission, then (as Dr Cuffe agreed)⁶⁵⁴ the first place one would go looking is in RecFind. To look elsewhere would only make the task harder.

- 6.672 Dr Buckland eschewed any knowledge of such practice being routinely adopted or the so-called 'draft' characterisation of submissions.⁶⁵⁵ I accept his evidence in this respect.

Findings against Dr Buckland

- 6.673 I make the following findings with respect to Dr Buckland in addition to those findings I have made in Chapter Four:

- (a) On and after 24 March 2005, being in possession of information that provided reasonable grounds for Dr Buckland to believe or suspect that:
 - (i) Dr Jayant Patel, the Director of Surgery at the Bundaberg Base Hospital ('the Hospital') had a significantly higher complication rate than his peers;
 - (ii) Dr Patel undertook surgery beyond the capacity of the Hospital and possibly beyond his own skill and experience;
 - (iii) Dr Patel had delayed the transfer of patients to tertiary hospitals in circumstances where those patients should have been so transferred;
 - (iv) The Chief Health Officer Dr FitzGerald had serious concerns about Dr Patel's clinical judgment;
 - (v) Dr Patel had never been credentialed or privileged by the Hospital, under Queensland Health's Policy requiring as much;
 - (vi) Staff complaints about Dr Patel had not been appropriately acted upon by the Hospital executive over a period of at least 12 months;
 - (vii) The data presented in the Chief Health Officer's audit report of 24 March 2005 showed that the complication rates for laparoscopic cholecystectomy procedures at the Hospital were 28 times the national average over the previous 18 months.

⁶⁵³ Exhibit 460

⁶⁵⁴ T6549-6550

⁶⁵⁵ T7109 line 10-20

- (viii) The Hospital had increased rates of wound infection and wound dehiscence probably associated with Dr Patel's surgery; and
- (ix) Issues with respect to Dr Patel had been raised in Parliament, and
- (x) Dr Patel would be continuing to perform procedures at the Hospital at least until 1 April 2005 and possibly until 31 July 2005

Dr Buckland (A) failed to take any, or any appropriate action, to suspend him from duty, or providing surgical services, or further restrict his scope of practice, and (B) failed to take any step to further investigate, or cause any further investigation of Dr Patel's conduct until 9 April 2005, after Dr Patel had left the country. Each failure, in the circumstances, was deliberate or careless and incompetent and unreasonable.

- (b) Being in possession of the information referred to in paragraph (a) above, Dr Buckland deliberately or carelessly and incompetently and unreasonably:
 - (i) Failed, at any time, to provide Minister Nuttall, but in particular prior to the meeting at the Bundaberg Hospital, a copy of the audit report;
 - (ii) Further, failed, at any time, to provide Minister Nuttall with a copy of the audit report or the memorandum of Dr FitzGerald to Dr Buckland dated 24 May 2005, which accompanied delivery of the report to Dr Buckland;
 - (iii) Failed to enquire of the Minister, at any time, but in particular prior to the meeting at Bundaberg Hospital on 7 April 2005, whether he had read or knew of the contents of the said audit report or the said memorandum;
 - (iv) Failed, at any time, but in particular prior to the meeting at Bundaberg Hospital on 7 April 2005, to inform and accurately brief the Minister on the content of the audit report or the memorandum;
 - (v) Advised the Minister, on or shortly prior to 7 April 2005, that the audit report could not be completed because of the absence of Dr Patel from Australia; and
 - (vi) Formed the view and determined, on or shortly prior to 7 April 2005 (and prior to Dr Buckland undertaking an internet search revealing the disciplinary record of Dr Patel in the United States) that any further investigation of Dr Patel's conduct at Bundaberg Hospital would not be pursued because of his absence from Australia, the lastmentioned fact being a convenient excuse for such view and determination because it

afforded a means of avoiding further embarrassment to Queensland Health arising from Parliamentary and media publicity.

- (c) On 7 April 2005 at Bundaberg, in circumstances where Dr Buckland knew that the Chief Health Officer's audit report had been completed on 24 March 2005:
- (i) Dr Buckland advised a meeting of staff that the report could not be completed because Dr Patel had left Australia, and
 - (ii) Dr Buckland advised Minister Nuttall to that effect.

Dr FitzGerald

Dr FitzGerald's background

- 6.674 Dr Gerrard Joseph FitzGerald, from the end of January 2003 until quite recently, held the position of Chief Health Officer in Queensland Health. That is a statutory position created in accordance with the *Health Act* 1937. It entails membership of a number of statutory bodies, including the Medical Board of Queensland. In addition the Chief Health Officer provides advice to the Minister and the Director-General on the quality and standards of health care.
- 6.675 Under Part 6 of the *Health Services Act* 1991, Dr FitzGerald was appointed, from 21 April 2001 as an investigator. This entailed him having standing approval to undertake investigations as may be required from time to time within Queensland Health.⁶⁵⁶
- 6.676 Dr FitzGerald possesses an impressive curriculum vitae.⁶⁵⁷ He obtained a Degree of Bachelor of Medicine and Bachelor of Surgery from the University of Queensland in 1976. In 1993 he became a Foundation Fellow of the Australasian College for Emergency Medicine. He obtained a Bachelor of Health Administration from the University of New South Wales in 1998. He became a Fellow of the Royal Australian College of Medical Administrators in 1990. Also in 1990 he obtained his Doctorate in Medicine from the University of Queensland.
- 6.677 Dr FitzGerald has held a number of statutory and teaching positions. He was Medical Director of the Queensland Ambulance Service from 1990 to 1993 and Commissioner of that service from January 1994 to January 2003, when he took up his present position.

⁶⁵⁶ Exhibit 225 paras 9, 10

⁶⁵⁷ Exhibit 225 attachment GF1

- 6.678 I might add that, from my impression of him in the witness box, and from the evidence of others, Dr FitzGerald seems to be, and to be regarded as an affable and decent person.

Clinical audit

- 6.679 The history of matters leading to the canvassing and pursuit of the clinical audit undertaken by Dr FitzGerald appear in Chapter Three of this report.
- 6.680 It was on 17 January 2005 that Dr FitzGerald first became involved in a prospective clinical audit concerning Dr Patel. It was then that Dr FitzGerald first became aware that the clinical standards of Dr Patel had been called into question. Dr FitzGerald was also advised by Mr Leck, in Mr Leck's memorandum of 19 January 2005⁶⁵⁸ that Dr Patel did not intend to renew his (Dr Patel's) contract when it expired on 31 March 2005.
- 6.681 Dr FitzGerald decided that further enquiries would be necessary before he could offer any opinion about standards. He advised Mr Leck that his review would take the form of a clinical audit and would not be an investigation into any individual.⁶⁵⁹ That was, to say the least, curious, given that the material forwarded by Mr Leck, which included the letter of Ms Toni Hoffman of 22 October 2004 and the interviews with the three practitioners undertaken by Mr Leck and Dr Keating in the fortnight following that, was focused upon Dr Patel and his practices.⁶⁶⁰
- 6.682 On 14 and 15 February 2005 Dr FitzGerald, and his assistant Ms Jenkins, attended the Bundaberg Hospital to interview staff and collect further information. He said in evidence that the nature of his audit process, while at Bundaberg, was expressed to be, and intended to be 'non-judgmental or non-threatening to ensure that people do participate in the clinical audit'.⁶⁶¹ Again, that was curious, given the nature of the material and the potential seriousness of the criticism of Dr Patel which it contained.
- 6.683 The principal issue of concern for Dr FitzGerald during his visit, it seems, was that Dr Patel was conducting surgical procedures beyond the scope of practice of the hospital and that there was delay in transfer to a larger hospital where appropriate.⁶⁶²
- 6.684 Prior to leaving Bundaberg Dr FitzGerald obtained assurances from Dr Patel and Dr Keating that these practices would cease.⁶⁶³ Unfortunately, and in my view inappropriately, he did not give any definition of this protocol to ensure Dr Patel's

⁶⁵⁸ Exhibit 225 attachment GF10

⁶⁵⁹ Exhibit 225 para GF61

⁶⁶⁰ Exhibit 225 attachment 10

⁶⁶¹ T3214 line 25

⁶⁶² Exhibit 225 para 65

⁶⁶³ T3210 line 25

evidently poor judgment prevented him from falling into his previous harmful habits.⁶⁶⁴

You would expect, in respect of either aspect of the undertaking, that Dr Patel was the person who would be obliged to exercise the principal judgment in respect of either matter?-- Yes, the principal judgment of whether the patient needed that procedure, and that was the procedure to be performed. The judgment of whether that procedure would be performed at Bundaberg could be determined by the Medical Superintendent, by a number of people.

In either case it would be left to his judgment, as a surgeon still undertaking work from the time the undertaking was given in February 2005 in the course of day-to-day practice at Bundaberg Hospital?-- Yes.

Was there any written protocol which was entered into in that respect?-- No.

Such as to particularise the types of matters - or exemplify the types of matters to assist Dr Keating and Dr Patel in exercising that judgment?-- Not to my - not that I was aware of, no.

Do you think it should have been, in retrospect?-- Probably. In retrospect I think the Medical Superintendent should have made it clear with the doctor concerned about what should or shouldn't be done.

I suggest you should have made it clear to Dr Patel that you, as the person eliciting the undertaking, required a very strict and exemplified adherence to what was required in that respect?-- Yes.

But it didn't happen?-- It didn't happen, no.

The fact that it didn't happen, I suggest, exemplifies a very poor approach to your undertaking of this audit. ... -- Well, I don't believe it was a poor approach. I believe, obviously in retrospect, there are things we could have done better.

- 6.685 Upon returning to Brisbane, Dr FitzGerald, on 16 February 2005, spoke to Mr O'Dempsey, from the Medical Board of Queensland, the result of which was that it was agreed that the Registration Advisory Committee of the Medical Board would defer consideration of Dr Patel's current application for renewal of registration until finalisation of his clinical report and further investigation.⁶⁶⁵ Thereafter Dr FitzGerald began to compile his report.
- 6.686 It was Dr FitzGerald's stance in evidence that there was insufficient evidence to take any particular action against any individual and to suspend anyone would be unjust and inappropriate.⁶⁶⁶
- 6.687 Dr FitzGerald's approach to conduct of the audit, and his interpretation of his results, in my view, were quite inexplicable.
- 6.688 Dr FitzGerald chose the clinical audit path as a means of responding to Mr Leck's request which concerned complaints about the competence and conduct of Dr Patel. But his position in respect of clinical audits, at the time, was.⁶⁶⁷

⁶⁶⁴ T6108 line 45, T6108 line 30 to T6109 line 10

⁶⁶⁵ Exhibit 225 para 27, T6146-T6417

⁶⁶⁶ T6138 line 40-50

⁶⁶⁷ T6121 lines 10-30

... the clinical audit should avoid adverse comments about individuals but it doesn't necessarily exclude positive comments ... the intent behind a clinical audit is to try and avoid adverse comments about individuals ... every bit of information that I have from experts in the field and from the literature regarding clinical audit, that a non-judgmental or non-adversarial approach is the way to exact systems improvements and improve the quality of health care.

- 6.689 After acknowledging that this was his approach he agreed in evidence that suspending a surgeon was something he could have done but he preferred referral to the Medical Board of Queensland. In response to a question from me in relation to the adequacy of mere reference to the Medical Board, the following answers were given by FitzGerald:⁶⁶⁸

Well, that's a grossly inadequate response though isn't it ...? -- -Yes sir

You did a grossly inadequate response just to refer it to the Medical Board?--
Well, the Medical Board were in a position to take action.

So were you? -- Yes, or the administration of the hospital, yes.

- 6.690 Dr FitzGerald went on to describe his approach, and a critique thereof, in the following fashion in answer to Mr Allen, counsel for the Nurses' Union⁶⁶⁹:-

Doctor, if you follow that approach of only including positive comments about an individual and deliberately omitting any negative comments, that must necessarily present to any reader of the report a skewed picture of the individual, surely?—I'm sure you're correct, yes.

And that's what your report did?—yes.

By only including positive comments about Dr Patel and deliberately omitting any negative ones, it presented a false picture regarding Dr Patel to any reader of the report?-- I accept your point, that was not the intent, the intent was to identify the issues, the structural and organisation issues that needed to be improved to address the issue -- address the concerns.

You say that it was not your intent, but that is the obvious inevitable consequence of such an approach? -- I accept that.

- 6.691 Dr FitzGerald finalised his report on 24 March 2005 and provided a copy to Director-General Buckland under cover of a memorandum of the same date.⁶⁷⁰ Dr FitzGerald did not provide a copy of the audit report to any other person until 7 April 2005. The 24 March memorandum was not supplied to anyone else.

- 6.692 Dr FitzGerald wrote to the Medical Board of Queensland also by letter dated 24 March 2005. That letter provided (in part):

My investigations to date have not been able to determine if Dr Patel's surgical expertise is deficient, however, I am concerned that the judgment exercised by Dr Patel may have fallen significantly below the standard expected. This judgment may be reflective of his decision to undertake such complex procedures in a hospital that does not have the necessary support, and in his apparent preparedness to retain patients at the hospital when their clinical condition may warrant transfer to a higher level facility.

⁶⁶⁸ T6121 lines 40-60

⁶⁶⁹ T6121 line 50 – T6122 line 12

⁶⁷⁰ Exhibit 225 – Attachment 'GF14'

- 6.693 It is plain that Dr FitzGerald was leaving it to the Medical Board to undertake a thorough assessment or investigation of Dr Patel.
- 6.694 The audit report, to the extent that it adverts to the conduct of Dr Patel, and the memorandum of 24 March to Dr Buckland contrast in content and emphasis. Dr FitzGerald's evidence was that they 'were intended to be complementary and for a different purpose'.⁶⁷¹ He said that the memorandum was intended to raise issues 'about the standard and quality of medical services ... concerning Dr Patel'.⁶⁷²
- 6.695 The content of the memorandum, in my view, was self evidently alarming. I have already canvassed this above in respect of Dr Buckland. At its base lies a non-compliance in the credentialling and privileging policy required by Queensland Health particularly in circumstances in which, as in the case of Dr Patel, the employee was a foreign trained surgeon who had not previously worked in Australia prior to appointment to Bundaberg where he was Director of Surgery.
- 6.696 On any view of the content of the memorandum, Dr FitzGerald was satisfied that Dr Patel had poor clinical judgment. The undertaking given with respect to undertaking particular surgery, and effecting early transfers, undefined as it was, did not address these defects. He also expressed at least strong suspicions about the clinical competence of Dr Patel.
- 6.697 The statistics about Dr Patel's complication rate for a routine procedure, set out in the report, were equally alarming. This showed a complication rate that was 28 times the national average.
- 6.698 In evidence Dr FitzGerald said:⁶⁷³

As to the conduct of clinical audits, do you consider that Queensland Health have learnt any lessons from this particular audit procedure in respect of Bundaberg?-- Well, I'm sure I have in terms of process, but certainly what we've learnt, of course, is that we do need to be - to try and get experts in initially. I felt that at the time I was being called upon to

try and judge surgical procedures where I didn't have the expert - personal expertise. The subsequent establishment of the Mattiussi Review et cetera brought that expertise to bear.

There is some other evidence before this Commission to the effect that you remarked to Dr Buckland on or about the 24th of March 2005, if not two days earlier, the 22nd of March (t)hat Dr Patel was not the best of surgeons but he also wasn't the worst?-- Yes.

Do you recall saying something like?-- That - yes, I do because that was the information we obtained from people in Bundaberg at the time, comments to that effect were made to us.

⁶⁷¹ T6115 line 45

⁶⁷² T6132 line 25

⁶⁷³ T6118-6119

I suggest to you on the information that you knew on or about the 24th of March 2005, you couldn't bring to mind a worse surgeon, that is, a more incompetent surgeon apparently than Dr Patel working within Queensland Health?-- I wouldn't - there was certainly none that I was aware of but I would - could I just comment on the fact that comment that was – he wasn't the best, he wasn't the worst, that came from the people who knew him and observed his surgery, but it also came from the data which we retrieved which we commented on at some length because one of the things that did concern us then when we drew that data from various hospitals, various hospitals are up and down across the parameters and some of them were much more.

The patients (sh)ould have been given the benefit of the doubt in relation to Dr Patel pending an investigation, shouldn't they?-- Yes, I'd accept that.

And they weren't Dr FitzGerald? -- That's true.

- 6.699 In my view, any sensible administrator in Dr FitzGerald's position, having formed the views contained not just in the audit report but in the memorandum, would have moved to immediately suspend Dr Patel from providing clinical services (on full pay). To leave matters, as Dr FitzGerald did, for investigation by the Medical Board of Queensland, with whatever delay that may entail, and in the knowledge that Dr Patel probably wouldn't, but may seek interim registration in the meantime or may leave Australia, was a wholly unsatisfactory response.
- 6.700 The audit report was an inadequate document. I canvass this in Chapter Three of this report. Dr FitzGerald conceded that, in drafting the report, he believed that the persons to whom the report was disseminated, and in turn those to whom it might be passed for action, would be relying upon him candidly to express the opinions he held and evidence for them.⁶⁷⁴
- 6.701 As to the audit report:
- Dr FitzGerald knew that serious allegations had been made about Dr Patel's clinical practices.
 - he knew that serious allegations had been made as to Dr Patel having a high infection rate.
 - he accepted that he had discerned from his investigation that Dr Patel apparently had a high complication rate (in the case of the common procedure, cholecystectomies, 28 times the national average)⁶⁷⁵ and infection rate but he didn't identify this as a freestanding category of complaint in his summary.
- 6.702 On 22 March 2005 Dr FitzGerald provided to Minister Nuttall a document dealing with the Patel issues.⁶⁷⁶ Dr FitzGerald accepted that he should have been far more specific and direct in conveying the information he did in that document, particularly in relation to infection rate.⁶⁷⁷

⁶⁷⁴ T6098 line 45

⁶⁷⁵ T6109 line 30

⁶⁷⁶ Exhibit 391

⁶⁷⁷ T6162 line 50

6.703 In my view Dr FitzGerald:

- adopted a wholly inappropriate approach to the investigation in response to the request of Mr Leck. If a 'no blame' neutral clinical audit, of the type he described, was a generally acceptable method of investigation (which I do not accept) it was a wholly inappropriate response to the complaints about Dr Patel given the content of the allegations and the materials provided to Dr FitzGerald by Mr Leck.
- at the lowest, the approach of Dr FitzGerald in the views expressed and advice he gave in his audit report and the memorandum was inappropriate and incompetent. Any sensible person in his position ought to have immediately advised suspension of Dr Patel.
- permitting Dr Patel to continue to practise (including during the term of the audit once Dr FitzGerald had formed his views) and then leaving it to the Medical Board of Queensland to take whatever steps they thought necessary, was a course designed to minimise publicity and in effect conceal the truth.

6.704 In my view, Dr FitzGerald had it in his mind from the outset that it was likely that Dr Patel would not remain in practice in Australia beyond 31 March 2005. This was likely to put an end to the issue. He did this against the background of knowing that from 22 March 2005 the issue had become a political one, it being raised in Parliament by Mr Messenger MP, with the consequence of him having to provide information to the Minister that same day.

6.705 Importantly, Dr FitzGerald knew that Dr Patel, a foreign trained surgeon, who was not credentialled and privileged under longstanding Queensland Health policy, and was the subject of serious (albeit not yet wholly substantiated) complaints, had been undertaking surgery in Bundaberg on many patients for two years and would continue to do so, unless stopped, until he left, whenever that was. The interests of the patients were ignored.

Findings against Dr FitzGerald

6.706 My findings in respect of Dr FitzGerald are these in addition to those findings I have made in Chapter Four:

- (a) On 24 March 2005 Dr FitzGerald, believing that there were reasonable grounds to believe or suspect that, following completion of his audit investigation prior to 22 March 2005, and his audit report of the Bundaberg Base Hospital:
 - (i) Dr Patel had a significantly higher complication rate than his peer group;
 - (ii) Dr Patel undertook surgery beyond the capacity of the Hospital and possibly beyond his own skill and experience;

- (iii) Dr Patel delayed transferring patients who should have been transferred;
 - (iv) Dr Patel had not been appropriately credentialed or privileged;
 - (v) There was reason to hold serious concerns about Dr Patel's clinical judgment;
 - (vi) Staff complaints about Dr Patel had not been appropriately acted upon by the Bundaberg Base Hospital Executive
- (A) deliberately or carelessly and incompetently failed to include this information in his report of 24 March 2004; (B) deliberately or carelessly and incompetently failed to inform the Minister for Health of any of the above information when it would have been reasonable to inform the Minister because on 22 March 2004 he advised him that there was 'insufficient evidence to take action against any individual' as at the time he had no comparative data or complication rates; (C) in addition to the above matters knowing that the completion rate at Bundaberg for a common surgical procedure was 28 times the national average, deliberately or carelessly and incompetently failed to take steps to suspend Dr Patel, or advise the Director-General, Dr Buckland that Dr Patel be suspended from surgical practice until further notice.
- (b) Each omission, or at least some of them, were for the purpose of limiting the publication of these matters to the general public.
 - (c) Dr FitzGerald's response to the complaints and concerns raised by Mr Peter Leck, in light of his investigations leading to his audit report, was inadequate in the following respects:
 - (i) Dr FitzGerald failed to take any steps to review, or have reviewed, Dr Patel's credentials or clinical privileges;
 - (ii) Dr FitzGerald failed to take any step to restrict Dr Patel's surgical practices through suspension, limitation of practice, or restriction of duties at the Hospital, whether temporarily or otherwise, when such action was reasonably appropriate and warranted;
 - (iii) Dr FitzGerald failed to provide a copy of his report to the Minister for Health instead of relying on the Director-General to do so.
 - (iv) Dr FitzGerald failed to provide a copy of his report to the District Manager until 7 April 2005, some 2 weeks after the matter had entered the public domain notwithstanding that Mr Leck commissioned him to perform the audit;
 - (v) In circumstances where Dr FitzGerald had doubts about Dr Patel's clinical judgement, he failed to clearly identify with Dr Patel and the Director of Medical Services, Dr Darren Keating, the scope of practice with which Dr Patel was to comply;
 - (vi) Dr FitzGerald failed to obtain a specific undertaking from Dr Patel with respect to paragraph (v) above.

I recommend that the Director-General give consideration to taking disciplinary action against Dr FitzGerald pursuant to s87(1)(a) of the *Public Service Act* 1996 on the basis that he may have performed his duties carelessly and incompetently.

Dr Keating

6.707 I have canvassed in Chapter Three the conduct of Dr Keating at Bundaberg.

6.708 Dr Keating's conduct, in my view, evinces an intention to shield affairs in his domain from any real scrutiny. There was a very steady stream of complaints about Dr Patel, containing very serious allegations and emanating from well qualified people. Those complaints were not well received and, in my view, the circumstances (which are set out in detail in Chapter Three) demonstrated more than a mere failure to comply with the Queensland Health policy on complaints handling. They demonstrated a propensity to downplay or 'fob off' any attempts to scrutinise Dr Patel's conduct.

6.709 Specific instances were these:

- (a) When Ms Hoffman raised concerns about oesophagectomies in June 2003, Dr Keating told her that she should raise the matter with Dr Patel herself and that, on Ms Hoffman's version (which I accept), Dr Patel was a very experienced surgeon who should not be lost to the hospital.
- (b) When Mr Fleming complained to the Base about Dr Patel in October 2003, he testified (and I accept) that the conversation with Dr Keating began with the latter saying that Dr Patel was 'a fine surgeon and we are lucky to have him';
- (c) When Dr Cook raised concerns about the same issue in July 2003, Dr Keating told him that they would be considered by the Credentialing and Privileging Committee, even though there was never such a committee for surgeons. Dr Keating did not return to Dr Cook after he discussed the matter with Dr Patel, nor otherwise seek the advice of an independent surgeon.
- (d) Whereas Dr Smalberger gave cogent evidence (which I accept) that he sought to make a formal complaint about two issues concerning the care given to P51, namely Dr Patel's poor clinical decisions and his unprofessional conduct, Dr Keating did not document the matter, and treated the approach simply as a request for advice in dealing with Dr Patel.
- (e) When the Renal Unit nurses approached Dr Keating through their line manager about the 100% peritoneal catheter complications, Dr Keating told line manager that if the nurses 'want to play with the big boys, bring it on'. When Dr Miach raised the same issue, Dr Keating maintained that

he did not receive the report until October 2004, which I do not accept. Even then, he took the view that the report was ambiguous, but did not return to Dr Miach and, instead, informed Mr Leck that the report was based on 'poor data'.

- (f) When Dr Keating received the Hoffman letter of 22 October 2004, he took no steps to confirm or deny the extraordinary allegation that the Director of Medicine at his hospital refused to allow his patients to be treated by the Director of Surgery, or to ensure that, at the very least, a chart audit was performed by an independent surgeon.
- (g) Indeed, even after three doctors had provided some corroboration of Ms Hoffman's concerns, Dr Keating continued to advise Mr Leck that the complaint was largely personality-based.
- (h) Dr Berens said that when he and Dr Carter raised concerns about the Kemps' oesophagectomy (against the background of the earlier complaints), Dr Keating showed little interest in investigating and that it was a matter for them whether they reported it to the Coroner, which evidence I also accept.
- (i) When Dr Rashford raised serious 'sentinel' concerns about the care of P26, Dr Keating completed a report immediately, and without speaking to the treating surgeon in Bundaberg, i.e. Dr Patel, or Brisbane. The only conclusion was that transfers should happen more promptly but even this view was not articulated in any formal policy.
- (j) There was a general trend in the evidence of Dr Keating failing to inform staff whether their complaints were being progressed.
- (k) Dr Keating's assessments of Dr Patel's performance to the Medical Board were glowing and knowingly exaggerated, even as late as February 2005.
- (l) Dr Patel was not credentialed even on an ad hoc basis, when that would have been a simple matter to arrange.
- (m) Dr Keating did not seek 'deemed specialist' status for Dr Patel with the Medical Board, even though that was the obvious way to ensure that he complied with Australian surgical standards.
- (n) When Dr FitzGerald visited the Base on 14 February 2005, and notwithstanding the serious concerns raised in Dr Keating's briefing note of early January 2005, Dr Keating did not volunteer any significant information about the perceived shortcomings of Dr Patel.

6.710 These events occurred in circumstances where Dr Patel was giving significant assistance to the Base in reaching its elective surgery targets, where there would be real difficulties in recruiting a new staff surgeon and where any

disruption of surgical services at the Base was likely to attract the kind of media attention to which Queensland Health was so averse.

- 6.711 When the matters are considered together, they lead to the view that there was a strong element of orchestrated incompetence, or wilful blindness, in Dr Keating's response to complaints about his Director of Surgery.
- 6.712 I find that Dr Keating deliberately diminished or downplayed complaints about Dr Patel. He declined to initiate inquiries into Dr Patel where, at the very least, serious concerns had been raised, and he promoted or acquiesced in a perception amongst staff that Dr Patel was 'protected' by management because he was valuable. I make no separate recommendations in that regard.

Mr Leck

- 6.713 Like Dr Keating, Mr Leck's conduct, in my view, evinces, if not a policy of calculated concealment, an attitude that discouraged any frank discussion of clinical issues within the Base.

The circumstances are discussed in Chapter Three, but I note the following in this regard:

- (a) Dr Baker gave evidence (which I accept) that when he resigned in November 2001, Mr Leck told him that the Director-General was not happy with the media embarrassment and that 'we don't want to see your career affected'.
- (b) Dr Jelffe gave evidence (which I accept) that, when he declined to provide anaesthetic services for certain surgery on the basis that his fatigue made it unsafe, he was asked to attend Mr Leck's office and the conversation commenced with what was clearly a veiled threat, namely Mr Leck asking Dr Jelffe to remind him of his visa status.
- (c) Mr Leck was provided with the peritoneal catheter audit in the first half of 2004 but took no steps to talk with Dr Miach.
- (d) When Ms Hoffman personally set out her serious concerns about Dr Patel to Mr Leck in March 2004 and then in October 2004, Mr Leck did not approach any independent surgeon for a review. He took no steps to disabuse staff of the perception, of which he was informed, that Dr Patel was protected, and he did not approach Dr Miach despite the extraordinary allegation that Dr Miach would not let his patients be operated upon by Dr Patel.
- (e) When an external investigation was instigated on 17 December 2004, Mr Leck is recorded as telling the Audit and Operational Review Branch that the District 'needed to be handle this carefully as Dr Partell (sic) was of great benefit ...and they would hate to lose his services'.

- (f) Mr Leck emailed Dr Keating on 21 December 2004, immediately after learning of the Kemps' oesophagectomy, to ask if 'any of these patients have survived' what was, of course, elective surgery, but he did not follow up the email.
 - (g) Mr Leck's address to certain nurses on 23 March 2005 appears to have been calculated to give all those present a sense of fear as to what could happen if they raised issues outside Queensland Health. That is rather confirmed by his subsequent suggestion to the zone manager that 'perhaps we have the Audit team come up and deliver some training sessions around the Code of Conduct and deliver some firm and scary messages'.
 - (h) Mr Leck's letter to the Bundaberg News-Mail of 23 March 2005, saying that he 'had received no advice... that the allegations had been substantiated' and that there was a 'range of systems in place to monitor patient safety', at best created a false impression.
 - (i) Mr Leck was present at, and acquiesced in, the comments made by Mr Nuttall and Dr Buckland which, I am satisfied, were generally critical of the disclosure of information. This occurred in circumstances where Mr Leck should have appreciated the frustration of staff that they had been raising concerns for a long period and no serious attempt had been made to test them.
 - (j) When Mr Leck received an email on 13 January 2005 from one of the nursing staff saying simply 'Dear All, Treacherous Day', he asked the Director of Nursing to find out what was meant and continued, 'I assume it relates to Jay – so we need to quieten this down'.
 - (k) Mr Leck's email to the Zonal Manager on 7 April 2005 said 'perhaps we have the Audit Team come up and deliver some training sessions around the Code of Conduct and deliver some firm and scary messages'.
- 6.714 One needs to bear in mind that the Bundaberg Base Hospital was only 140 beds. It was a relatively small institution.
- 6.715 It beggars belief that Mr Leck could have no knowledge of the personal and professional concerns about Dr Patel, and the many complications that were arising, unless he took some steps to quarantine himself.
- 6.716 As with Dr Keating, I am satisfied that, against a background of elective surgery targets, a dearth of doctors wishing to work under the poorly resourced conditions at the Base, and Queensland Health's sensitivity to media exposure, Mr Leck discouraged criticism and complaint within the hospital generally and of Dr Patel in particular. I make no separate recommendations in that regard.

Conclusion with regard to concealment

- 6.717 Successive governments followed a practice of concealment and suppression of relevant information with respect to elective surgery waiting lists and measured quality reports. This, in turn, encouraged a similar practice by Queensland Health staff.
- 6.718 Queensland Health itself, by its principal officers Dr Buckland and Dr FitzGerald, implemented a policy of concealment and suppression of events, the exposure of which were potentially harmful to the reputation of Queensland Health and the government.
- 6.719 The conduct of officers of Queensland Health, together with its strict approach to surgical budget targets enforced by penalties, led to similar practices in hospitals, especially with respect to complaints about quality of service and it also led to threats of reprisal in some cases. These caused suppression of complaints which ought to have been exposed earlier.
- 6.720 In my view it is an irresistible conclusion that there is a history of a culture of concealment within and pertaining to Queensland Health.

Chapter Seven – Amendments to the Coroners Act 2003

'This isn't my fault. This has nothing to do with my surgery'

[attributed to Dr Patel during the second operation on Mr Kemps]¹

Medical non-reporting of deaths to the coroner

Unexpected deaths resulting from surgery at Bundaberg

- 7.1 As I have said in Chapter Three, Dr Woodruff identified 13 deaths of patients in which an unacceptable level of care, on the part of Dr Patel, contributed to the adverse outcome.² Ten of those deaths occurred within 30 days of surgery;³ a period which Dr Woodruff referred to as the peri-operative period.⁴ Six of the 13 deaths had terminal pathology but did not present in extremis.⁵
- 7.2 Twelve of the 13 deaths arose out of elective surgery in the sense used by the Australian Institute of Health and Welfare, and adopted by Queensland Health for funding purposes; namely, care that, even if necessary, in the opinion of the treating physician, could have been delayed for at least 24 hours without adverse consequences.⁶ Even in the one trauma case, the case of Mr Bramich, the patient did not, in the opinion of Dr Woodruff, present in extremis.⁷
- 7.3 Dr Woodruff said that Dr Patel's level of care in each of those cases fell short of the reasonable standard expected from a surgeon and that that level of care was a contributing cause to the deaths.⁸ Dr Woodruff said that treatment in seven or eight of them involved 'absolutely non-defendable processes'.⁹
- 7.4 There were a further four deaths of patients without terminal pathology in which Dr Woodruff said doctors, other than Dr Patel, had a significant

¹ T2206 line 15

² T4284 line 10-30, Exhibit 283 Statement Woodruff, Tables B3, C3, and D3

³ T4284 line 15

⁴ T4273 line 15, 55, 4284 line 15

⁵ Exhibit 283 Statement Woodruff, attachment PWHW3 Table B3

⁶ Exhibit 326 para 7 Statement Zanco

⁷ Exhibit 283 Statement Woodruff, attachment PWHW3 Table C3

⁸ T4284 line 20-25

⁹ T4282 line 55

contributing role and which were not caused by an iatrogenic process.¹⁰ There were also four deaths of patients without terminal pathology in which Dr Woodruff said that unacceptable care on the part of Dr Patel may have contributed to the outcome.¹¹

- 7.5 Dr de Lacy said any death resulting from elective surgery is a disaster¹² and very rare.¹³ The reason for this is understandable. There is ample time to assess the patient, arrive at a treatment path, and decide whether the local hospital has adequate supporting structures for the path envisaged.¹⁴

The failure to report the deaths to a coroner

- 7.6 Of the 13 patients in respect of which an unacceptable level of care on the part of Dr Patel contributed to the adverse outcome, only the trauma case of Mr Bramich¹⁵ and the case of Mr Nagle¹⁶ were initially reported to a coroner. The other 11 deaths together with the four deaths in which doctors other than Dr Patel had a contributing role and the further four deaths in which an unacceptable level of care on the part of Patel may have contributed to the outcome, each of which were elective surgery patients, were not reported, at least, not before investigation into Dr Patel, to a coroner. In the case of Mr Bramich which was reported, the report was made by Nurse Hoffman.¹⁷
- 7.7 It was not only Dr Patel who had a duty under the *Coroner's Act* 2003 to report a reportable death of a patient upon whom he had operated. Under s7 of the Act, the duty to immediately report a death was imposed upon all who became aware of a death that appeared to be reportable and who did not reasonably believe that someone else had already reported or was reporting it.
- 7.8 At the Bundaberg Base Hospital and, perhaps, generally within Queensland Heath, there appeared to be no adequate system of audit or review of deaths to ensure there were no instances of misstatement or mis-diagnosis of deaths or whether treatment may have caused or contributed to any death. There were instances where particular deaths were reviewed, for example, the deaths of Mr Bramich and Mr Kemps,¹⁸ but these seemed limited and arose because of complaints about them.

¹⁰ Exhibit 283 Statement Woodruff, attachment PWHW3 Table B2; T4279 line 50

¹¹ Exhibit 283 Statement Woodruff, attachment PWHW3 Table C2

¹² T3602 line 50, 3603 line 5

¹³ T3602 line 50

¹⁴ T 3602 line 40 - 50

¹⁵ T1414 line 40

¹⁶ T3995 line 50

¹⁷ T1414 line 40, 1415 line 25

¹⁸ Chapter 3

Current reporting requirements for health procedure deaths

- 7.9 Whether a death enters the coronial system or not is dependant upon whether a doctor is able to issue a cause of death certificate without involving a coroner under s30(1) of the *Births Deaths and Marriages Registration Act* 2003. A doctor may do so if the doctor is 'able to form an opinion as to the probable cause of death'. By s26(5) of the *Coroner's Act* 2003, a cause of death certificate must not be issued if the death 'appears to the doctor to be a reportable death unless a coroner advises the doctor that the death is not a reportable death'. A coroner may do this if the coroner comes to the view that the death is not a reportable death and accepts that the doctor has sufficient basis for the proposed diagnosis.
- 7.10 As I have said, under s7 of the *Coroners Act* 2003, a person, who becomes aware of a death that appears to be a 'reportable death', and the person does not reasonably believe that someone else has already reported or is reporting the death, is obliged to immediately report the death.¹⁹ If the death is a death in custody, the report must be made to the State Coroner. Otherwise it is made to a coroner or a police officer who must, in turn, report it to a coroner.²⁰
- 7.11 A 'reportable death' is defined by s8 of the Act. By s8(1), a person's death is a reportable death only if the death is a death to which s8(2) and (3) both apply. The provisions of s8(2) are concerned with jurisdictional matters; the death must be connected with the state of Queensland.²¹ Section 8(3) provides for a list of circumstances where a death is a 'reportable death'.
- 7.12 Queensland is one of only two Australian jurisdictions that has a special category for deaths related to medical procedures, the other being the Australian Capital Territory.²² In Queensland, s8(3)(d) provides that a death is a 'reportable death' if 'the death was not reasonably expected to be the outcome of a health procedure'. A 'health procedure' is defined in Schedule 2 of the Act. It means 'a dental, medical, surgical or other health related procedure, including, for example, the administration of an anaesthetic, analgesic, sedative or other drug'.

Problems with current requirements

- 7.13 The current requirement under s8(3)(d) that a death be reported to a coroner if 'it was not reasonably expected to be the outcome of a health procedure', replaced an earlier requirement in the *Coroner's Act* 1958 to report deaths that

¹⁹ *Coroners Act* 2003, s7(1) and (2)

²⁰ s7 s (2) and (3)

²¹ ie the death happened in Queensland or, although it happened outside Queensland, the body is in Queensland, the person ordinarily lived in Queensland, person was on a journey to or from Queensland or the event that caused the death happened in Queensland

²² *Coroners Act* 1997 (ACT) ss13(1)(e), 77(1)

occurred while the deceased was 'under an anaesthetic in the course of a medical, surgical or dental operation'. The provisions removed the focus away from when the death occurred to why it occurred. The shift in focus, however, has brought with it a number of problems.

Dependent upon the integrity and care of a certifying doctor

- 7.14 First, the effectiveness of the system of reporting is dependant upon a doctor correctly identifying deaths which should be reported and then notifying a coroner of those deaths. This gives rise to the risk of concealment of medical error or neglect or, more seriously, as occurred in the case of Dr Shipman in the United Kingdom, crime or other wrongdoing by that doctor. As the Queensland State Coroner has pointed out,²³ the person best placed to make the assessment as to whether or not a death was a reasonably expected outcome from a health procedure, is the person who knows the most about the patient's condition leading up to death. However, he or she is also usually the person whose performance will be scrutinised if a Coroner investigates the death. He or she, therefore, might not be seen as sufficiently impartial to make an independent judgment of these issues.
- 7.15 Dr Patel has shown that it is easy for a doctor to avoid reporting a death to the Coroner and thus also to avoid any official inquiry into the death of a patient. There was evidence before the Commission of Dr Patel asking junior doctors to certify deaths. Indeed, there was evidence that it was the usual practice for the most junior doctor on the team to complete the death certificate.²⁴ It would take little for a dishonest doctor to try and persuade a junior doctor to certify a false cause of death so as to avoid it being reported to a coroner. It would be very hard for a junior doctor to withstand that sort of pressure. The risk also is that a dishonest doctor may seek to have another doctor less familiar with the case state a cause of death which is not true, and thereby avoid suspicion by others, including hospital administrators and family members.
- 7.16 In the case of the death of Mr Kemps, who died as a result of an oesophagectomy performed by Dr Patel in Bundaberg, the death certificate was completed by Dr Athanasiov, a junior doctor who was not making clinical decisions, whose role in the operation was not doing much more than holding the retractor and who was involved in his first oesophagectomy.²⁵ The unexpected nature of Mr Kemps' death was evident from the agitation and repeated protestations by Dr Patel during the second operation on Mr Kemps that the bleeding which could not be stemmed had nothing to do with the

²³ para 10 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

²⁴ Athanasiov T2066 line 5, 2067 line 20; Kariyawasam T3091 line 45

²⁵ Athanasiov T2066 line 10 – 15

oesophagectomy he had performed earlier that morning.²⁶ Dr Athanasiov said he discussed the cause of death with Dr Patel. Dr Patel told him what the cause of death was and then he filled in the gaps.²⁷ He said that he had earlier been concerned enough to ring the coroner's office after the operation to clarify the requirements for reporting a death.²⁸ He said he was told that if the cause of death was known or if it was an expected outcome of surgery, then no report to the coroner was required.²⁹ The first limb of this advice, if it was given as Dr Athanasiov said, of course, was erroneous. But, in any event, Dr Athanasiov said that when he told Dr Patel this, Dr Patel explained that he knew what the cause of death was; it was a thoracic aortic bleed. Dr Patel said that, because Mr Kemps had previously had problems with his aorta having had an abdominal aortic aneurysm repaired, the aneurysm must have started bleeding higher up in the lower thorax area.³⁰ Dr Kariyawasam who was also present said Dr Patel had said that, because he knew the cause of the bleeding, the case did not need to be reported to a coroner.³¹ Dr Athanasiov³² and Dr Kariyawasam³³ both said it would be better if the person doing the operation was responsible for signing the death certificate.

- 7.17 There are other indications in Australia, aside from Dr Patel, that doctors may not be reporting all cases of reportable deaths. The Victorian Parliament Law Reform Committee in its recent Discussion Paper relating to reform of the Victorian *Coroners Act* 1985³⁴ cites a study involving doctors practicing in non-metropolitan Victoria including Resident Medical Officers, hospital doctors, specialist physicians, surgeons and general practitioners which found 27 percent of certificates inaccurately represented the cause of death, with a higher inaccuracy rate of 51 percent for Resident Medical Officers. It also found that 20 percent of doctors involved in the survey would be prepared to alter certificates to avoid the involvement of the coroner. The Committee noted that this figure was consistent with a study in the United Kingdom which found that 17.2 percent of general practitioners who were surveyed would alter certificates to avoid referral to the coroner.³⁵

²⁶ T2206 (Ms Law); Exhibit 160 para 15

²⁷ Athanasiov T2066 line 20

²⁸ T2064 line 40

²⁹ T2064 line 45

³⁰ T2065 line 40

³¹ T3090 line 20 - 60

³² T2067 line 5, 30

³³ T3091 line 20

³⁴ p25 Victorian Parliament law Reform Committee *Coroner's Act 1985 Discussion Paper* April 2005 available at <http://www.parliament.vic.gov.au/lawreform/coroner>

³⁵ Also Ranson D *How Effective? How Efficient? The Coroner's Role in Medical Treatment related Deaths* (1983)23 *Alternative Law Journal* 284 and other studies cited by Victorian law Reform Committee *Coroner's Act 1985 Discussion Paper* April 2005 note 90

Ambiguous

- 7.18 Secondly, the meaning of 'reasonably expected' is unclear. It is unclear on whose expectation and to what standard the outcome must have been unreasonable. Is it the person in the street, the family or relatives of the deceased, the general practitioner, the specialist practitioner, a coroner, or some other body? The view taken by the author of the State Coroner's Guidelines, probably correctly, is that it means an independent medically qualified person apprised of all the circumstances of the case.³⁶ However, even within that class, there are varying degrees of medical qualification and independence.

Complexity of issues of causation

- 7.19 Thirdly, a determination as to whether the outcome was 'reasonably expected' involves complex issues of causation. The language leaves open a significant degree of difference of opinion and debate about whether or not the health procedure was the cause of the death, rather than the underlying condition that made it necessary. Often there is a coincidence of factors.
- 7.20 The *State Coroner's Guidelines* suggest that in determining whether a death is reportable under this provision, coroners should, in consultation where necessary with an independent medical practitioner (eg a pathologist skilled in coroner's autopsies), consider the following questions:³⁷
- i. 'Did the health procedure cause the death?
 - ii. Would the person have died at about the same time if the procedure was not undertaken?
 - iii. Was the procedure necessary for the patient's recovery, rather than optional or elective?
 - iv. Did the death result directly from the underlying ailment, disease or injury?
 - v. Was the procedure carried out with all reasonable skill and care?
- If 'yes' to all – the procedure didn't cause the death
- i. Was the death an unexpected outcome?
 - ii. Was the condition of the patient such that death was foreseen as more likely than not to result from the procedure in question?
 - iii. Was the decision to undertake the procedure anyway, a reasonable one in the circumstances having regard to the patient's condition including his/her quality of life if the procedure was not carried out?

³⁶ *State Coroner's Guidelines* 2003 p3.9 available at <http://www.justice.qld.gov.au/courts/pdfs/guidelines.pdf>

³⁷ *State Coroner's Guidelines* 2003 p3.9

- iv. Was the decision to undertake the procedure based upon the assessment that the risk of death was outweighed by the potential benefits the procedure could provide?
- v. Was the procedure carried out with all reasonable care and skill?

If yes to all – death was not an unexpected outcome.’

Whether a pathologist skilled in autopsies is the correct standard against which reasonableness should be adjudged highlights the uncertainty I referred to earlier. But leaving that aside, these questions, which are relevantly formulated, are not easily answered. They involve difficult issues of causation. In many cases, the answer will permit many differing opinions and views from differing persons and from differing standpoints. In discussions with doctors, the State Coroner also has suggested doctors determine whether a medical practitioner familiar with the condition of the patient before the procedure that led to the death would feel obliged to warn the patient or his or her family that there was a real and substantial risk of death rather than the ordinary risk that accompanies the procedure.³⁸ However, in my view, this still allows too much latitude for differing views.

Anomaly of independent cause

- 7.21 There is also the anomaly that the circumstance may arise where the risks of a particular health procedure are so high that death is an expected outcome but not in the particular manner in which it subsequently occurs. For example, an elderly patient with a delicate heart may have such high risks associated with anaesthetic that the probability of death is so high as to be an expected outcome but, because the procedure is potentially lifesaving, the risks are taken. In that case, the death of the patient may not be reportable even though he or she dies as a result of something other than the anaesthetic, such as blood loss or falling off the operating table.

Degree of certainty

- 7.22 Finally, the Act does not give an indication of the degree of certainty required for a determination that a death was not reasonably expected. The question that arises is when does the possibility of death reach a high enough degree as to become expected. Some assessment systems may enable outcomes to be expressed in terms of a percentage. But at what percentage does a death become reasonably expected: 10%, 25%, 50% or more? As Dr Kariyawasam

³⁸ para 5 Submission Michael Barnes State Coroner 14 October 2005 (Final Submission Vol No2)

said,³⁹ any operation that involved general anaesthetic may involve the possibility of death.

Lack of audit

- 7.23 These problems are exacerbated by the lack of any check on the truth or accuracy of a certification once a doctor has certified the cause of death. As I have said, no system of auditing those cases where a doctor certifies the cause of death, and does not report the death to the Coroner, so far as I am aware, exists.
- 7.24 The relatives of the deceased person may agitate the possibility of a report to the Coroner, or the possibility of an autopsy. However, it would be understandable if families were inclined to avoid such processes because of the possibility of a disrupted burial and the trauma associated with an autopsy.

The experience elsewhere

- 7.25 The problems have been considered elsewhere. Recently, they were considered by a number of Commissions of Inquiry in the United Kingdom brought about by the murder conviction of Dr Harold Shipman a family general practitioner, who as part of his practice made house calls to his elderly patients. They have also recently been the subject of consideration by the Victorian Parliament Law Reform Committee.
- 7.26 In the public inquiry known as the Shipman Inquiry into how Dr Shipman, remained undetected by the United Kingdom authorities in the mass murder of 215 of his patients over 20 years, Dame Janet Smith, in her 3rd Report,⁴⁰ proposed a number of changes to the English systems of medical certification of death, and investigation by the Coroner's Service. She found that the English procedures, because they were dependent upon the integrity and judgment of a single medical practitioner, failed to protect the public from the risk that, in certifying a death without reporting it to the Coroner, a doctor might successfully conceal homicide, medical error or neglect leading to death.⁴¹ She recommended that, in recognition of the difficulty of determining, or of effectively separating unexpected deaths that warranted some investigation from expected deaths, all deaths should be reported to the Coroner, and that the Coroner would be responsible for certifying all deaths.⁴² She recommended that there should be both medical coroners and judicial

³⁹ T3090 line 5

⁴⁰ United Kingdom, *Death Certification and the Investigation of Death by Coroners* (Cm 5854, 2003) (known as the Shipman Inquiry's 3rd Report) available at: <http://www.the-shipman-inquiry.org.uk/reports.asp>

⁴¹ pp3, 118-9 Shipman Inquiry 3rd Report;

⁴² pp 27, 129, 502-7 Shipman Inquiry 3rd Report

coroners to scrutinise the cause of the death.⁴³ Doctors could express an opinion only as to the cause of death.⁴⁴ Dame Janet Smith referred to the research which had shown that some doctors were willing to modify what they believe to be the true cause of death in order to avoid a report to the coroner⁴⁵ and that even when making a proper effort to reach the right decision, doctors failed to do so in an unacceptably high proportion of cases.⁴⁶

- 7.27 In an allied review⁴⁷ into death certification and the Coroner's Service in England, Wales and Northern Ireland conducted by Mr Tom Luce, the same problem was canvassed. The Luce Report found that there was no reliable mechanism to check that the deaths which should be investigated by the Coroner are reported to him.⁴⁸ Mr Luce recommended that all deaths be subject to a second certification by a doctor, who has not been involved in the treatment of the deceased,⁴⁹ and the creation of a new post in the Coroner's office filled by a doctor, who would audit deaths certificates relating to deaths, not reported to a Coroner, to ensure the criteria for reporting deaths were being observed.⁵⁰
- 7.28 In 2004, in response, the Home Office published a Discussion Paper⁵¹ which has proposed the implementation of a system similar to the Luce recommendations except that it has recommended that the second certifier be attached to the Coroner service so that every death was examined and not just those reported. To my knowledge, no legislation or draft bill on the reforms has yet been enacted or introduced.
- 7.29 In April 2005, the Victorian Parliament Law Reform Committee published a Discussion Paper⁵² inviting comments and submissions about matters which could inform its recommendations for amendment of the Victorian *Coroners Act* 1985 including the death certification system. The options it is considering are those recommended in the Shipman and Luce inquiries and the United Kingdom Home Office discussion paper.⁵³ It noted the opinion of the Director of the Victorian Institute of Forensic Medicine that the certification system in Victoria, which is similar to that in Queensland in that it relies wholly upon the

⁴³ pp 25, 490-2 Shipman Inquiry 3rd Report

⁴⁴ pp 27, 499 Shipman Inquiry 3rd Report

⁴⁵ pp121-2 Shipman Inquiry 3rd Report

⁴⁶ pp 123-5 Shipman Inquiry 3rd Report

⁴⁷ United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* (Cm 5831, 2003) (known as the Luce report) available at: <http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.htm>

⁴⁸ p 16 Luce Report

⁴⁹ p 221 Luce Report

⁵⁰ p 220 Luce Report

⁵¹ United Kingdom, *Reforming the Coroner and Death Certification Service* (Cm 6159, 2004)

⁵² Victorian Parliament law Reform Committee *Coroner's Act 1985 Discussion Paper* April 2005 available at <http://www.parliament.vic.gov.au/lawreform/coroner>

⁵³ pp xv, 31-2

integrity of the certifying doctor, would not have detected the Shipman killings.⁵⁴

Proposals for change

Need for reform

- 7.30 In my view, the present position under s8(3)(d) of the *Coroner's Act* 2003 whereby, in effect, a single medical practitioners decides whether a death, particularly one arising from elective surgery in a public hospital, was a reasonably expected outcome of a health procedure, is in need of amendment. Obviously, deaths which are, or might be caused or contributed to by medical error or neglect, should be investigated by a coroner and, as Dr Patel has shown, at present the reporting of such deaths may be able to be avoided.

Options for reform

- 7.31 The advantage of the operation of s8(3)(d) of the Act, no doubt, is that it is speedy, cheap and convenient. The completion of the relevant certificate can occur quickly. To the extent possible, any proposed changes should strive to minimise affecting this feature. But that feature also gives rise to the main disadvantage; its dependency upon the integrity and honesty of a single medical practitioner for a determination as to whether that death should be reported to the Coroner.
- 7.32 If reforms to s8(3)(d) are to be proposed, they sensibly should deal not only with respect to deaths resulting in hospitals, but also more broadly with deaths resulting from health procedures generally. As the State Coroner points out,⁵⁵ the potential for apparent conflict of interest is not limited to post operative hospital deaths. It exists also in the case of general practitioners or other health service professionals treating patients in their surgeries or patients' homes. Reforms need to be broad enough and robust enough to capture all cases of medical errors, neglect and misconduct leading to death by health service practitioners.
- 7.33 There are a number of options for reform. The most obvious are to adopt the recommendations, or variations of the recommendations of each of the Shipman Inquiry, Luce Inquiry or the United Kingdom Home Office in its position paper. Essentially these options, which are the ones being considered by the Victorian Parliament Law Reform Committee, are as follows:

⁵⁴ p 31

⁵⁵ para 11 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

- (a) (the Shipman Inquiry) to require all deaths resulting from a health procedure to be reported to a coroner so that the certification as to the cause of death or, alternatively, at least a certification audit and any decision about which deaths should be investigated is determined by a coroner. The health practitioner's involvement would be effectively limited to providing a medical opinion on the cause of death;
- (b) (the Luce Inquiry) to require a second health practitioner, preferably a more senior practitioner in the line of management or of equal standing also to certify the cause of death and to continue to require a coroner to be notified only of reportable deaths as presently defined;
- (c) (United Kingdom Home Office) to require that the cause of death be certified by two doctors but have the second doctor attached to the coroner's office. This would ensure impartiality and allows the coroner's office to scrutinise all deaths.

7.34 My main concern about option (a), the Shipman Inquiry option, is that the State Coroner and other coroners in Queensland would require substantial support and resources to enable such an extensive certification and/or examination process to occur. The consequence of requiring the reporting of deaths without the early certification by a doctor that it was not an unreasonably expected outcome is that it would be necessary to ensure that the State Coroner, and other coroners, throughout the State are able to determine such questions promptly.

7.35 The submission of the State Coroner⁵⁶ reveals that there are already deficiencies in the extent to which the State Coroner is able to appropriately investigate medical deaths. The difficulty is that a determination as to whether or not a reportable death should be extensively investigated needs to be made with the assistance and input of a doctor. At present, a doctor who seeks the authorisation of a Coroner to issue a cause of death certificate in relation to a reportable death must complete a form that requires the doctor to provide information about the circumstances of death, and to submit a draft cause of death certificate for the consideration of the Coroner. However, the difficulty pointed out to me by the State Coroner⁵⁷ is that he or she must rely upon the advice of the treating health practitioners that nothing untoward occurred, and that no aspects of death warrant investigation. He seeks to augment that advice by discussing questionable cases with one of the forensic pathologists from the John Tonge Centre. Even at present, therefore, there is a need for the State Coroner and other coroners to have a dedicated medical officer to review medical charts and to assist in determining whether a cause of death

⁵⁶ paras 25 – 33, Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁵⁷ para 23, Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

certificate should be issued without further investigation of the death. If it were to be the case that all deaths were referred to a coroner, the need for such assistance would be substantially greater. The time constraints of this Inquiry have not enabled me to examine closely the full requirements and ramifications of such a change to the system. Presently, in any event, I am not convinced such a dramatic change is necessary.

- 7.36 The difficulty I see with option (b), the Luce Inquiry option, is that, although the risk of dependence is lessened, it is not, in my view, sufficiently removed. The opportunity will still exist for a dishonest health practitioner to seek co-signature of a dishonest or careless colleague. The proposal by the Luce Inquiry that the second certifier only be persons approved by the coroner service will not eliminate this opportunity merely because of the magnitude of numbers of second certifications required. Health practitioners in remote locations also may experience difficulty obtaining a co-signatory, particularly of another medical practitioner whose impartiality can be seen to exist. In the case of public hospitals, it would not be sufficient, in my view, to require that deaths be co-certified by the medical superintendent. The evidence before this Commission is that most of these persons are no longer practicing clinicians. Moreover, in the case where a patient has been under the care of a specialist consultant, the Medical Superintendent usually will not have sufficient specialist skill or knowledge to act adequately as a safeguard against a rogue specialist.

Preferred option for reform

- 7.37 An elective procedure in a public hospital by its definition and nature is surgery from which a death is not an expected outcome. As I have stated, by definition, the scope of procedures that constitute elective surgery is surgery which can be delayed for a period of at least 24 hours. I see no reason why, in the provision of any other health service, any other health procedure which could be delayed for a period of 24 hours, also would not by its nature be a procedure from which death would be a reasonably expected outcome.
- 7.38 In my view, the intent of the s8(3)(d) would be better achieved and the mischief to which I have referred overcome simply by including within the meaning of a reportable death, an additional category being a death that happens within a certain time of an elective procedure. The requirement that all deaths happening within a certain period of time following an elective health procedure are reportable, removes the dependence presently placed upon a single doctor to decide whether a death was reasonably expected. At the same time, it should not overburden the State Coroner's office with the responsibility of investigating all deaths arising from a medical procedure. Trauma deaths would remain subject to the existing provisions.

- 7.39 Dr Woodruff described a 30 day period, the perioperative period, as an accepted yardstick of surgical performance⁵⁸ and, perhaps, this could be a reasonable period to adopt. Alternatively, a shorter period may also be appropriate. Further medical input may need to be sought about the length of such a time period.
- 7.40 The Australian Capital Territory has a special category of reportable deaths being where a person dies during or within 72 hours after or as a result of an operation of a medical, surgical, dental or like nature or an invasive medical or diagnostic procedure other than an operation or procedure that is specified in the regulation to be an operation or procedure to which the requirement does not apply.⁵⁹
- 7.41 For present purposes, I will adopt the period referred to by Dr Woodruff and recommend amendment to s8 by adding a new subparagraph, after subparagraph (d) to read:
- ‘The death happened within 30 days of an elective health procedure’.
- And by adding a new definition in Schedule 2, to read:
- ‘Elective Health Procedure’ means a health procedure that can be delayed for a period of 24 hours without death being a likely outcome.
- 7.42 The health practitioner responsible for the care of the patient should still be obliged to provide a medical opinion on the cause of death, if possible. However, the final certification of the patient’s death would be determined by a coroner thereby removing the risk of concealment of medical error or neglect or misconduct by a doctor in certifying the cause of death. Obviously, there would be a need to ensure that the Office of the State Coroner and other coroners is adequately equipped and resourced to discharge the responsibility of investigating and determining the cause of such deaths. However, the burden will be not as great as it would be if all deaths were referred to a coroner.

Need for expert support

- 7.43 I am informed that a need already exists for the State Coroner and other coroners to have a dedicated medical officer to review medical charts and to assist in determining whether a cause of death certificate should be issued without further investigation of the death.⁶⁰ In my view, such a position should be provided.

⁵⁸ T4273 line 10

⁵⁹ *Coroner’s Act* 1997 (ACT), ss13(1)(e), 77(1)

⁶⁰ para 24 Submission Michael Barnes State Coroner 14 October 2005: (Final Submissions Volume 1, No 2)

- 7.44 Additionally, in my view, a need will exist for a coroner to have more specialised assistance available. The investigation of deaths in a medical setting, as I have said, involves particularly complex and challenging issues. I am informed that when a death occurs in other unusual settings, coroners already have available to them persons from specialised investigative bodies: for example, inspectors from the Department of Natural Resources and Mines in relation to mining deaths; officers from Maritime Safety Queensland in relation to boating accidents; and officers from the Australian Transport Safety Bureau in relation to aircraft accidents.⁶¹ By contrast, I am informed that most coronial investigations in the medical setting are undertaken by police officers, who have a reasonable level of expertise in investigating matters such as suicides, motor vehicle accidents, homicides and many other matters that frequently come before a coroner, but who do not have medical expertise.⁶² I am further informed that hospitals frequently fail to co-operate with police investigators. The State Coroner receives complaints from police and local coroners that doctors and nurses will not provide statements despite repeated requests, and on occasions, police have to resort to search warrants to obtain medical files.⁶³
- 7.45 The State Coroner informs me⁶⁴ that currently he has arrangements in place with the Chief Health Officer, whereby coroners who need access to independent expert medical opinions can approach the Chief Health Officer to have him nominate an expert. However, those experts can only be provided with medical reports and the self serving statements clinicians may have provided. There is no system in place, I am told,⁶⁵ for experts to take a more proactive role such as for example interviewing witnesses. On occasions, the State Coroner has received reports of investigations undertaken by senior clinicians appointed to act as investigators under the *Health Services Act 1991* and these have been very useful.
- 7.46 In my view, the State Coroner should, in addition to current arrangements, and those which I have already proposed, have access to a specialised panel of trained persons in various health service disciplines, appointed from either the public or private sector, who would be prepared to consult and provide assistance on an hourly or part time basis in relation to what deaths resulting from an elective health procedure might requiring investigation, what investigative steps might be appropriate and what, if any further independent experts might needed to provide an opinion in the matter. Members of the panel should be given the powers necessary to enable effective investigation,

⁶¹ para 26 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁶² para 26 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁶³ para 27 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁶⁴ para 31 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁶⁵ para 31 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

including, for example, if considered necessary, the power to require prospective witnesses to answer questions or attend for interview.

- 7.47 I am informed⁶⁶ that the Victorian State Coroner has such system in place. Under the Victorian system all deaths are initially reviewed by a multi-disciplinary team of clinicians who advise coroners whether a death warrants investigation. In the event that the advice of this clinical liaison team is that a particular death should be investigated, the team then advises what investigative steps are appropriate, and what independent experts might need to provide an opinion in the matter. This information is then used by those persons involved in the investigation, including police officers.
- 7.48 The State Coroner has drawn my attention⁶⁷ to a recommendation which he has made at the conclusion of a recent inquest, that the Chief Health Officer develop, with the State Coroner's assistance, a policy and process for the independent expert investigation of all deaths that are not reasonably expected to be an outcome of a health procedure. He also recommended that the reports of such investigations should be made available to the coroner, and the family of the patient, as soon as possible. Given the recommendations I propose, an independent investigation and report in respect of deaths resulting from elective health procedure deaths and occurring within 30 days should not be essential. Such a report, however, would be most helpful to a coroner and to the auditing processes of a hospital. Other reportable deaths also may still arise within a hospital, including under the current category of a reasonably unexpected death. In those cases the recommendation of the State Coroner remains apt.

Certification by junior doctors

- 7.49 The anomalous practice highlighted by the evidence of Dr Patel getting the most junior doctor in the operating theatre to sign a death certificate should be addressed. Sensibly, in my view, the person responsible for the care of the patient or in charge of the relevant health procedure should be responsible for signing a death certificate and certifying to the appropriate authority, that the circumstances of the death do not require further investigation.

Recommendations

- 7.50 I make the following recommendations:
- (a) The *Coroners Act* 2003 be amended by:

⁶⁶ para 33 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁶⁷ para 32 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

- (i) adding a new subparagraph to s8(3) after subparagraph (d) to read:
‘The death happened within 30 days of an elective health procedure’.
- (ii) adding a new definition in Schedule 2, to read:
‘Elective Health Procedure’ means a health procedure that can be delayed for a period of 24 hours without death being a likely outcome.’

The 30 day time period specified in my proposed amendment may need to be the subject of further medical input.

- (b) The *Births Deaths and Marriages Registration Act* 2003 be amended to ensure that:
 - (i) in the event of a death happening within 30 days of an elective health procedure, the health practitioner in charge of the procedure is obliged to provide to the coroner his opinion on the cause of death;
 - (ii) all deaths otherwise occurring in public hospitals are certified by the health practitioner responsible for the care of the deceased person;
- (c) A dedicated medical officer be appointed to the State Coroner’s office to assist in determining whether deaths happening within the stipulated period of an elective health procedure are required to be further investigated and to assist in the conduct of that investigation;
- (d) A panel of specialised persons trained in the various health service disciplines be appointed, and given such powers as are considered necessary, to enable coroners to consult with and receive assistance from such persons, on an hourly or part time basis, for the purposes of determining whether deaths happening within the stipulated period of an elective health procedure should be investigated and for the purposes of conducting that investigation;
- (e) A process of auditing compliance with the reporting obligation be undertaken at all public hospitals;
- (f) Queensland Health put in place a policy to ensure investigation is undertaken in relation to each death that occurs in a facility operated by them, and that a report of that investigation be provided to the coroner and the family of the deceased;
- (g) Continuing training be provided to all doctors to ensure that they remain aware of their obligations to report.

Chapter Eight – Conclusions

- 8.1 It would be a pity if the impression gained from this Report was that there were few capable, industrious and caring doctors still working within public hospitals. On the contrary, there are many, some of whom gave impressive evidence before this Commission.
- 8.2 But many capable, industrious and caring doctors have left the public system, particularly from provincial hospitals. The causes of this have been excessive and unsafe working hours caused by inadequate numbers of capable doctors, inadequate salaries and conditions, and a failure to involve them in decision making in areas in which there is tension between, on the one hand, patient care and safety, and on the other, budget integrity. The provision of inadequate funds to provide the services promised, is a root cause of all of these.
- 8.3 There has been a similar problem with nurses in public hospitals. One of the few heartening aspects of this Inquiry has been the positive remarks made about the high quality of nurses. But that is not the same thing as saying that the quality of nursing care was high. It was not because, as with clinical care, there were too few nurses to provide it, they were working unsafe hours, and quality thereby necessarily suffered.
- 8.4 Nor should it be thought from the defective nature of administration at Bundaberg, Hervey Bay, Charters Towers and Rockhampton that all or even most administrators are incompetent. On the contrary, I heard evidence from many able and dedicated administrative officers. Moreover, their performance must be viewed in the context of constraints imposed on them by inadequate budgets and then strict enforcement.
- 8.5 These constraints and their strict enforcement have been the main cause of conflict between administrators, whose main concern has been budget integrity, and clinicians, whose main concern has been patient care and safety. Unfortunately, the conflict seems too often to have been resolved in favour of an economic rationalist view of budget management, sometimes with harmful effects on patient health and safety. The view, which seems to be that of Queensland Health, that substantial adverse publicity is as serious a consequence as multiple deaths is shocking.
- 8.6 Also shocking is the view expressed by Dr FitzGerald to Ms Hoffman, echoed by both Mr Leck and Mr Allsopp, that even in the case of elective surgery, it is better to provide an inadequate service than none at all. Whilst it may be necessary, particularly in rural or provincial hospitals, for a doctor other than a specialist in the relevant speciality to provide urgent emergency care to a

patient, there can be no justification for providing elective care, including elective surgery, which is less than adequate and reasonably safe.

8.7 Because there are so many cases in which patient care and safety will conflict with budget integrity, it is essential to have clinicians involved in decisions about what is needed to provide adequate, reasonably safe clinical care, and, consequently, how much needs to be spent to provide that.

8.8 As indicated in Chapter Six, there were five deficiencies which together contributed to the unfortunate situations examined by this Inquiry in Bundaberg, Hervey Bay, Townsville, Rockhampton, Charters Towers and Prince Charles Hospitals. It may be reasonably inferred that they contributed to similar problems in other hospitals. They were:

- (a) An inadequate budget defectively administered;
- (b) A defective administration of area of need registration;
- (c) An absence of credentialing and privileging or any like method of assessment of doctors;
- (d) A failure to implement any adequate monitoring of performance or of investigation of complaints;
- (e) A culture of concealment by Government, Queensland Health administrators, and hospital administrators.

8.9 All of these deficiencies need to be addressed and effectively overcome. Anything less would be an inadequate response to the urgent need for a safe public hospital system. In Chapter Six I have suggested ways in which these deficiencies may be overcome.

8.10 There is one final point which I should make about this Inquiry and this Report. Upon publication of it, this Report will immediately be put on to the Commission's website. As has been shown in respect of other inquiries, particularly those into a public health system, reports such as this, and, indeed, the evidence on which they are based, are a valuable public resource. The websites of the Shipman Inquiry and the Bristol Royal Infirmary Inquiry in England remain as valuable public resources of fact and opinion. It would be a great pity if that were not permitted to remain the case in respect of the website of the Inquiry. I therefore recommend that it remain in existence for a period of 5 years from today.