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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BUNDABERG

..DATE 29/06/2005

..DAY 15

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THE COMMISSION RESUMED AT 9.36 A.M.

COMMISSIONER: Good morning, ladies and gentlemen. Mr Andrews?

MR ANDREWS: Good morning, Commissioner. I recall Dr Miach.

COMMISSIONER: Thank you, Mr Andrews.

PETER JOHN MIACH, RECALLED:

COMMISSIONER: Dr Miach, before we open your cross-examination, I want to make it very clear that there was - I think, three weekends ago - there were media reports about your Registration status. What I want to make clear is that that is really of no interest at all to this Commission of Inquiry. As I understand, the position legally, given the reciprocal admission legislation that exists in Australia, anyone holding qualifications in any part of the country is automatically entitled to have those qualifications recognised in any other State or Territory. It is a matter of administrative oversight. An analogy that springs to my mind is that it is not unlike the situation where I or Mr Andrews or Mr Boddice get briefed to appear in a case in Melbourne and put in the right papers to have our admission recognised in Melbourne, but then get recognised in Melbourne the fact that we have taken silk and appear wearing a silk gown rather than a stuff gown. It's ultimately a matter of trivia. One of the concerns though is who chose and why they chose to spread that story to the media and that's a matter that we will need to look at more closely.

In that context, Mr Boddice, our attention has been drawn to Mr Thomas' article in this morning's Courier-Mail referring to the report co-written by four Queensland Health professionals, which has been sent in strict confidence to the department's Charlotte Street headquarters in recent days. I wonder whether there is some reason why Mr Thomas gets a copy of that report before we do.

MR BODDICE: Commissioner, I spoke to Mr Andrews this morning. My instructions are Mr Buckland, the Director-General, received the final report last night and it will be transmitted to the Commission today. Mr Buckland is, in fact, on the Gold Coast this morning, but when he gets back it will be sent directly to the Commission. Those are my instructions.

COMMISSIONER: That is as may be, but why has someone in your department chosen to provide it to the Courier-Mail before giving it to us?

MR BODDICE: I don't have instructions in relation to that.

COMMISSIONER: Would you kindly get those instructions?

MR BODDICE: I will seek those instructions.

CROSS-EXAMINATION:

MR HARPER: Dr Miach, my name is Harper, I represent the patients. I would like to discuss with you, firstly, the processes for recording and notifying adverse events. When you spoke in Brisbane you talked about that there's a whole industry of Adverse Events Forms - this is page 342 and 343 of the transcript - everybody fills in everything. Is it right for me to assume from that that you don't have a - don't place a great deal of trust in those processes?-- Adverse events are taken very seriously. I have always taken them seriously. The recording, the reporting of them, as far as I was concerned, was somewhat less than adequate. But certainly adverse forms, complications, and all of those things, in fact, are very serious. The process that existed or exists, I am not quite sure, I felt as being inadequate.

In what respects were they inadequate?-- The fact that adverse events - I rarely wrote adverse events myself. People in my department wrote them, nurses wrote them. I understand that they were sent up through the appropriate channels. Feedback was minimal and non-existent. That's the issue.

Was there a notional process which was supposed to occur for feedback?-- One would have assumed that, in fact, if there was a problem in a department, whatever department it might be, if a concern was raised that in fact there would have been feedback. As the years went on - in fact, I made a point at some of the meetings that I used to attend that, you know, we wanted some feedback. But, you know, that aspect of it, in fact, was highly - was highly inadequate as far as I was concerned.

Can I just ask when an Adverse Event Form is filled out, is it only the relevant surgeon or practitioner who is performing the task that fills it out, or can anyone else who observed it also fill it out?-- Adverse Event Forms are filled in by all sorts of people. Usually people who observe it, usually people who have issues, usually people who think that there's a problem. They can be filled out by anybody. From experience, I mean, I would rarely fill them out. When an adverse problem occurred and it occurred in my department, then I made sure that it was brought to my attention and I sorted it out. I mean, I used to sit with people fairly frequently and discuss issues. But a lot of the adverse events were, in fact, written or recorded by other people, sent through their stream of administration up to wherever they went. I mean, I would assume they went to the relevant

Directors and perhaps to the Executive some of them.

So do I take it from that then you think the best process is for the Adverse Event Form to go to the immediate supervisor or the relevant practitioner to discuss corrective action, rather than up to some other bureaucratic-----?-- I would think there is all sorts of complications, complaints, adverse events. Some things can be rectified fairly simply. If there was certain statue or certain seriousness, then I think it's reasonable for them to be taken up to a higher level. I don't think it's practical for every adverse event, for every complication, for every issue to go up to the Executive. That would be totally unworkable. A lot of these problems, side-effects, adverse events, in fact, are sorted at the appropriate level.

COMMISSIONER: Dr Miach, it strikes me the problem with that approach is that it leaves a lot to the responsibility of the relevant medical practitioner. If that person is a totally responsible person and puts the appropriate steps in place to rectify the problem, that's fine, but the evidence that we're hearing suggests that a man like Dr Patel, for example, either wouldn't fill in an Adverse Event Form or would ignore it if it were filled in, and that's why someone suggests that there has to be a fail-safe mechanism that the form gets sent to the Executive or to some other Central Registry so that someone has the responsibility for checking that appropriate steps are taken?-- Well, I would certainly agree with that approach. I mean, forms coming to me and from my taking action, signing off on them, or making comments on them, and then sort of sending them up the chain. So a Central Registry for complaints, I think, is an excellent idea. The approach of every problem or every complication, or every adverse event having to go and be managed by - at a very high level, I'm not sure whether that's practical, but certainly the recording, the registration and the filing of an adverse event is extremely important.

And I suppose there are other practical reasons why that ought to be done. For example, if the adverse event ultimately gives rise to litigation or forms part of a pattern, it's only if you've got a Central Registry to have access to those records across a broad spectrum of practitioners and incidents?-- I would certainly agree with that.

MR FARMER: Can I ask then where there is a complaint from a patient about treatment, would that ever lead to the creation of an Adverse Incident Form?-- Well, it should. It depends how the complaint - where it comes from, where it is sent and how it is handled. A lot of complaints, in fact, from a patient may go, for example, to the staff on the ward.

Can we take that example? If a patient gave a complaint to staff on the ward, in what circumstances would it be incumbent upon the staff member to fill in an Adverse Event Form?-- Well, in principle, theoretically, every time there's an adverse event or complaint I think some form should be filled in. Some of the adverse events, some of the problems, in

fact, is just an expression of explanation. Some of them are important to patients and their relatives. For example, there may not be important in the scheme of things. For example, I've heard complaints - I've heard people complaining about the food at the hospital, for example. I mean, that's a complaint. It's a relevant complaint to the patient and family, I don't deny that, but in the whole scheme of things, in fact, you know, whether a form should be filled in for that and sort of put in a registry, I don't know, but there are whole levels of complaints and it depends who raises them and who they are raised to. There are different levels. Some patients, for example, may send letters directly to the hospital and that's, you know - so there are different levels of complaints.

Okay. But say, for example, the patient of Dr Patel - a hypothetical patient - who complains to a staff member about they had this surgery last week, it's not improving since, where should that complaint to that staff member go from, where should that go? What should be the action which is taken?-- In that sort of situation in which there was a procedure performed or therapy or treatment given and there was a complication, that's a different story from the example I actually gave a few minutes ago.

Right?-- In that situation, I certainly would think that a form or a, you know, formal complaint or a formal reporting should exist and that's - in principle it should actually go to the people who initially - who actually were involved with the treatment, whatever it might be, if it can be rectified at that stage. But if there isn't an appropriate or a reasonable response, then it should go further up and where it should go is, in fact, to who is next responsible for the clinicians who practice in the hospital. It would actually go to the Director of Medical Services.

So in your view then there should be some feedback obviously to the patient after that complaint?-- Absolutely. My understanding is that - and I've seen statements, I've seen letters written, and the patients, I think, are usually advised, they are usually followed up, they are usually given some explanation of what happened.

Can I take - I want to take you through some of the evidence about individual patients, and I would like to take you, firstly, to patient P53, which you deal with at paragraph 73 of your statement. Now, have you got that there?-- Yes, I have.

Now, can I just confirm this occurred in June or July 2003?-- The date, I can't remember, but I have no doubt that's when it would be.

Because you mention in paragraph 74 that you had a discussion with Dr Jenkins in or around that time. So I would be right to assume it's somewhere around that period then, shortly before that June/July 2003?-- I spoke - there's been a number of communications with Dr Jenkins. This patient that's

referred to there, in fact, he rang me after the patient was transferred to Brisbane. So that was a discussion with Dr Jenkins. He actually rang me and asked me - had a discussion with me about this particular patient.

COMMISSIONER: Mr Harper, you said 53, patient 53?

MR HARPER: P53.

WITNESS: Could I have a list of the patients, because I don't have it?

COMMISSIONER: I will lend you mine for the time being?-- Yeah.

Yes, we're all talking about the same patients, are we?-- Yes.

Yes?

MR HARPER: That patient, you say, had problems with vascular access and that Dr Patel performed a procedure, which I think in your evidence in Brisbane you said was an arterio-central fistula?-- Arteriovenous fistula.

Right. What were the problems which arose after that surgery?-- The arm became ischaemic. That means it was in danger of being lost.

Right?-- The blood supply to that arm, in fact, became acutely deficient and that's the reason that, in fact, she was transferred to Brisbane straight away and the arm was repaired, it was salvaged.

And what aspects of Dr Patel's surgery do you think contributed to that?-- These are anatomical and surgical issues, and the anatomy of veins and arteries in an arm, and also proximally up near the heart is what this relates to, and again I haven't - my memory, my recollection of this is, in fact, if you are to connect - please stop me if I - if you are to connect two large vessels, an artery and a vein together, then, in fact, there must be run-off. In other words, the blood flowing must, in fact, be able to circulate properly. If, for example, there is stenosis, a narrowing of some of the major systems more proximally in the body, then, in fact, the blood flow can't dissipate, can't disperse and that was the issue in this case here.

And that was the result of Dr Patel's-----?-- No, it wasn't a direct - the narrowing, the stenosis as we call it, blockage, in fact, was preexistent.

Right?-- It was preexistent for months, probably years beforehand, and there are reasons why that may have, in fact, occurred. In fact, nephrologists, we don't do certain procedures in certain parts of the body because we are aware of these blockages that can occur subsequently. But usually when you operate on this sort of situation, you actually

ensure that the run-off is adequate.

Right. And Dr Patel didn't ensure that in this case?-- I can't - I can't be sure of that, but my understanding of this particular lady was, in fact, there was a narrowing in what's called the subclavian system.

Okay?-- So that the blood, in fact, got into the venous circulation but it couldn't dissipate and this is the reason that, in fact, the arm became ischaemic.

Can I take you now to patient P31?-----

COMMISSIONER: Before you move on, the patient we were dealing with, is it your view that that surgery was surgery that ought to have been performed at Bundaberg at all? Were the facilities and resources appropriate for that level of surgery?-- This type of surgery is usually performed by a vascular surgeon.

Yes?-- I actually had Dr Patel perform another piece of vascular surgery. I think that it was before this patient, I think it was before, and that went all right. It was a procedure which is usually done by a vascular surgeon. He did this procedure and it worked and, in fact, the lady is still using the procedure, the prosthesis there. When I - in my discussions with Dr Patel, I mean, he gave me the distinct impression that, in fact, he was quite competent at doing this type of surgery, and he did one procedure for me which worked so I let him - so I gave him another procedure to do. But this procedure here, in fact, is usually done by a vascular surgeon but a vascular surgeon ensures that the anatomy in the patient was adequate for it.

Am I right in recalling from somewhere in the evidence there is a private vascular surgeon practising in Bundaberg?-- Yes, there is.

And were such a situation to arise again, you would obviously prefer it to be performed by a specialist vascular surgeon?-- Absolutely. I mean, this vascular surgeon, in fact, performed a lot of vascular accesses, as we call it, while he was at the hospital. When he left the public system, then it was difficult or impossible to have public patients be operated by him because he didn't have an appointment at the hospital.

Yes?-- So, obviously, if he was available certainly he would - I would have referred her to him. The other alternative is to refer the patient to Brisbane. But early on I had the impression that Dr Patel, in fact, was competent in these types of procedures. So actually, as I mentioned, I gave him one to do that work and, in fact, followed that on, but that was the end of that as far as vascular access was concerned.

Yes. I wonder whether this is just another instance where the failure of Queensland Health generally to encourage the use of Visiting Medical Officers would have seen a better outcome if you had had the opportunity to utilise the services of a

vascular surgeon as a VMO?-- Absolutely. I agree with that 100 per cent. In fact, subsequently I did everything in my power and, in fact, there is some evidence that, in fact, that's exactly what I tried to do. I tried to actually institute the specialist vascular surgeon in the private system to somehow be involved in supplying vascular surgery to the patients in Bundaberg and in Hervey Bay. So, I mean, I agree with you. The point I made a few times to a number of people is it was a pity if vascular surgery in the State of Queensland is deficient and if you have a vascular surgeon in the region that you don't utilise him. I think that was always a very strange anomaly and I did everything in my power to try and redress that.

And this is a particular case in point, because I guess it's rather lucky for a town the size of Bundaberg to have available and on-hand a vascular surgeon and yet no attempt seems to have been made by the Administration to arrange for that man to be available to perform vascular surgery for public patients?-- He had an appointment at Bundaberg as a vascular surgeon and that he left the public system. I don't precisely know the exact date that that happened and how this fits in with vascular surgeries somewhere, but certainly he did have an appointment there but that for a variety of reasons in fact was stopped. He left the public system. Then he practices in private. As I said before, if a patient has private insurance, it is, in fact, very easy, he will do the vascular surgery in the private system.

That also fits in though with the evidence we have heard from you and other sources about the arrangement that was entered into to have public patients fitted with catheters at a private hospital here in Bundaberg at the expense of the company which supplies the material. I mean, there's been some suggestion that that's a great idea because it allows public patients to have the benefit of that treatment. But it would seem even better if that could be done at the public hospital where you and the public hospital nurses, and so on, are available to look after your patient from go to woe, rather than having to transfer that patient out to a private hospital?-- Absolutely agree with you, Commissioner, absolutely agree with you.

MR HARPER: Could I take you now, Dr Miach, to patient P31 and that's at paragraph 84 of your statement?-- Paragraph what, I'm sorry?

Sorry, patient P31 at paragraph 84 of your statement?-- 84.

The paragraph begins, "P31 was a young patient who arrived at the hospital"?-- Yeah.

You describe there what you may have described in your evidence-in-chief, I think it was, that that patient underwent a pericardiectomy, which is about draining the fluid away from around the heart. Could I just get you to describe physically how that surgery was done?-- Just the background to this is, in fact, it's a recognised severe complication with kidney

therapy that they accumulate fluid between what's called the pericardium, which is a fibrous sac which encloses the heart. If fluid accumulates in that space it then squeezes the heart, circulation fails and patients are in extreme danger. The way that is managed, it's managed acutely by putting in a fine needle in a catheter inside the pericardium sac and the fluid comes away and when that happens then, in fact, the patient improves. In fact, in this particular patient that was done. The problem with that is you can't leave a tube, you can't leave a catheter inside the pericardium forever. In the majority the fluid reaccumulates. If you take the catheter out, the fluid reaccumulates and you are in the same position as you were before. So it's classically done. In fact, a piece of the pericardium or fibrous sac is removed so it allows the fluid to drain away and it drains in what's called the pleural space in sort of another potential sac around the lungs and that is absorbed and that is the end of it. So the surgery that's performed is what's called a pericardiectomy or the institution or the production of what's called a pericardial window. A small amount of the pericardium is removed and that's it and the situation is fixed.

How is that accessed physically? How is it accessed?-- It's accessed just under the upper part of the abdomen, just underneath the notch, just underneath the ribs and going upwards.

Okay?-- These are surgical procedures. The way I have seen them done in previous hospitals that I have worked in, in fact, that's the way they are done. Some surgeons may make - some cardiac surgeon may prefer to go through the actual rib cage itself and other approaches, but the idea is in fact just to remove a bit of the pericardium. The way it's done, surgeons have different approaches. The way I have seen it done and used to is in fact by that approach, that in fact it's up there through there. You don't open the thoracic cage, you just do a pericardial window.

It's normal, though, to have that done under anaesthetic?-- Absolutely. Absolutely.

Without that anaesthetic it would obviously be an extremely painful incision in the chest?-- Well-----

It would be extremely painful?-- Not - I have never seen it done without anaesthetic and I have seen quite a few of them done.

Yes?-- To be able to - to be able to do that, in fact, you have got to go through the skin, through the diaphragm, through tissue, so that's a fair amount of tissue that you actually have to go through, and it's quite - it's - you know, it's for - a cardiothoracic surgeon it's - they do it.

Yes?-- But it's - it is done with an anaesthetic.

But in this circumstance, your evidence - when you gave evidence in Brisbane and your statement - is that Dr Patel did not use anaesthetic in that case?-- I came into theatre late. I have only been in theatre in Bundaberg a couple of times, once in this situation. This young man was fairly sick, so in fact I wanted to make sure that things were done the way I wanted them done, but I actually came in late and the operation was already underway. There was a fair - fair amount of tension, a fair amount of turmoil. The patient was quite uncomfortable and he had a sedative, yes, some sedation, but that's not enough for this sort of operation. Anaesthetic is what's required. He didn't get that. He was quite - it was quite distressing.

COMMISSIONER: Would you normally expect a general anaesthetic or local anaesthesia?-- Well, usually you would expect a general anaesthetic. Even a local anaesthetic, I think, you have to - again I'm not - I am not an anaesthetist or a surgeon, but to be able to give an adequate local anaesthetic I think you would have to infiltrate - you would have to sort of look at specific nerves, tissues, but usually the ones that I have been involved in over many years I have given an general anaesthetic and that is what I would have expected this young man to have.

Would I be right in thinking that the reason for using anaesthesia for such treatments are, of course, primarily for the comfort of the patients, so the patient doesn't have the agony of a chest operation without appropriate anaesthesia, but to make the operation or to improve the prospects of success of the operation and have the patient still and not wriggling around or leaping in pain or whatever?-- I think that's true. The discomfort of a patient is a major issue. I mean, I don't think patients should suffer pain at all. The other thing is to actually - there are very good analgesics these days as far as making pain not a problem. But the other issue is anaesthesia is in fact the awareness of the whole thing. That's another - that's another issue. The safety is something else. I mean, if you are actually operating near the heart and the patient is uncomfortable and is moving, I mean, I would suggest the operation would be more difficult and more dangerous.

Yes?-- I do know, for example, that when patients are anaesthetised and a surgeon's operating, not only this, in other situations, if the anaesthetic's too light the surgeon will sort of stop operating, he will sort of let the anaesthetist know it's too light and, in fact, adequate anaesthetic will be given and that affects muscle relaxation as far as making sure the patients are asleep. So there's a number of issues of anaesthesia which are relevant, and in this particular case all those issues were important.

Yes?

MR HARPER: Can I take you now to the evidence you gave surrounding the audit of the catheter placements, and I will take you back firstly to your evidence which you gave in Brisbane. It's at pages 294 and 295 where you talked about a protocol. You say, "There is a protocol, which in fact has been written by an international body, which we follow and I distinctly remember speaking to him", which was Dr Patel, "about catheters and offering - trying to give - it is very hard to give advice physician to surgeon, but I remember where it was and I spoke to him about these peritoneal catheters." Those protocols that you talk about, that is the accepted standard and procedure for the placement of these catheters; is that correct?-- There are protocols and there are protocols, but there are certain things that - that are standard. As far as peritoneal catheters are concerned, it is not a particularly difficult operation. It's sort of a simple procedure. When I - when I started doing renal I used to put them in myself in the ward. These days we don't. The catheters have changed, and these days in fact sometimes nephrologists put them in. I think there are another two nephrologists that do that. But usually they are put in - they are put in by surgeons. They have to be placed meticulously in a sterile way in a certain spot with the exit site coming in a certain - at a certain direction. Now, that's - that's what's basically - everybody that does peritoneal catheters in fact knows that. I read - I mean, I am aware of these issues. After the first one, two, three - I

don't know how many - in fact that there were issues, I spoke to him at least once, perhaps twice, I just can't recall, in general terms about some of the issues with the peritoneal catheters. He listened but he was not communicative. I mean, my impression was that in fact, you know, "I'm a surgeon, you are a physician. This is a surgical thing. This is what I will do". But I pointed him out - I actually offered to sit down with him to discuss things. I discussed it with him on a number of occasions.

When the audit was conducted, there was six in the audit. Did you directly yourself examine any of those patients and the placement of the catheter?-- Well, the catheter is the place - I follow up everybody.

Right?-- I follow up everybody. I have a system in the hospital that - you know, that I look after - there's a routine. I have special clinics that actually have to do with - with dialysis. So these catheters I knew about. I wasn't happy with them. This is why I suggested that the audit is done. So I saw them all.

Right. And in your view, and I can go though each of them specifically if that assists, but in your view were each of them below professional - a competent professional standard?-- The only thing that you can actually see in a catheter is, in fact, where the catheter comes out through the abdomin. What actually happens inside the abdominal - inside the abdomen you can't see. I mean, you can guess and you can assume, and there's certain things that we do, but the only thing that you can actually see is in fact how the catheter - where it comes out and what the direction of the exit site is. Now, usually in catheters, in fact, the exit - the exit site should actually be pointing down towards the feet, and there are reasons for that.

Yes?-- If they point sideways or sort of upwards, it's not at all good for a variety of reasons, and I can give you examples of the sorts of issues that we actually have when that happens.

Well, I'm happy for you to give-----?-- There's one gentleman now, for example, that the catheter was placed in 2003. He's still dialysing. The catheter is still being used but he has complications. For example, he has recurring infections. He's had a number of infections. And that's just common sense. If you actually - you are leaving it in a human climate like this and people are sweating and, in fact, you desquamating cells, it will come down to gravity. There's a pocket to catch these cells, this sweat, this dust and everything else, and basically it's a culture medium. In fact, it's very, very common to get infections there. That is the reason that, in fact, we are very specific for the exit site to point downwards.

Yes?-- And in this particular man, in fact, it's pointing in the wrong direction, and he's had a number of episodes of peritonitis. We have been able to manage them but he knows

that if he keeps getting them I will have to take the catheter out. They are the sorts of issues. It's not a question of sort of having a complication there and then. In fact, you have to sort of think months, years ahead in these patients.

Can you see - you have got the patient key there. Is that patient listed on the patient key?-- I will have - yes, he is. P45.

Thank you. Can I take you now to patient P52, which is at paragraph 75 of your statement?

COMMISSIONER: That's a name that is no longer subject to any restriction.

MR HARPER: The woman's name was Marilyn - Daisy Marilyn or Marilyn Daisy?-- Marilyn Daisy.

Marilyn Daisy. Ms Marilyn Daisy. And at paragraph 75 of your statement - now, this was the woman who was originally a patient of yours, was that right?-- She's always been a patient of mine. She still is.

Right. And she had an episode which was performed by Dr Patel. Can I just ask, was this - to your knowledge was that related to her kidney problems or her diabetes or one of the two?-- Related to her diabetes.

Okay?-- The diabetes was responsible for her kidney problems and also for her ischaemic leg.

Okay. So, it wouldn't have been necessary for you to be consulted about whether the amputation was appropriate or necessary?-- Well, the amputation, perhaps not, but in fact it's custom and it's everything else that one would, but the corollary of that for the rest of her treatment is yes, because in fact she wasn't in danger of dying from her amputated leg, but she was in danger of dying of the other comorbid medical conditions that she had.

You expressed concern, I think, that you weren't consulted about her by Dr Patel?-- That's correct.

You further raised concerns - sorry, she was then transferred down to see Dr Jenkins. Is that right? And can the witness be shown Exhibit 17? I have got a copy here that I can put up on the screen if it's quicker.

COMMISSIONER: It's probably easier to use the copy. Can I just make a point, that we now have close to 100 exhibits. If you are expecting to refer to something it's better to give the Secretary a moment's warning so he can-----

MR HARPER: My apologies. I don't need to take you to the detail of that letter at the moment, but do you accept that there are, it seems to me, two separate issues there which Dr Jenkins addresses? The first relates to - which is the first paragraph, it seems to relate to the vascular access for

the purpose of her dialysis; is that right?-- That's correct.

And the second relates to matters arising from the amputation of the leg?-- That's correct.

Was the patient referred to Dr Jenkins for the access to the - for the dialysis access or for the issues regarding the amputation of her leg?-- Primarily for the vascular access.

Right. Did you have a discussion with Dr Jenkins before you sent her down?-- Not personally with him. The way we - referrals are made, in fact, they are done via the PHOs, the Principal House Officers. This lady, in fact, went down to Brisbane some weeks after she had her leg amputated. She needed a lot of treatment in Bundaberg by the Renal Unit to actually make sure that she was fit to go down to - down to Brisbane. So she had a lot of dialysis which was instituted in an acute fashion. When she was well, and in inverted commas "stable", she went down to Brisbane with a construction on her arteriovenous fistula so that she could continue dialysis. Once you start someone on dialysis and they have chronic renal failure you can't stop, you just have to keep going.

When she went down to Brisbane were the stitches still in place? I gather from the letter from Dr Jenkins that they were?-- Well, obviously they were. He's a vascular surgeon. I mean, this lady had an amputated leg. That is a surgical thing. She was critically ill as far as her renal failure was concerned. We sorted that out. I didn't look at - at the leg. I may not have been able to sort of recognise the stitches and the necrotic material in the rest of the site, so I personally didn't have a look at the stitches. It's one of the things that surgeons do. Surgical PHOs, surgeons who are responsible for her, they are the ones that sort of follow up. We have had a recent patient that in fact came up and the surgeons had another amputation - totally unrelated - there was - there was a strict protocol between the surgeons down there and ourselves about when the stitches were to come out. So that's an inter-relationship as far as stitches are concerned in amputated limbs. In this patient, in fact, the stitches were left there. They were there when she went down to Dr Jenkins. That's the way it was.

COMMISSIONER: All right. Mr Harper, I wonder if I can interrupt just to follow this up a little? Presumably for the management of this lady's renal condition she would have been moved into a medical ward. Would that be right?-- She would have been moved. She would have been moved up to the Dialysis Unit but I still remember myself putting in a large catheter to be able to dialyse this lady, and I think that she - she stayed on the Medical Ward, I think, but I can't - she may have gone down to Surgical when she went, but-----

I'm just wondering whether the issues - issue with her stitches may have been - as tragic as it is - may have been more an oversight than anything else, that normally a surgical patient would be in a Surgical Ward where surgical staff would

be attending to things like checking the stump for the stitches and so on, but because she was removed to the Medical Ward there was, I guess you might say, a breakdown in communications?-- That's possible. That's possible. Certainly when medical patients find themselves in the Surgical Ward the overview of them is not as good if they are in the Medical Ward, and the same thing may have happened as far as a surgical issues were concerned. I think she came to the Medical Ward but, as I say, I just can't remember.

Can you tell us whose responsibility it was to manage her - I will say her wound, it's really the amputated stump - whose responsibility that was once she arrived in the Medical Ward?-- Oh, still the Surgical Unit. I mean, they are the ones that do the operation. They are the ones that the follow-up. They are the ones who have got the expertise. They are the ones who know when stitches need to come out in a particular case. So even though she may have been on the Medical Ward, as far as the surgical issues as far as her leg was concerned, the would remain a surgical problem.

You see, Dr Miach, one of my concerns about this aspect of the evidence is that there's no-one here representing Dr Patel to put his defence, so I have to be to some extent the devil's advocate and ask you whether there is any excuse for Dr Patel, his surgical team, that this patient was taken or may have been taken to the Medical Ward and whether that, as it were, took her out of their responsibility, whether they were able to wash their hands of her and say, "Well, now, she's in the Medical Ward, she's Dr Miach's responsibility and not ours"?-- I appreciate that. As far as the surgical issues are concerned, they remain surgical issues. She came to the Medical Ward because the acute and major issues with her at that stage were her medical management, which we did, but she had a surgical problem. I mean, physicians and surgeons, we work together frequently. In fact, I look after medical patients and surgical patients and vice versa. So the fact that this lady had an amputation, in fact, remained - as far as I'm concerned always remained a surgical issue.

Could it be suggested, and I'm certainly not making the suggestion myself, but could it be suggested that perhaps practices in Australian hospitals are different from those in the United States and that, for example, Dr Patel may have thought, based on his experience in the United States, that once the patient went out of his ward the patient was no longer his responsibility, it was up to someone else to check the surgical wound?-- That's possible. I don't know the sensitivities in the - what's done in the United States, but that's a theoretically - it would be possible.

The other possibility that's emerged, I think, from some questions yesterday is that Dr Patel may have gone on holidays a few days after the amputation was performed. What in your understanding would be the responsibility of the surgeon who performed the operation to ensure that someone was deputed or delegated to look after the patient?-- That's routine. You know, if someone - if there's an acute medical or surgical

patient and, in fact, you take some leave or you go away, you delegate that automatically to your surgical staff, whoever that might be.

Yes?-- So I don't - I don't know whether he went on holidays or not, I have go idea.

MR DIEHM: That was a different patient, Commissioner. That was P26.

COMMISSIONER: I am aware it was a different patient but I just want to explore these probabilities.

MR DIEHM: Very well.

WITNESS: No, I think if a surgeon's performed a procedure and he goes on leave for whatever reason, that is delegated to the surgical part of the hospital, whoever that might be.

COMMISSIONER: Yes?-- You can't leave acute surgical problems and just disappear. I mean, I don't leave acute medical problems when I leave. I'm always contactable or I get a locum or whatever. So I think there's to be continuity. So, you know, exactly the same as surgery.

Thank you for that.

D COMMISSIONER EDWARDS: It was said there are protocols and understandings relative to the management of patients between one, two, or three different medical people?-- Well, certainly. Certainly there are understandings. Sometimes there are protocols. Certainly there are understandings. It is just common sense if someone has an acute procedure and the operating surgeon disappears for whatever reason someone needs to follow that patient up, otherwise the patient will get into trouble.

COMMISSIONER: And I would have thought that these protocols are well settled and well understood because we're not only talking about patients transferred from surgical to medical wards and vice versa, but you might have a patient coming from an entirely different area of the hospital, from obstetrics or even possibly - even psychiatry, or something like that, and you would need to have those protocols in place to know that if the patient has been - has received surgery that patient will be continued to be monitored by the surgical staff, even if he or she ends up in a psychiatric bed or in an obstetric bed or something else?-- That's extremely well understood. It's extremely well understood. If patients have two or three problems at the same time, very frequently, especially medical patients, they are frequently co-managed as - you know, by psychiatrists or by obstetricians or surgeons. In fact, they get the best possible result for patients. There's frequently sort of a number of unions, a number of specialists involved managing the patient. It's exactly the same. For example, this lady here, she has a number of issues and I think needs to be managed by vascular surgeons, by a nephrologist, by cardiologists, by rehabilitation people, physiotherapy, social

work. This is a multidiscipline. So I don't think you can - I don't think it's - you can say, you know, the leg came off, went to the Medical Ward and that's it. It doesn't work like that. It's a very counterproductive approach and it doesn't occur in any reasonable hospital.

Well, if I can then put the ultimate question to you. If Dr Patel had chosen to be represented in these proceedings and there was a barrister here on his behalf putting questions to you and said, "Dr Miach, isn't it the fact that the problem with this lady with her sutures not being taken out and so on occurred in your ward, in your Medical Ward, she was lying there for six weeks with her wound unattended to, that's your fault, isn't it?"?-- One could say that. One could say that. But my - my knowledge, my understanding, is the practice is, in fact, as I have mentioned, if that's a surgical issue, the surgeons continue fixing - fixing it up. That's the way it's done routinely everywhere.

And as you say, you wouldn't even necessarily have looked at the stump because it was no part of your treatment for her?-- Well, I didn't look at the stump myself. I know I am sort of saying I assumed other people would have done it, that's probably not a very good way of putting it, but I would expect, as is part of normal medical surgical practice, that in fact the Surgical Unit would have come up and reviewed this leg. Stitches, it may not have been done by the consultant surgeon. Certainly his staff, in fact, would have - would have been expected to do that, and that's - what's what's always - that's commonsense, as far as I am concerned.

It is staff who might have done it but it was his responsibility to ensure that it was done?-- That's the way I would see it.

D COMMISSIONER VIDER: Dr Miach, when correspondence such as is before us now is received, is that information passed on to the relevant clinical staff at ward department level or wherever so that everybody gets to see those expressions of concern or otherwise?-- This letter here?

Yes?-- I got this letter a few days after this lady went down to Brisbane some weeks, as I mentioned, for a vascular, and I got this letter some time after - after she was - after she was - the Renal Unit staff were aware of it. I'm not sure whether I specifically gave it to the Renal Unit staff, but I phoned the staff quite a number of times and I made the relevant people aware of this letter.

And that would routinely happen in your unit or anywhere that you're responsible for, in terms of any communication like that, it is discussed with the relevant staff so they all have an opportunity to review it and learn?-- Absolutely. This particular letter, in fact, is quite unusual. It is very rare you get this type of letter. The first thing I did, in any event, I rang Dr Jenkin and tried to explain to him what actually was going on in Bundaberg and he was somewhat more understanding of what happened. I mean, no-one was aware that

this lady in fact was around. No-one from the Medical Ward, from the Renal Unit, wasn't aware this lady was around until she was in extremis.

MR HARPER: Can I just pick up on that? You said you rang Dr Jenkins. Was that-----?-- Yes.

Was that after you got the letter?-- Yes, after I got the letter.

You didn't have any discussions with him before he sent the letter?-- No. No. We sent this patient down, as I mentioned, for a routine review, as far as the vascular access was concerned.

Right?-- He quite correctly - he's a surgeon, so quite clearly looked at all the surgical issues, including the stump, and that's what the - that's why he wrote me this letter.

Okay. You said before you explained to him a situation in Bundaberg. What do you mean by that?-- What I meant by that is in fact that I let him know that in fact this lady was admitted under the surgeon, that she had a procedure there, she was in severe renal failure, we weren't aware she was there-----

Right?-- -----for quite an initial - I can't remember how many days, but it would have been three, four, five, six days, I just can't recall the exact - it wouldn't be more than that because she, in fact, wouldn't have lasted much longer the way she was. Then, as I mentioned, she was taken to the Renal Unit and the Medical Ward and we worked on her to make sure she was all right and then she went down.

Did you explain to Dr Jenkins it was Dr Patel who'd done the surgery?-- Absolutely.

Did he know that before you had that discussion with him?-- He must have known because, in fact, a copy of this letter, in fact went to Dr Patel, so-----

Okay?-- The letter, that must have been written by the PHOs, the juniors. In fact, it's very likely that was mentioned. I didn't see the letter. It's - obviously Dr Jenkins knew about - who the surgeon was.

In paragraph 77 of your statement, you talk about when you went to see her in the ward. You say she was almost comatose. She was suffering from uremic encephalopathy. Did you, after discovering that, deem it necessary to fill out an Adverse Event Form?-- No, I didn't fill out an Adverse Event Form. My pre-occupation was to make sure that this lady was okay. So, I didn't fill out an Adverse Event Form. I took her up to the Renal Unit and made sure of the fact that she survived and in the event - that was my main pre-occupation, and, in fact, - but when this letter came back as far as event forms are concerned - I mean, the event form, if I filled it in, would have gone up a certain way. It would have gone up to the Director of Medical Services. When this letter came, the first thing I did was I photostated it and brought up myself - brought this letter to the Director of Medical Services, so that's the adverse event. He got it from the horse's mouth - from both me and also from Jason Jenkins down in Brisbane.

It would have been more effective than filling out a standard proforma form and sending it through?-- Filling in forms, I think, is fine if - you know, if there's a purpose to it. I mean, we actually discussed - some time before - I personally don't have time to fill in forms. I rattle around the Wide Bay area all the time. 30 per cent of the time, in fact, I'm not even in Bundaberg, I'm running the Renal Unit down in Hervey Bay and Maryborough, so I don't fill in forms. I make sure that adverse events are handled appropriately. In fact, the people I think are important know about it. I mean, I knew about it, I let Dr Jason Jenkins know about it, the Renal Unit staff knew about it and I let my immediate superior know about it. One of the things that was of quite a concern to me was that this lady wasn't aware until quite recently when I actually sat down with her and some of the Renal Unit staff of what actually happened to this lady. She was under the impression that, in fact, the Renal Unit and the physicians, including myself, knew that she was there and we didn't do anything, and she was quite relieved that it was, in fact, pointed out to her that no-one knew she was there. She couldn't remember some of the things that went on when I discovered her and took her to the Renal Unit she was so obtunded. So, that's the way it happened.

D COMMISSIONER VIDER: Dr Miach, your clinical assessment of renal encephalopathy would have been recorded in the clinical notes and it would not have been your usual practice to single out an incident like that for an Adverse Event Form, would it?-- I can't recall. I mean, I'm sure I would have written in this lady's notes, but I can't recall. I haven't had the time to go through dozens of charts, you know. Almost certainly I would have recorded something, but from my recollection, you know, my priority with this lady was to make sure she was treated acutely and urgently and appropriately, and I remember sort of bringing her up to the Renal Unit very, very quickly and putting in a large catheter myself, which I - you know, which helped her quite significantly.

MR HARPER: You mentioned before you explained to Ms Daisy

what had gone on and you said your staff didn't know she was in the ward. I guess I just find that a little hard to believe. She is in a bed in a ward, she has a chart on the end of her bed-----?-- No, no-----

COMMISSIONER: When she was in the surgical ward?-- When she was in the surgical ward. She was admitted to surgery. She had her leg off and was left there. The surgery ward is different to the medical ward. When she was in the medical ward, everybody knew everything about her.

MR HARPER: My apologies.

COMMISSIONER: It is not the practice of you or your staff to go looking in the surgical ward for potential renal patients?-- No. No, you don't do that.

MR HARPER: Dr Miach, I would like to now take you back and trace through, if you like, the history to when you first identified the problems with Dr Patel. Now, on my reading of it in your statement, the first patient you mentioned was patient P51, and that's at paragraph 36 of your statement - paragraph 37, actually?-- 37, was it?

Paragraph 37. Patient P51 - it is the case where Dr Patel was, I'll put it, roaming through the wards and looked at the scan and thought there was a ruptured spleen, but the person didn't have one. You intervened to make sure that he didn't go in - that that patient wasn't taken into surgery?-- That's correct.

And your evidence was that if you had not done so, that patient's life would have been seriously threatened if that surgery had been conducted?-- I think if this surgery had been conducted, he would have been at risk.

When did that - do you know exactly when that occurred, that incident?-- No, I don't, but - I can't remember the date.

COMMISSIONER: We can pick that up from the files?-- Absolutely.

MR HARPER: Can I take you now to paragraph 46 of your statement, patient P45? This was a patient having a Tenckhoff catheter inserted. When you examined him, you saw that he had a hernia. Dr Patel didn't recognise the hernia and wanted to perform catheter surgery?-- This 46, 47 and 48 needs a little bit more explanation. This statement, in fact, I gave - initially I was interviewed by combination of the Commission - from the Commission here and also from the CMC and they taped everything - hours and hours of it. In fact, this statement was elaborated and I went through it and corrected a number of things. To the best of my recollection, that's exactly what I said. I subsequently went to this gentleman's records and charts and just sort of refreshed my mind. The chronology is just a little bit different. This man, in fact, had a Tenckhoff catheter - he is the gentleman we actually spoke about before with the - this gentleman actually had a

Tenckhoff catheter inserted. He started dialysis and then, in fact, he developed a hernia. I then sent him to Dr Patel to have this rectified, and the message I got was that, in fact, there was no hernia worth repairing in this man. I can't remember whether, in fact, it said "no hernia" or "small hernia", but, in fact, there was an insignificant hernia which did not need any repair. Now, to me, this was strange, and, in fact, I immediately sent this man to another surgeon in town who agreed with my idea that, in fact, the hernia was significant; in fact, it was a large hernia. He wrote me a letter subsequently. There was a large hernia there which was repaired.

What would have been the consequence if that hernia hadn't been repaired?-- One of the contrary indications and one of the reasons for not commencing peritoneal dialysis or stopping peritoneal dialysis is if there's a hernia there, because with peritoneal dialysis you introduce regularly - all the time - large volumes of solution - large volumes of water into the abdomen. If there's a hernia there, the hernia just gets bigger and bigger and bigger and bigger and, you know, the scrotum becomes gigantic. So, it is not - having a hernia is not compatible with peritoneal dialysis. Usually when a hernia is present, we either do temporary peritoneal dialysis or, if it is there, we stop peritoneal dialysis. In this particular gentleman, he lived out of town and it would have been difficult for him to travel to the unit three times a week for dialysis week in, week out, month in, month out. This man also had an arteriovenous fistula, which we routinely put into these patients, so what I decided to do with this man is I took him off peritoneal dialysis, I had the hernia fixed, I left it alone for some weeks - two, three, four, five, six weeks, whatever it was - until the incision and everything had fibrosed up and everything was repaired, then I instituted peritoneal dialysis again, and it is still working. That's an unusual approach, but in this particular gentleman, it worked.

You said that you had reviewed the notes. Are you able to tell us, then, what date this occurred?-- No, I didn't review the date, I just - I can't - it would have been in the latter half of 2003. The date I can't recall.

Can I take you now to paragraph 53 to 61 and we talk here about patient P33. This is the man who had a small hole in his carotid artery?-- Carotid artery, yes.

Dr Patel was proposing to go in and do some surgery to put a stitch in the artery to stop the bleeding?-- That's correct.

And your quite common sense solution, might I say, was to stop the anticoagulants and put a bit of pressure on it?-- That's correct.

Which did stop the bleeding?-- That's correct.

You gave evidence that this patient had a combination of a heart condition, kidney failure and was anaemic?-- That's correct.

And in that circumstance-----

COMMISSIONER: And was also a Jehovah's Witness with the significance that has as regards transfusion?-- Yes.

MR HARPER: The consequence of that would be that had this surgery been performed, it would most likely have been life-threatening?-- I think the chances of him getting out of theatre would not have been great.

Okay. And, again, do you know roughly when this occurred?-- That was a relatively recent occurrence. Again, I don't know the date, but it would have been the last three to six months, I would guess.

The last three to six months just gone?-- Just gone. Either the end of last year or earlier this year. I don't know. But that was a relatively recent event. Again, this patient wasn't one of my patients.

COMMISSIONER: Mr Harper, I'm not sure it helps asking Dr Miach to guess about dates. We can pick up the specifics from the files if it is necessary.

MR HARPER: My main question is in relation to timing - is whether you recall if it was before or after the treatment and subsequent death of patient P34 which, again, I think the name is now public - James Phillips?-- I think it would have been after that.

After that. Can I - but it is fair to say, isn't it - sorry, can I take you then to patient P34, and that's at paragraph 66 of your statement. That's James Phillips. Now, this person was one of your patients, wasn't he?-- Yes, he was.

And he underwent an oesophagectomy?-- That's correct.

And you gave evidence that you had asked Dr Patel for an opinion-----?-- That's correct.

-----about that surgery?-- My - under my direction - I'm not sure if it was precisely me, but people who worked for me - my unit - you know, under my direction, they would have done that, yes.

You never got that opinion, did you?-- No, I didn't.

Dr Patel fast-tracked him into surgery?-- That's correct.

And the patient subsequently died?-- That's correct.

After that surgery occurred, did you raise anything with Dr Patel?-- If my memory serves me correctly, this was fairly early on when Dr Patel arrived. I think Dr Patel arrived in April 2003 and this was some weeks later, I think. I think it was - I think it was in quick succession. I can't - after this occurrence, I can't specifically recall discussing it

with him. It is very likely that I did, though, but I just can't specifically recall whether I did or not.

It would be very likely that you did, wouldn't it?-- Absolutely.

And you don't recall, though, any part of that conversation?-- No, I don't. No, I don't. I mean, early on, I used to talk to Dr Patel quite frequently about all sorts of issues, but I can't - I must have spoken to him about this patient, but I just can't, for the life of me, recall any specific - this patient, in fact, was in intensive care and he was managed by the intensive care people, including ourselves, because he was on dialysis.

I will just mention now that you mentioned that you are aware that Miss Hoffman gave evidence that she was of the view that you had agreed with the performance of that surgery?-- Depends what you mean by surgery and it actually depends on how you view the management of a patient in this particular situation. I think it is relevant to actually - to understand an oesophagectomy is one type of surgery. In people who have got this sort of problem, in fact, there are a number of other types of surgery. What physicians do and what I do is, in fact, when someone - a young patient has a surgical problem, we get an opinion. We get an opinion - when cancer is concerned, in fact, we routinely get opinions from all sorts of people: from palliative care physicians, from surgeons, from radiation oncologists, from oncologists. We do that mainly because, in fact - sort of to say, "We are not going to do anything.", is very, very difficult. We do that for a number of reasons, and I do it for a number of reasons - I have done it all my life and I'll keep doing it - you do it to show the patient you are doing everything you possibly can, you show the relatives, you show the staff, you show the family you are doing everything you possibly can, so that's what's done. As far as surgery goes, that's another story. I mean, I know this man. I have been managing him since I arrived in Bundaberg. He was very frail. Every time he developed a complication, he ended up in intensive care. Sometimes he was critically, critically ill. The amount of work that we kept doing to keep this gentleman alive was significant. So, the idea of him having an oesophagectomy is quite unusual. When people have cancer - when people have a carcinoma of the oesophagus, there's a number of things you can do, and it could be called "surgery". For example, you may - you may decide to sort of bypass the obstruction in the gullet by putting a tube in. I don't know whether it is still done, but it used to be done. You may decide to do that - you may decide for feeding purposes - which again is not - is another mild operation on the stomach so you can feed the patient. In this sort of situation, you wouldn't do that. Oesophagectomy is another thing, but it wasn't an issue - it wasn't a consideration in this gentleman. As I said before, I was quite surprised when I discovered that's what he had.

You deny, then, or you don't agree with Ms Hoffman's assertion that you agreed to the performance of this surgery?-----

COMMISSIONER: I think, to be fair, Ms Hoffman's evidence was clarified yesterday that she assumed that Dr Miach had approved of the procedure because Dr Miach or his staff provided the after-surgery assistance that was needed in the ICU?-- That's correct. I mean, the approval - the approval of an oesophagectomy by me is quite strange. This man obviously would never have tolerated it. Some of the minor surgery - palliative - you know, in fact, that's something that would have been up for discussion, which was sensible or reasonable to do. To just elaborate on this, some months later - and not related to any of this - there was another man on dialysis with the same problem: carcinoma of the oesophagus. I also referred him to another surgeon and that surgeon, in fact, operated on him, but the operation he did was, in fact, a very, very fine incision up under here - quite a minor thing. He had a look and said, "Nothing can be done.", and repaired the incision and that was it, and the reason for doing that is, in fact, to see if the surgery would have been viable. If that was viable, he would have been sent to Brisbane. This is what's usually done. In fact, you try and help a patient as much as you possibly can. The idea that if someone has got a carcinoma of the oesophagus and you perform an oesophagectomy, I think that's not the way it works.

Dr Miach, again just playing the devil's advocate for the moment, on your evidence, without putting too fine a point on it, Dr Patel killed a patient who you had been struggling to keep alive for quite some time?-- Three or four years, yes.

Some people might think it is surprising then that you didn't have strong words with Dr Patel over that?-- Commissioner, I may have. I just can't remember. I mean, I think it is sensible to say that if I had strong words with him, I would remember, I understand that, but it is very likely that I did speak to him, but I wish I could recall. I mean, I do know that, in fact, once this gentleman ended up in intensive care, that most of the management, in fact, was done by ourselves and the intensivists for the four or five days that he was there.

Mr Harper, would that be a convenient time to take the morning break?

MR HARPER: Yes, it would, Commissioner.

MR BODDICE: May I raise something?

COMMISSIONER: Yes, certainly.

MR BODDICE: There's just one matter, if I could place it on record. I had a discussion this morning with Mr Andrews about the patients' charts, because other representatives are seeking access to the patients' charts.

COMMISSIONER: Yes.

MR BODDICE: The way we have arranged it is this: a lot of them are original, but we are going to formally provide a copy to the Commission of the patients' charts, but we are going to retain the originals, obviously. We are going to scan them and put them on a disc so the representatives, subject to a Fielder Gillespie-type undertaking, can then get access to the charts for the purpose of investigation. That's the arrangement I have reached with Mr Andrews.

COMMISSIONER: That's very sensible, and I think, given the simplicity and cheapness of replicating CDs these days, it would probably be useful if you had copies of the CDs for all of the legal representatives here and, subject to that sort of Fielder Gillespie order, everyone could have access to the CD.

MR BODDICE: It is our intention that that would occur.

COMMISSIONER: Mr Tait, welcome back, by the way.

MR TAIT: Thank you, Commissioner. I was going to seek leave to appear, but Mr Harper was too quick for me. I seek leave to appear for Dr Miach. I would like to make it plain it is not within the scope of my original appearance where I appeared for the AMA and its members. My instructions come from Harry Mackay, solicitor from United Medical Protection, to appear for Dr Miach, who was notified - who I think was notified by Mr Atkinson yesterday and had discussions about it.

COMMISSIONER: You certainly have such leave. There's no difficulty with that. I assume from counsel of your experience that you would have considered whether there was a conflict with your other retainer.

MR TAIT: I have.

COMMISSIONER: You are satisfied that there isn't?

MR TAIT: I am satisfied of that.

COMMISSIONER: Was there any desire on your part to adduce further evidence-in-chief-----

MR TAIT: No, thank you.

COMMISSIONER: -----from Dr Miach?

MR TAIT: No, thank you.

COMMISSIONER: All right. Well, welcome back anyway.

MR TAIT: Thank you very much.

COMMISSIONER: We will resume about 10 past 11.

THE COMMISSION ADJOURNED AT 10.53 A.M.

THE COMMISSION RESUMED AT 11.14 A.M.

PETER JOHN MIACH, CONTINUING CROSS-EXAMINATION:

MR DIEHM: Commissioner, I just had a matter before my learned friend continues that I wanted to raise that arose just before we broke, and that concerns what you related to the witness in an exercise of fairness to him about what Ms Hoffman's evidence yesterday was.

COMMISSIONER: Yes.

MR DIEHM: As I understood what you related to the witness now, it was that the effect of Ms Hoffman's evidence yesterday was that the consent that she supposed with respect to Dr Miach arose out of his and his unit's participation in the management of the patient after the operation.

COMMISSIONER: Yes, that was my understanding of it. She described it as an assumption, I think.

MR DIEHM: Yes. She went further than that, Commissioner, in my submission, and it appears from page 1,503 of the transcript. Her evidence was that she made that assumption because of Dr Miach and his unit's involvement in preparations for the operation. So, before the event. I can happily put the page on the screen-----

COMMISSIONER: No, no.

MR DIEHM: I thought in fairness to the witness, and so that everybody understands, it does go further than that

COMMISSIONER: Look, we should follow that up. This is in relation to Mr Phillips, of course.

MR DIEHM: Yes, it is.

COMMISSIONER: I think your evidence in Brisbane was that you were unaware of the operation on Mr Phillips when it took place, and you thought you might have actually been down in Hervey Bay on the day he was operated on?-- I don't know where I was. It was two and a half years ago. I can't even remember - I can't recall exactly whether I knew that Mr Phillips was going to theatre. I don't think I was, from the best of my recollection. That's the first issue. The second issue is the type of surgery that was done. There is no way, according to me, that in fact I would have consented to an oesophagectomy on this man. As I mentioned before, there's a number of different procedures that people contemplate, if anything is contemplated, and what I wanted is an opinion from a number of people.

What would your answer be to a suggestion that you must have at least been aware of some surgery, even if not strictly consenting to it, because your unit took some part in preparing the patient for surgery?-- Well, the preparation for surgery with someone who has got chronic renal failure - in fact we do that with everybody, because in fact it revolves around preparation of dialysis, continuation of dialysis. So that's done routinely, irrespective of what surgery in fact is contemplated. So if the unit - some surgery in fact - depends what the surgery was. I hadn't sort of seen the consent, I hadn't actually been involved in the discussions and explanation with Mr Phillips or his family. I was caught by surprise when in fact he had surgery. But as I said, it depends what surgery in fact was contemplated, because there's a number of different types of surgeries that could occur in this sort of situation. I gave you the example of the patient subsequent who had a minor procedure and that was it.

Is it possible that Dr Patel or someone else from surgery would ask staff from your unit to prepare a patient for surgery without that coming to your attention?-- I don't think so. I mean, the preparation is, as I say, mainly dialysis, which is a continuation. If surgery was to be done, whatever it was - because this man was quite frail and in fact had experienced many complications with sort of relatively minor procedures. In fact the idea of leaving him in Intensive Care for one or two days is something that would have gone on anyway. So the idea of because he was going to Intensive Care that major surgery was contemplated, in fact that doesn't follow because this man in fact had come to Intensive Care repeatedly with relatively minor procedures.

D COMMISSIONER VIDER: My understanding, Dr Miach, was that you have previously given evidence to say that when Dr Patel was asked for an opinion - in Australia it's the usual protocol that if you ask another doctor for an opinion, that doctor comes back to you with the opinion. That wasn't what you experienced with Dr Patel. He acted?-- Absolutely.

Without coming back to you necessarily?-- Absolutely. This man was never referred specifically for surgery. He was referred for an opinion.

That's right?-- Which is what's routinely done, which is what I've done all my life, and is what I intend doing. Consulting physicians do that anyway. Opinions are related to the whole treatment of a gentleman like this because it's much more complicated than saying, "You'll have surgery/you won't." There's a whole - there's families involved, there's palliative care, there's other specialties that are involved. It's very difficult to tell a patient, "We can't do anything" without getting the appropriate opinions.

Yes.

COMMISSIONER: And also you'd need to get those opinions because it involves a number of different specialist areas. You might have a surgeon say, "Well, an oesophagectomy is a

possibility with this patient", but then you'd need to assess that from the viewpoint of the impact on his renal condition?-- Absolutely. Absolutely.

D COMMISSIONER EDWARDS: That is standard procedure for activities within hospitals for Terms of Reference?-- That's correct.

COMMISSIONER: Just before we continue, there's one other thing that I should raise. We have received from The Honourable, The Premier, Mr Beattie and The Honourable, The Minister for Health, Mr Nuttall, a letter bearing yesterday's date, 28 June, and accompanying that is an issue paper entitled "Health Workforce Paper 1 - Medical Workforce". The Premier has invited us to treat this as a submission or exhibit and to give it appropriate publicity. So that will be marked as Exhibit 96.

ADMITTED AND MARKED "EXHIBIT 96"

COMMISSIONER: It will be placed on the Commission of Inquiry website and the secretary will arrange copies of that for anyone from the press or media, or indeed anyone else who wishes to have copies of it as soon as that can be done. Yes, Mr Harper?

MR HARPER: Dr Miach, is it fair for me to summarise your evidence that from at least the middle of 2003 you had serious concerns about the professional competence of Dr Patel?-- Middle of 2003 is June 2003. I think he was there one or two months. As things went along - I mean, I had indications, and some of them were fairly subtle. Some of them can't be explained. Some of them have to do with dealing with all sorts of people for a long time, but I had - I commenced having doubts about certain aspects of Dr Patel's competence in surgery, yes.

And over the ensuing 18 months you had numerous individual instances which you've given us very detailed evidence about to confirm those initial concerns?-- I think that's correct.

Did you discuss those concerns more widely with your colleagues in the medical profession?-- With the other physicians almost certainly, yes. The reason is that in fact I was concerned with the patients, and I sort of made them aware to be very careful. In fact - eventually in fact I was more forward with that advice. But, you know, my advice was sort of subtle, that, you know, "Be careful with this gentleman."

When you say the other physicians, who are you talking about there?-- The other three physicians are Dr Strahan, Dr Smallberger, and more recently Dr Conradie, but it is very likely that I would have communicated the same sorts of

concerns to other people. For example, some of the senior nurses.

You obviously had some discussions with Dr Jenkins as well generally about - at least about the specific patients who Dr Jenkins had also treated?-- The two discussions I've had - I've had a number of discussions with Dr Jenkins, but they're mainly sort of my explaining some patients need to come up - sometimes you expedite things by doing that. The two discussions I had with Dr Jenkins about Dr Patel were the lady that - I've forgotten her name - P53, and also Marilyn Daisy, whose name we can mention. They're the two patients that I specifically discussed with Dr Jenkins. In the case of P53 I rang him, and in the case - did I ring him or did he ring me for 53? No, P53 he rang me, and Marilyn Daisy I rang him. So they're the two. After the discussion with P53 he let me know over the phone that it would not be wise to have any further vascular surgery done by Dr Patel. That's the opinion that I came to myself anyway.

Did you in that discussion then say generally, "Look, I agree. This surgeon is a major problem here."?-- I didn't put it as firmly as that. I mean, I agreed with his idea that in fact no further vascular surgery should be done by him. I concurred with that, but that's the opinion that I came to for myself anyway.

Yes. Again if I can summarise the evidence, the steps that you took to deal with your concerns about Dr Patel were primarily you reported it to Dr Keating over - on a number of occasions?-- I had a number of discussions with Dr Keating ranging over a number of issues. Again I wish I could recall specifically discussing Dr Patel. I'm sure I did. I can certainly remember on one or two instances discussing him with him, but the other times I can't specifically remember. But my opinion is that I would have mentioned it because in fact it was an issue with me. I'll say my bit when I need to.

The other step which you took which we've heard lots of evidence about is that you effectively were black banning Dr Patel from treating your patients?-- I did that. I mean, I made people aware of that, that renal patients in fact were no longer - this was still the end of 2003 - I can't remember the exact date or early 2004 - before I disappeared for a couple of months. So I certainly made people aware of that. That was mainly referring to renal work, but as far as I was concerned - in fact I also did the same thing for other surgical issues in medical and renal patients.

Did you consider any other options for bringing your concerns about Dr Patel to the appropriate authorities?-- I expressed my concerns, as I mentioned, a couple of times verbally. There was also some documentation of my concerns, and one of them was in fact they ordered peritoneal catheters, which has been discussed. Another one was a copy of the letter that I had from Dr Jenkins. So they were handed over. So I did have concerns, yes.

Did you consider reporting it to - I'll go through some of the other authorities that you may have referred it to. In relation to the patient P34 who died, did you consider reporting that matter to the coroner?-- No, I didn't.

Did you consider in relation to any of the patients which Dr Patel had treated over which you had concerns - did you consider reporting any of them to the Health Rights Commission?-- The ones I had concerns for were the peritoneal catheter patients. I didn't report those to the Health Rights Commission, no.

Did you consider reporting any of your concerns about Dr Patel to the Director General of the department?-- No, I didn't.

Did you consider reporting any of your concerns about the conduct of Dr Patel to the Medical Board?-- No, I didn't.

Did you consider reporting any of your concerns about Dr Patel to the Australian Medical Association?-- No, I didn't.

Did you consider reporting any of your concerns about Dr Patel to the individual patients or their families?-- I'm just trying to remember that. No, I can't specifically remember putting it to the families.

Did you discuss any of those options at all with any other members of the medical profession, whether it be Dr Jenkins, Dr Strahan, Dr Smallberger or later another one, Dr Thiele?-- No, I didn't. I mean, these - I didn't, but we can expand on that if-----

Okay, so you didn't.

COMMISSIONER: Dr Miach, the first question in this series was put in terms of reporting to the appropriate authorities. Am I right in thinking it was your view that the appropriate authority here was Dr Keating?-- Absolutely.

And did Dr Keating raise with you any suggestion that you should take these matters further, to the Director General, the Health Rights Commission, the Medical Board or any of these other authorities?-- No, that never came up. That was never a consideration.

MR HARPER: So is that the reason why you didn't deem it appropriate to report any of the conduct to any of these other authorities?-- Well, my immediate superior was in fact Dr Keating and he was aware of my concerns.

Do you accept that it was open to you, though, to report your concerns to any of those authorities?-- Well, there is some resistance within the organisation to actually do that. What I did is in fact I reported to the appropriate authorities, but I also took steps to protect patients, and once that happened - in fact as far as I was concerned patients were protected and I did my duty by reporting my concerns to the appropriate authorities.

Well, some of the patients were protected. Your patients were protected?-- That's right.

But Dr Patel continued to operate for probably 18 months after you first had these serious concerns?-- But I'm a physician. I run a general medical unit. I'm not an ombudsman in a surgical ward. I don't de facto become sort of a policeman for the surgical unit. I mean, I don't know what goes on down there. I heard rumours. I'm in charge of the medical unit, and what I did is in fact I perceived a problem, I let the appropriate authorities know on several occasions, and then I took steps to protect patients and to put other systems in place to actually be able to work and to actually manage patients properly.

Okay?-- I think you're quite correct. I didn't, you know, run around the surgical wards trying to sort of stop people. That's not what I do.

But it was more than just - you mentioned just then that you heard rumours. It was much more than that, wasn't it? You've given evidence about specific instances of your direct knowledge about the poor clinical practice of Dr Patel?-- Well, I can't remember all the evidence I gave, but in fact there was one gentleman that in fact had a question of a ruptured spleen. That was an issue that came up. It was sorted out appropriately as far as I was concerned. The patient was protected. He came back. There was another patient with a carotid problem. I got involved with that. That was sorted out properly according to my satisfaction. There were a number of other instances. In fact there were documentation that was actually given to the appropriate authorities. But, you know, I didn't make it my practice to go around the hospital looking at every possible complication in surgery. That's not what I do.

Nurse Hoffman gave evidence yesterday, and in Brisbane, about Dr Strahan saying, when the concerns were eventually raised about Dr Patel, that - I think the quote was, "There's widespread concern, but no-one wanted to stick their neck out." Would you agree that that would be an accurate description of how your colleagues in the medical profession regarded the situation with Dr Patel?

COMMISSIONER: I don't think that's an appropriate question. I mean, it's emotive language, whether someone "sticks their neck out". The evidence we've heard from Dr Miach is that he did what he considered appropriate. Now, based on Dr Miach's evidence - I'm not saying there's any conclusion about this, but based on Dr Miach's evidence, he reported it to the person he viewed as the appropriate authority and left it in that person's hands. Some would say that was sticking his neck out. I just don't think it helps us to use those emotive words and require Dr Miach to give some response to that. He's told us what he did. You may wish to argue that it was inadequate. Others may argue that Dr Miach did everything that could have been expected of him and more. Let's leave it

at that.

MR HARPER: Can I attempt to put it another way?

COMMISSIONER: All right.

MR HARPER: If I put to you an assertion that there is a culture within the hospital that you keep the reports within the system and that you don't go outside that system, would that be a fair reflection of the culture of the Bundaberg Hospital and the associated medical profession surrounding it?-- I think there's probably - I think that's probably accurate, yes. I mean, it's well known that if you go outside "the system" you get into trouble, and you've got a structure in the hospitals for people reporting to people. I mean, I know my structure. People reported to me and I know who I had to report to, and that's what I did. As it happened, later on in fact I also indirectly made the Zonal Manager aware of some of the issues that were going on, in a very - in an indirect way.

Can I just ask just one further question. I recall from your evidence-in-chief that there was some reference to you asking that the direction which you gave not to treat your patients, that that not be minuted. Was that a fair reflection of-----?-- I read that. I don't remember that, but I don't dispute it. I mean, the people who said that are quite sensible and honest, their integrity - they're excellent people. So if I said it, I accept it. So if I said it, fine.

I have nothing further, Commissioner.

COMMISSIONER: Thank you, Mr Harper. Mr Allen?

MR ALLEN: Yes, thank you, Commissioner.

COMMISSIONER: Sorry, you seemed a bit surprised. Are you ready to go?

MR ALLEN: No, I'm quite happy to go next, and I understand that everyone else is too.

CROSS-EXAMINATION:

MR ALLEN: Dr Miach, John Allen for the Queensland Nurses' Union. You mention at paragraphs 53 through to 58 of your statement the incident involving a patient P33?-- Yes.

And that matter was involving one of your patients?-- No, it wasn't. It was someone else's patient.

Okay. In fact one of the unusual aspects was that you were called upon by nurses to lend your assistance despite that patient not being one of yours?-- That's exactly correct.

Because it seems that they were so concerned about the prospect of Dr Patel operating on that patient they sought your assistance?-- That's correct.

And you indeed, once you came down and assessed the situation, were quite concerned yourself?-- Yes, I was.

And that was because Dr Patel was apparently making arrangements to take that patient into theatre?-- That's correct.

He was in his surgical gown?-- That's correct.

Were you informed that he'd actually taken steps to tell theatre staff to prepare for surgery?-- I think that was the understanding. I think that was the case, but I can't be more specific than that.

And your concern was that because of the condition of that patient, that he in fact wouldn't survive such surgery?-- That's correct.

And you have indicated earlier in your evidence that you hold that opinion quite strongly?-- Yes, I do.

In fact you said in Brisbane he would have had no chance of coming out of theatre alive and - absolutely no chance?-- Well, one per cent, two per cent, no-one knows this. Those terms were sort of indicative of the fact that I - 100 per cent, who knows. I mean, it's obvious that I didn't mean that.

No, your experienced medical opinion was that it was certainly much more likely than not that this patient wouldn't survive surgery?-- That's exactly right. You couldn't transfuse that patient.

Yes. You intervened, spoke to Dr Patel, saying that he was not going to operate on that patient?-- That's correct.

And-----

COMMISSIONER: Mr Allen, all of this has been covered. Are we going somewhere new?

MR ALLEN: I'll be very quick. I just want to fill in a bit of a picture.

COMMISSIONER: Yes, certainly.

MR ALLEN: You indeed say that Dr Patel then left?-- That's correct.

Are you aware at all that in fact he continued to hang around the unit for some considerable length of time?-- Well, I left at that stage after - he left and I left. I don't know whether he came back. I left instructions for what needed to

be done with this patient, which is what in fact was done. That's what actually happened. I'm not aware whether he came back or anything else.

Okay. And Ms Hoffman in fact states that you told her, "Whatever you do, don't leave this patient's bedside, and if Dr Patel goes near him, telephone me immediately."?-- If she said that, I don't doubt that at all.

And indeed are you aware that she in fact then stayed at the nurses' station for about six to seven hours keeping an eye on the patient?-- No, I'm not aware of that.

Okay. But would it be fair to say that your opinion is that your intervention, and then Ms Hoffman's vigilance afterwards, basically saved that patient's life?-- It's my opinion.

You gave some evidence this morning in relation to a patient P53 concerning - or touching upon the vascular system, the factors that can impact upon blood circulation. Now, you didn't have any involvement in the care of a patient who - I should use the number perhaps - has been referred to as P26, and I recognise that you're not a vascular surgeon, but given the evidence that you did give, perhaps you can help to some extent. There's going to be evidence given that in relation to this 15 year old boy, that he was admitted to the hospital on an emergency basis on 23 December 2004 and then operated on in relation to a femoral artery injury at about midday on 23 December?-- I've never - I don't know this young boy.

In any event, he ended up returning to theatre about 4 p.m. for fasciotomies for compartment syndrome, and indeed compartment syndrome is something which relates to the sort of vascular problems you were referring to earlier?-- Probably. Compartment syndrome is in fact when the muscles swells up for whatever reason and compresses the circulation and the limb becomes embarrassed.

COMMISSIONER: Mr Allen, I won't prevent you from pursuing this line of questions, but I suspect it's unhelpful. It would be like putting me in the witness box and asking me about family law. It's really out of Dr Miach's area of specialisation, and I'm sure we'll have other witnesses, with the greatest respect to Dr Miach, who are far better qualified than he is to express opinions about this, and who will have had the benefit of looking at the charts and knowing the details rather than simply basing an opinion on a thumbnail sketch of the facts. As I say, I won't prevent you if you feel it's important to proceed, but I'm inclined to think it's unhelpful. Would you agree with that, Dr Miach?-- I don't know this young boy. I've never seen him. I didn't know he existed, and I don't know very much about the particular issues and I'm not experienced - not the chap to talk about a vascular emergency in this situation, whatever it was.

MR ALLEN: Given that, I won't take that any further.

COMMISSIONER: Thank you, Mr Allen.

MR ALLEN: Now, you gave some evidence - and this was in the context of patient P31 - this morning as to the fact that there are different methods by way of accessing the pericardial sac around the heart?-- That's correct.

And is it the case that in relation to the insertion of a drain initially to drain the pericardial fluid, that involves the insertion of a drain which is designed to go through the skin of the chest and enter into the pericardial sac?-- That's correct.

And that, indeed, as I understand it, is one of the steps you took in relation to a patient who you referred to in your statement?-- That's P31 that you say?

The patient, who subsequently required, as you understood it, some surgery to place a pericardial window-----?-- That's right.

Yes. Now, in relation to the first procedure, not the pericardial window but just the insertion of the drain?-- Yes.

Is that something which any reasonably competent surgeon could do, a general surgeon?-- Yes, I don't think - I'm not sure who did that. I think it was an anaesthetist. I'm not sure if it was a surgeon that did it. I think it may have been an anaesthetist that did it initially. That's a procedure that's sort of done by a lot of cardiologists, a lot of physicians. I have done one or two, but I didn't do it because my expertise many years later wasn't good. So I let somebody else to do it who do it better. I can't be - I think it was an anaesthetist who did that.

All right?-- But I can't be certain of that.

It's expected that there will be some evidence given by a nurse that, in fact, she's seen that procedure done many times and that it's been accomplished on first attempt by surgeons she's seen over the years, including surgeons who were doing it for the first time?-- Well, that's fine. The actual - the actual problem is not that common. It's seem by a nephrologist because it specifically occurs in people who have kidney failure. It does occur in a lot of other situations, but I can tell you it's not very common. Sometimes it occurs in traumatic injuries of the chest. But unless you work in an unusual cardiothoracic unit, then, you know, it's not a procedure that's done very commonly.

Well, perhaps you are unable then, or you feel unwilling to express an opinion as to what it would say about the surgical competence of a doctor if they were unable to successfully insert such a drain, even after repeated numerous attempts to do so, something in excess of 10, even up to 50 times?-- Usually if you've got fluid in the pericardial sac, the heart's a fairly large organ in the chest, if you've got fluid there, that in fact you would be able to - you would be able to insert it. If you don't have fluid there, for whatever

reason, then in effect you could sort of keep going forever and not get anything out. So that's the question, I think. Because if there is an infusion and, in fact, the way the procedure is done is done under ultrasound, is done with sort of specific probes, it's done under direct vision, in fact exploration. It's quite - even though it's not a difficult procedure, in fact, it's quite a - the protocol to do it is quite defined. But if there's fluid there, then, in fact, you would hit it.

COMMISSIONER: So the real point you're making is if he got to half a dozen attempts and still hadn't found any fluid, it would be a strong indicator of incompetence if he kept trying?-- Incompetency in the technique or incompetency in making the diagnosis? Because if there's no fluid there you can actually keep going forever and according to me, for whatever reason - I think I know what you are referring to.

Yes?-- But for whatever reason there is no fluid there, in fact you could keep going forever. If there is fluid there, you would expect to hit it pretty quickly because, in fact, the way it's done, it's done sort of with direct control with ultrasound and with special probes, et cetera.

MR ALLEN: You deal with Dr Qureshi at some point in your statement. Could I ask you to comment upon some evidence that has already been given by Ms Hoffman in relation to Dr Qureshi. Her recollection is that in mid to late 2003, you attended a Medical Services Forum meeting and described Dr Qureshi as being "totally incompetent". Do you recall whether you may have made such a comment?-- I don't recall, but it wouldn't surprise me because that's what I regarded him as being.

Yes.

COMMISSIONER: I think your evidence in Brisbane was along the lines that you seriously doubted whether he had any genuine medical qualifications?-- I certainly had major concerns about his competence.

MR ALLEN: Who would attend a Medical Services Forum in a general hospital?-- They're usually attended by the head nurses of the different areas of medicine. It would have been attended by the Rehabilitation Manager, the Medical Ward Nurse Unit Manager, it would have been attended by the Renal Unit Nurse Unit Manager, by the Intensive Care and Coronary Care Nurse Unit Manager and by myself. That's who usually attends. You know, sometimes there are apologies, but that's who usually attends.

Okay. Thank you. Look, just finally, in relation to the patient Marilyn Daisy, your concern seems to be that she ended up being left in the Surgical Ward until you discovered that she was there?-- That's correct.

And that that shouldn't have occurred?-- That's correct.

All right. And the amputation of her leg, that occurred on the 20th of September; that's so?-- It's in the correspondence. I mean, I can't remember the date, but I'm sure that's correct. It's on the letter that was recently up here.

Okay. The letter from Dr Jenkins, was it?-- I think that's correct.

COMMISSIONER: Yes.

MR ALLEN: And the concern was, as you understood it, that basically she's in the hospital for about six weeks and no-one's attended to her amputation stump?-- I think it was days, not weeks.

Days?

COMMISSIONER: The letter from Dr Jenkins identifies the date of the surgery as the 20th of September 2004. Look, Mr Allen, I think you're confusing two points. The first point is that she was left in the Surgical Ward for some days before Dr Miach's staff became aware of her presence there and therefore her renal problems were untreated. The second problem is the one that Dr Jenkins identifies, that she was left six weeks without anyone attending to her sutures. So it's really two different problems in relation to the treatment of the same patient?-- That's correct.

Is that correct?-- I think it is correct, Commissioner.

MR ALLEN: I was just trying to ascertain, are you saying then that she remained in the Medical Ward during that period of six weeks without Dr Patel or anyone under his supervision appropriately going to attend to her amputation stump?-- It's very likely because the stitches were there six weeks later. As I mentioned, she was critically ill. We managed her in the Renal Unit. It is very likely - I can't remember but in fact the notes will decide - it was very likely she remained in the Medical Ward, not the Surgical Ward, and six weeks' later, when she was well or six weeks after surgery, in fact, she went home to Brisbane with the specific idea of having a vascular access put in and this suturing and necrotic leg and those things were discovered, yes.

I'm just trying to understand the basis upon which Dr Patel or people in his, I think you said, surgical team would have been responsible for the removal of the stitches. Does that automatically follow from the fact that he undertook the surgery?-- Absolutely. It's a surgical procedure. So, in fact, the surgical procedure, in fact, is not just operating on a person today and forgetting about everything. In fact, you follow it through until a reasonable completion. I mean, stitches need to come out. That's under the control and the direction of the surgeon. Physicians don't do that. I mean, we don't even know, for example, whether the surgeon wants to leave the stitches in for one week, two weeks, two and a half weeks. You know, he would know that because of the blood

supply of what he perceived when he amputated the leg. So there's a lot of issues that occur. So if junior doctors or physicians are, in fact, instructed or are told by the surgeons that the stitches can now come out, we will do it. That's what we did just this week. There was some man who had his leg amputated. We cooperated with the surgeons and under their direction we took them out. But it's always under the control of the surgeons, it's a surgical procedure.

You answered my next question, which was whether there was any particular set time after which the stitches should be removed. There isn't, it depends upon the surgeon's assessment-----?-- No, it doesn't. The stitches on the example were removed very quickly. Stitches in ischaemic limbs are a while longer. Sometimes tension sutures are, in fact, left there for a long time. This is what the surgeons do. They direct those. This is why physicians and medical units stay out of it because it can be counterproductive. So we are always directed on surgical issues by the surgeons.

If the patient chose for their own reason to perhaps discharge themselves from the hospital against medical advice-----?-- Yes.

-----and state that they would have their wound attended to at another hospital, for example, should there have been some type of steps then taken by Dr Patel or one of his team to communicate to the other hospital or another doctor so that they're properly informed as to when stitches should be taken out, matters such as that?-- Not six weeks later. Six weeks, you never leave stitches in for six weeks.

No, not six weeks later, but perhaps if the patient chose to discharge themself after two weeks?-- Absolutely.

And say they will go to another hospital to get the stitches out?-- Absolutely. What's done is, in fact, the staff from the hospital where the patient left informs the staff of the hospital, lets them know the issue that the stitches need to come out or this thing needs to be done. So there's always a cooperation. It happens routinely.

When you say "staff", you mean medical staff, because it's up to the medical staff to make clinical assessments as to when stitches come out, et cetera?-----

COMMISSIONER: When you say "medical", would it be medical staff from the Surgical Ward?

MR ALLEN: Yes.

WITNESS: Absolutely.

MR ALLEN: Excuse me. I wasn't meaning staff under your supervision?-- No.

But doctors who are involved in the surgery, either Dr Patel or doctors underneath him, such as Junior House Officers?--

Very frequently patients are discharged with stitches still in. That happens all of the time. That doesn't mean that you leave them. In fact, you maybe take steps to ensure district nurses or the local medical practitioner or that they are referred back to the hospital to one of the PHO clinics. You never leave those sorts of things in limbo. There has to be a program to ensure that the end result is, in fact, well and what you expect and in this case there wasn't.

And that would have been - I'm just trying to ascertain - the responsibility of Dr Patel or a doctor under his supervision?-- Under the Surgical Unit. It would have been a Surgical Unit responsibility.

Yes. And, finally, in relation to that patient, if that patient was attending as an outpatient for renal care, that would have involved medical staff and nursing staff looking at her - the site of dialysis; is that correct?-- The site of dialysis.

Looking at the catheter site or any aspects involving renal dialysis?-- I mean, I run a specialised renal dialysis clinic. When they come to see me, I look at all aspects of their treatment and I do that in conjunction with one of the nurses that actually helps them to understand how I'm doing things and they tell me some of the issues, so it's a cooperative issue.

But it wouldn't have been expected of either yourself, the doctor working under you or nursing staff in that unit to be checking amputation stumps?-- Not in the medical unit because it's assumed that it is a surgical responsibility.

Yes, thank you, doctor.

Thank you, Mr Allen.

COMMISSIONER: Ms McMillan, the Medical Board would normally come next. I realise that your learned leader has been taken away from us for this week. Do you wish to cross-examine Dr Miach?

MS McMILLAN: I do, but I'd prefer to follow Mr Diehm because I think he is going to be quite detailed. It may be I won't have anything or very much after he has finished and he has access to the charts which, of course, is of interest to the Board.

COMMISSIONER: That sounds sensible. Nobody else has any objection to that course? Mr Diehm, are you ready to go?

MR DIEHM: Yes, Commissioner.

COMMISSIONER: All right.

CROSS-EXAMINATION:

MR DIEHM: Dr Miach, I'm Geoff Diehm and I'm counsel for Dr Keating. Excuse me whilst I get my papers organised. Dr Miach, the first matter I wanted to raise with you concerns something that arises out of your interview by officers from the Crime and Misconduct Commission and also from this Commission apparently. I'm sorry, I stand corrected. I think this may have just been Mr Brooks from the Crime and Misconduct Commission. What's attributed to you in the transcript following some questions that were posed to you concerning your attitude or feelings following Dr Keatings' failure that you attribute to him to respond to the catheter audit information that you had given him, and the interviewer asked you - for those who have this document it's page 19 - the interviewer asked you whether - using the interviewer's terminology - you felt disempowered as a result of Dr Keatings' failure to act in response. And what is attributed to you as your response that I will ask you to agree or disagree as to what you said was, you said, "Oh, to some degree, but, you know, you've got to be a realist. I mean, I'm not hear to impress anybody. I mean - ah, there's nobody - no-one in Queensland that's got my qualifications, my experience, you know. I mean, I've been impressing people in Victoria, Melbourne, all over the world my whole life. Up here in Siberia who cares, you know. So in fact I came here to sort of try and help people and I've actually opened one/two Renal Units. I've opened a clinical school so, you know, I would have felt disempowered years ago when I was young and brash. But these days I sort of regard these people as yocals and you get on with it. You know, that's the way I see it."?-----

COMMISSIONER: Does this question go to anything?

MR DIEHM: It goes to the witness's attitude towards others working in the hospital.

COMMISSIONER: That he considered your client to be a yocal?

MR DIEHM: Apparently yourself, Commissioner-----

COMMISSIONER: Do you consider Dr Keating to be a yocal?-- Absolutely not.

MR DIEHM: Did you make that statement?-- If it's in the transcript I must have.

Who were the yocals that you were referring to?-----

COMMISSIONER: Move on to something that matters. That doesn't seem to have anything to do with the Terms of reference or-----

MR DIEHM: Commissioner-----

COMMISSIONER: I will hear what you have to say.

MR DIEHM: Commissioner, you raised the other day certain issues that you said that my client would need to deal with.

COMMISSIONER: Yes.

MR DIEHM: One of those issues was why it was there was some apparent problems with respect to communications.

COMMISSIONER: Yes.

MR DIEHM: In my submission, evidence of this nature goes to that issue.

COMMISSIONER: What, the proposition is that Dr Miach didn't report his concerns to your client because he thought your client was a yocal?

MR DIEHM: Well, Commissioner, that's taking one word out of a passage that has-----

COMMISSIONER: What is the proposition? I won't take one word out of it, you tell me what the proposition is.

MR DIEHM: The proposition is that Dr Miach looks down with some degree of degradation to others within the system.

COMMISSIONER: I will let you pursue that.

MR DIEHM: Thank you. Who were the people that you were referring to when you referred to yocals?-- No-one in particular. It was just a term, you know, that slipped out. I mean, I certainly don't regard anybody in Queensland who I work with as being yocals. So, you know, you asked me whether, in fact, it is an accurate statement of my feeling and it isn't. You know, I regard everybody in quite a different light. If I made those statements it's - you know, I made them but I certainly don't regard anybody who I work with or who I deal with or who I cooperate with as yocals and I certainly don't think I'm in Siberia either.

There is a further passage, Dr Miach, in what may in fact be a second interview, and it appears at page 10 of that particular transcript, and this follows on from some questions and answers concerning the changes to the roster system that you have given in some evidence before the Commission here, and you were concerned about what Dr Keating did with respect to those changes. Towards the end of that passage, at about line 35, you referred to your view that patients had suffered because of these changes, and what is attributed to you is you then said, "You know, they - they tell me, you know, medicine is changing. I mean, that's - you know, what the hell do you know about medicine, you've been in the army all your life. You know, the sort of commando mates from the trees. You know this is what's - what's that got to do anything. I've been a physician all my life. I know what's needed in medicine,

that's what you're employing me for." Is that-----?-- I would say-----

I'm sorry. Firstly, do you accept that's what you said?-- If it's in the transcript.

Who is it that you are referring to when you talk about somebody having been in the army all your life?-- I think this is being taken out of context. I mean, I was giving evidence. I mean, it is known that Dr Keating spent some time in the army, so that's who I was referring to. But, you know, those comments are emotive and they don't reflect exactly what I feel about things.

Thank you. Now, you also gave evidence in Brisbane concerning a change that Dr Keating wrote to you and asked you to implement with respect to a protocol for dealing with peritonitis; do you recall that?-- Yes, I do.

And you said about that on that occasion that Dr Keating simply wrote you a letter and in effect told you to change the protocol with respect to dealing with cases of peritonitis and that you thought that it was wrong for that change to be made so you simply ignored it?-- Ignored the letter or ignored to make the change?

Well, you decided not to make the change?-- There was nothing wrong with the protocol.

Yes, I'm sorry, but have I accurately summarised - I'm not asking you for your explanation for it, we will come to it, but have I accurately summarised what your position in respect to that issue was?-- The issue was that I got a letter which I thought was inappropriate. I wasn't going to make a change which didn't need making and that's it.

Yes. And because you didn't think the change should be made, you didn't make it?-- That's exactly - absolutely.

You also said that you did not contact Dr Keating and say that you weren't going to make the change?-- I didn't answer that letter, that's correct.

And you did nothing else about the matter?-- The matter had to do with changing protocol that didn't need changing. The protocol has remained as it is and so I didn't change anything.

But my question is aside from not making the change, and aside from not contacting Dr Keating as being actions or inactions, if you like, in response to the direction, you didn't make any other inquiry or research the position any further as to whether or not you might have been wrong with your view about things and that perhaps the protocol should be changed?-- I did make inquiries. In fact, I've got all of the literature. I actually went to the respective books. I mean, the protocol that was developed is in consult with protocols that are available all over Australia. They're modelled on an

international group of specialists who deal with peritoneal dialysis and that's what the protocol is made of, is - you know, is founded on. So I did actually, I got all of the literature out and so I did know the protocol, yes.

Can I ask you to look at this document? The first - the page on the top first, please? Now, is this the - I think we concede virtually the whole body of the letter. Is this the letter that you received from Dr Keating?-- Yes, yes, it is.

All right. And it says there that you would find attached a copy of recommendations made for the Bundaberg Health Services District in relation to - it should say medicolegal case - excess Gentamicin dosages?-- That's right.

Pause there. You did say at the hearing last time, this arose as a result of a circumstance where one of your junior doctors had made a mistake?-- That's correct.

Resulting in excess Gentamicin being given to the patient and there was a claim brought as a result of that. My questions that follow don't cavil with any of that and don't make the suggestion that that one-off mistake was directly the reason for the suggestion that followed or the direction that followed with respect to changing the protocol, but nevertheless the protocol that we have been speaking about includes the regime for dealing with peritonitis by usage of Gentamicin; is that right?-- That's correct.

Thank you. If the second document could be put on the screen, please. Now, after you've had a chance to look at this, can you tell me whether this is the document that was attached to Dr Keating's memo?-- Yes, I think it was.

Do you know who Dr Whitby is?-- I think he is an infectious disease specialist.

I think he is purported to be, in fact, one of the leading infectious disease specialists in the country?-- He is an infectious disease specialist. I don't know what his standing is.

You don't know anything of his reputation?-- No, I don't. I think he is an infectious disease specialist in Queensland, so I don't come from Queensland, so - in fact, I know infectious disease people in where I come from. I mean, I don't have no suggestion that he can't be anything but a top-line infectious disease specialist.

The protocol that existed, one that presumably continues to exist, provided, did it not, for the administration of Gentamicin for up to 14 days?-- I think that's correct.

And, of course, what was being suggested apparently Dr Whitby was that that was problematic and that Gentamicin shouldn't be administered for that length of time?-- Well, that's Dr Whitby's - that's Dr Whitby's opinion. I mean, there are plenty of specialists around, international specialists who

have in their protocols Gentamicin for up to three weeks.

Dr Miach, I'm not about to get into a debate with you about who's right and who's wrong-----

COMMISSIONER: Well, what are we debating then? I mean, this doctor, whose qualifications and specialisations haven't been criticised, decides that he's not going to take notice of something said by the hospital administrator, who isn't a clinician, or medical director who isn't clinician, he is going to continue his patients the way he knows best. What's wrong there?

MR DIEHM: Commissioner, I have some further questions and I will make submissions about the effect at the end of the day. They go to matters, in my submission, that are relevant. Dr Miach, my question for you is: did you consider contacting Dr Whitby to discuss with him the apparent suggestion that he was making?-- No, I didn't.

Why not?-- Well, because I know the protocol. I know what's involved. I know what other Renal Units do. I know what international units do. I know what international protocols say. Our protocol is modelled on that. It is strictly a Renal Unit and Dr Whitby is an infectious disease specialist and so that's why I didn't contact him. What would I - I can't-----

It didn't occur to you that despite the fact that your extensive experience, the experience of other colleagues, that you might, in fact, learn something from somebody who is apparently a senior physician in another area of medicine?-- It's talking about Gentamicin. I know about Gentamicin.

When Dr Keating was apparently justifying the recommendation he had made on the basis of this advice coming from another physician in Brisbane, you still didn't see fit to contact Dr Keating and say, "Look, thank you for that, but frankly, with respect to Dr Whitby, I don't agree with that, so I think that I should continue to use the same protocol."?-- No, I didn't. The reason the whole issue came up was because it was a simple mistake of junior staff. There was nothing wrong with the protocol, so I didn't - I didn't answer the letter. I didn't contact Dr Whitby.

Thank you. I tender the documents, Commissioner.

COMMISSIONER: Dr Miach - on the basis of what?

MR DIEHM: It's in your hands, Commissioner.

COMMISSIONER: No. No, you tendered it. What does it go to?

MR DIEHM: It goes to demonstrating, in my submission, the attitude of the witness to a direction given to him by his inline manager about an issue with some justification, with some support from another physician, and demonstrates something about this witness's attitude to how he would deal

with those issues that arose between he and his manager.

COMMISSIONER: So just so I understand this contention, is it being advanced that a specialist physician, indeed, specialist nephrologist, is supposed to take what you have referred to as a direction from a man who has a medical degree but works as a bureaucrat as to how he is going to treat his patients?

MR DIEHM: No.

COMMISSIONER: Is that a proposition?

MR DIEHM: No, it is not, Commissioner.

COMMISSIONER: What does it go to?

MR DIEHM: Firstly, it wasn't a mere direction, it was a direction that carried with it information suggesting that this was a recommendation being made by another senior independent medical practitioner.

COMMISSIONER: It's expressed as a request, not as a direction of law.

MR DIEHM: I stand corrected then, Commissioner. I should use the word "request". The next proposition that follows from that-----

COMMISSIONER: It's a letter from the solicitors.

MR DIEHM: Yes.

COMMISSIONER: It's not from Dr Whitby at all. Minter Ellison gave advice as to risk management that a new protocol should be put in. A top-line specialist says, "Well, I know this medication. I know how I am going to use it, and I am going to do what's best for my patients, whatever the solicitors think", and you are putting that in as evidence that - what, that Dr Miach should have done what the solicitors were urging rather than what he thought was in the best interests of his patients?

MR DIEHM: The solicitors were a mere conduit expressing the view that Dr Whitby had expressed.

COMMISSIONER: "Our discussions with Mr Whitby", so it's not even there's a report from Dr Whitby or anything like that, it's just the solicitor's version of what was highlighted from their discussion with Dr Whitby.

MR DIEHM: Yes.

COMMISSIONER: Yes, all right. We will have that as an exhibit. If you want to put your client's case on the footing that document reflects adversely on Dr Miach, then you will have that opportunity. That will be Exhibit 97, is the memorandum from Dr Keating to Dr Miach of the 23rd of September 2003 together with the accompanying copy of letter from Minter Ellison Solicitors, or an extract from the letter of Minter Ellison Solicitors of 29 July 2003.

ADMITTED AND MARKED "EXHIBIT 97"

MR DIEHM: Thank you, Commissioner. I think-----

D COMMISSIONER VIDER: The correspondence we have just seen and had admitted into evidence indicates that Dr Keating was making written communication with you. Did Dr Keating at any stage contact you verbally and raise concerns about either the change in the protocol or specifically to discuss the major issue which you say was a one-off issue involving a junior house officer? Did Dr Keating attempt to contact you in any way? You have said you didn't contact him following that communication, but did Dr Keating attempt to verbally contact you or contact you to ask you to come to his office for a meeting?-- No, he didn't.

Thank you.

MR DIEHM: Dr Miach, in your statement in paragraph 53 you refer to patient P33 as being a man in his mid-70s and you have referred to the fact that one of the staff doctors, a doctor in your unit, made a mistake when inserting a catheter and as a result the carotid artery was damaged. You referred in your evidence to Dr Patel becoming involved in the case. It's the case, isn't it, that Dr Patel became involved in the case because the doctor who had, in fact, nicked the artery requested him to do so?-- I can't answer that. I don't know. This was not one of my patients. I was called because there was an issue.

All right. Now, again excuse me whilst I shuffle through some papers. You have told us in your evidence this morning about patient P45, who was the patient who had what you suspected to be a hernia and whom you referred to Dr Patel, and you have explained to us that there is some difference in the evidence that you give now, having reviewed the patient's records, since the time of your giving evidence in Brisbane. Now, it's the case, is it not, that as you have conceded this morning that Dr Patel did in fact diagnose the existence of a hernia when he saw the patient?-- Yes, he did.

And it is-----

COMMISSIONER: You have told us this morning that Dr Patel thought it was a small hernia that-----?-- That's right.

That required operation. That's what he diagnosed?-- That's exactly right.

MR DIEHM: And it was the case, was it not, that he suggested that it not be operated upon because the patient was able to tolerate dialysis in the supine position?-- Well, he wasn't.

Do you say the patient wasn't able to tolerate dialysis in the supine position?-- I also said when a patient has a hernia it is a contraindication, it's an impossible to actually dialyse people. You can't expect people to be supine for the rest of their lives.

Dr Miach, again I'm not here trying to defend Dr Patel and I'm not suggesting to you that he is right and you're wrong, I'm simply asking you that as a matter of history what he recorded in the chart was that he didn't think an operation should proceed because this patient was able to tolerate dialysis in the supine position?-- If that's what's written down, I don't dispute it.

COMMISSIONER: You don't dispute it was written down, you dispute it as a diagnosis?-- Well, the whole thing doesn't make sense, Commissioner. I mean, you know, if we are playing with words, it was - written down is one thing. If we are actually playing with ideas and treating patients, it's something else, and, you know, it's a matter of fact, as I have mentioned this morning, and everybody knows, at least everybody in the renal - nephrologists know that when you have a hernia, dialysis is not compatible. This man, in fact, developed a small hernia, it became large, if it was left alone it would soon have been massive and it needed repairing. The reason I sent him to Dr Patel is to point out to him there was a hernia there and that it needed fixing.

MR DIEHM: Thank you. Dr Miach, to repair that hernia in the hospital would have been part of the elective surgery program?-- Well, it's pretty urgent - it's a pretty urgent thing. It may not have been part of the elective surgery program because, in fact, if you have a hernia, then in fact it is elective. There are plenty of people running around the world, in Queensland, with sort of plenty of hernias which don't need operation. If they want it operated on then that is elective surgery. But when you actually have a hernia in a patient who is on peritoneal dialysis, then that is urgent business.

I may have asked you a question that carried with it what the Commissioners have referred to in the past, a variety of meanings in the word "elective". I don't mean to suggest by that that it was elective surgery, such as cosmetic surgery, but rather that it would fall within the definition of what Queensland Health describes as elective surgery. You may not be familiar with that definition?-- No, I'm not. But I certainly wouldn't regard it as elective surgery.

Thank you. You wouldn't regard it as that because in your view there is a clear medical need for the operation?-- Absolutely.

But it's not an emergency, is it?-- Well, it depends how you look at it. If you don't fix it, if you don't dialyse the patient, then it becomes an emergency very, very quickly, because of the hernia, because the patient becomes uraemic and is in danger of becoming very, very sick, so it depends how you define what "emergency"-----

It would need to be done within a week or so?-- Approximately.

But doesn't need to be done in the next few hours to save the

patient's life?-- No, not in the next few hours, no.

COMMISSIONER: There's been a suggestion, Dr Miach, that in the Queensland Health dictionary anything is elective if the patient can survive for up to 24 hours without having the operation?-- Certainly this man would have survived for 24 hours, probably a lot longer. What isn't brought out here is that this man in fact - which I think is relevant - this man had the luxury also of having arteriovenous fistula so this man would have survived forever because, in any event, I would have changed him from one modality of treatment to another one. But his quality of life was dependent on his peritoneal - on his peritoneal cavity being intact and being able to be used.

MR DIEHM: Doctor, I want to ask you some questions now about the P34. This is the patient who had this oesophagectomy early on in Dr Patel's time at the hospital. You have already answered some questions about it today. Now, with respect to that patient, you told us last time and you have referred to it again today, that you referred that patient yourself to Dr Patel for an opinion?-- I referred him from my unit. I said this morning I can't remember whether it was specifically me that spoke with Dr Patel. The way referrals are usually are made in the hospital, if you let me go through the journey, you say sort of, "I want an opinion on this gentleman here". If you ask the appropriate PHO, he knows the movements of the surgeons, so in fact we frequently go through a junior to get - it may be me that had done it, I can't remember - but in fact what usually happens is in fact if we want an opinion, if we want a referral, then it's done via - through the PHOs.

Now, the opinion comes back to you usually, you say. You ask for an opinion and you expect to receive it. In what form do you usually get that opinion?-- Either written or verbally.

If it is written, again by what means is it communicated to you, letter, or is it recorded in the notes?-- It's usually recorded in the notes. It may become as a letter. I mean, it varies but - you know, with what the consultants feel like doing.

You say that the - you said at 285.20 of the transcript last - when in Brisbane that the surgery was fast-tracked. Is that your explanation as to how it was that the oesophagectomy was arranged without your knowledge?-- I knew nothing about the oesophagectomy being done. As I explained this morning, when you ask for an opinion there's a lot of issues that in fact you are interested in. If surgery is an option, then the type of surgery that's involved is also relevant. There's a lot of things - a lot of things involved, as I mentioned.

You say that you would ordinarily ask for an opinion from a range of disciplines to consider a range of options with a patient. Can you tell us whether there were any other persons apart from Dr Patel from whom you sought an opinion?-- Well, the people you would actually seek an opinion from are the - the - the oncologists. They rotate up from Brisbane to

Bundaberg. The same consultant also is involved with radiotherapy. So, no, I didn't ask them because in fact I wanted - I mean, my impression was that this - that this man - in fact, these prognoses were sort of fairly limited, and I went through the motions of getting opinions of him. The first one that I asked, in fact, which was on site and which was very early on in the piece - and in fact you said that he was quite competent in sort of - the first one that asked for it, or me who asked for it, or one of the juniors, I don't know, I can't remember.

You had arranged for a CT scan to be taken for the patient, had you not?-- Probably.

The cancer was diagnosed in the Bundaberg Hospital, wasn't it?-- That's right.

And it was diagnosed in late April of 2004?-- 2003, I think.

Sorry, 2003?-- The approximate time would be that.

All right. Was the patient - did the patient remain under Renal Unit care following diagnosis as an in-patient?-- I can't remember, but in fact he came for dialysis regularly and when you are on dialysis they are technically classified as in-patients, so they get admitted and discharged the same day. The in-patient, which I think you refer to, is where he was admitted to hospital and stayed there for - sort of four or five days.

Yes?-- I don't think so, but I could be corrected there. I don't - I'm not aware of that.

Can you tell us now whether before the operation occurred you knew that this man was going to undergo some kind of surgery at that time?-- I so have thought about this repeatedly and continuously. I can't be very specific on that. I cannot recall whether, in fact, I knew that he was going to have surgery or not. I just cannot - I just can't remember that.

All right. You can't remember whether you knew that he was going to have surgery at all; is that what you are saying?-- Surgery wasn't an issue as far as I was concerned because, in fact, what I asked for was for an opinion. Once an opinion was given, then in fact one would have discussed the most appropriate management for this patient. So the surgery wasn't in my sensorium because I didn't ask for surgery, I asked for an opinion.

Yes. You see, there's evidence from Ms Hoffman that you were involved in a multidisciplinary team preparing this patient and preparing the arrangements for the patient before the surgery took place.

COMMISSIONER: Just by way of clarification - I don't have a transcript in front of me - did Ms Hoffman say Dr Miach was personally involved in doing that or simply-----

MR DIEHM: I believe so, but to be accurate and fair I will read the answer, if I might, Commissioner.

COMMISSIONER: Yes.

MR DIEHM: She said this in 1,503 of the transcript, "My impression, I think, was that he" - being Dr Miach - "he was helping because he was organising the dialysis." "So, I guess I assumed that he was in favour of the surgery going ahead, but I don't know whether he had that opinion or perhaps he didn't have that opinion, maybe I just assumed that because it was being done as - as a team. They were looking at it as a team." The next question was, "You did not hear him voice any opinion one way or the other about whether or not the operation should proceed?" Her answer, "At the time? At the time?", as a question, and then she said, "I can't remember. I can't remember back that far - of that particular-----", and I interrupted and said, "Nevertheless, as you say, he seemed to be actively involved in enabling the operation to go ahead by his cooperation with respect to the dialysis?" "He was cooperating with that, yes."?-- Well, if the - it depends on the type of surgery. I mean, if that's what - you know, I may have been aware some surgery was being - was contemplated. The issue is that, in fact, this patient was on standard chronic dialysis. As I mentioned earlier on, when this man had any sort of procedure done he became acutely ill because - there is no way that I would - would consent to this man - agree to this man having an oesophagectomy, not in Bundaberg, not anywhere.

When did you find out that he had had an oesophagectomy?-- I think that day, because he required dialysis.

Yes.

COMMISSIONER: You mean by later on the same day that he had the-----?-- I think so, either that day or the following day, I just can't remember, but in fact it would have been pretty early on because, in fact, his dialysis schedule would have been organised and altered and I would have done that.

MR DIEHM: How long would that take?-- To dialyse someone?

No, to organise those matters that you just referred to?-- Oh, half an hour, 15, 20 minutes, half an hour, three-quarters of an hour.

See, I suggest to you that you, in fact, saw the patient some 50 minutes - that's 50 minutes after he came out of theatre for the purposes of consulting him concerning his renal needs. Would you accept that?-- Well, if it's - if it's recorded that would be correct.

And I suggest to you that you saw him soon after he came out of theatre because you knew he was going to have this operation?-- That doesn't necessarily follow. If I'm around, then in fact - if someone goes to intensive care, people would call me to - it was, you know, whatever happened in theatre,

people would call me and I would see the patient to make sure it was safe for him. So I don't think that follows at all.

Yes. If I can ask you to look at this document from the patient's notes. That's an entry for the 10th of May 2003. It may need to be progressively moved up on the screen so you can read it all, as best as you can?-- Can you just lift it up a little bit?

COMMISSIONER: I think on this occasion it's probably easier if the doctor has the opportunity to read it.

MR DIEHM: Yes.

COMMISSIONER: The handwriting doesn't come across very clearly?-- Right.

Yes, Mr Diehm?

MR DIEHM: Now, Mr Miach, is that document the - does that document appear to be a recording of the opinion of Dr Patel after having consulted with the patient?-- I don't know when he consulted with the patient. All he's just stated there-----

Can I just borrow it again?-- Doesn't make any mention that he consulted with the patient there.

Does it express his opinion concerning the patient?-- Well, the assessment is-----

COMMISSIONER: If you can go slowly. This has to be taken down?-- The assessment is, "Acute carcinoma, GE junction, secondary to Barrett's, with no clinical evidence of metastases." That's the assessment.

MR DIEHM: Yes. That's his opinion of the patient?-- That's right.

COMMISSIONER: Is there any opinion in there, recorded in there, regarding the availability of surgery or the appropriateness of surgery?-- Nothing at all.

No?-- Not on this one, not on this statement here.

I think there may be some confusion. Your evidence was that you referred the patient to Dr Patel for an opinion?-- That's right.

And that was an opinion as to whether or not surgery was available or appropriate?-- An opinion on the best management. The surgery would have come into it.

Yes?-- Surgery would have come into it. He's a surgeon. I mean, we routinely refer patients to surgeons, plus the other specialities, as I mentioned.

But what you have in front of you there on that piece of paper

isn't the sort of opinion you are asking for?-- I already knew that.

Yes?-- I mean, you know, it sort of says CAT scans have been done. I can read CAT scans. In fact, I know there are secondaries. So that doesn't tell me anything. I mean, I already knew that. This is not an opinion at all.

Yes?-- What's the-----

MR DIEHM: Dr Miach, again, I will remind you that I'm not here defending Dr Patel, I'm merely exploring just what the sequence of these events were. But that does appear to be Dr Patel's opinion, good or bad as it may be, in response to a referral made to him by somebody concerning this patient. Is that right?-- Appears to be.

All right.

COMMISSIONER: You might say a diagnostic opinion rather than an opinion as to management or treatment?-- It's a diagnostic opinion, but that was available already in the notes. So there's nothing new there.

MR DIEHM: Thank you. I tender the document.

COMMISSIONER: Yes. The in-patient progress notes relating to James Phillips for the 10th of May 2003 will be Exhibit 98.

ADMITTED AND MARKED "EXHIBIT 98"

MR DIEHM: Commissioner, I may have to expand on it. Regrettably the photocopies of the documents I had were incomplete compared to the one that----

COMMISSIONER: Mr Diehm, I would normally break for lunch at a quarter to 1. Would it assist you to break now so that you can get any photocopies you need over lunch? And I am sure one of the staff of the Inquiry can assist you in copies made out the back here where there's a photocopier available.

MR DIEHM: Thank you. Yes.

COMMISSIONER: Is that convenient?

MR DIEHM: Yes, thank you.

COMMISSIONER: All right. We will resume at 2 o'clock.

THE COURT ADJOURNED AT 12.43 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.04 P.M.

PETER JOHN MIACH, CONTINUING CROSS-EXAMINATION:

MR TAIT: Commissioner, I have got commitments tomorrow in Brisbane. I was hoping to get the 5.15 plane back this afternoon, subject to how Mr Diehm is going and the other questions. Could I seek leave now, if necessary? Ms Gallagher will continue to look after Dr Miach's interests if it is not finished and I have to leave.

COMMISSIONER: That's certainly in order. The other possibility is that - I don't know how long Mr Diehm is going to go - he may not know himself at this stage - but if there are some issues you want to raise by way of re-examination, you could interpose that rather than leave it until the end.

MR TAIT: Thank you very much, Commissioner.

COMMISSIONER: Thank you, Mr Tait.

MR DIEHM: Dr Miach, there is, it appears, a second page to that note. Perhaps we were all a bit too cynical. If I can ask you to look at this document, and as it goes up, could I just explain, Commissioner, that, as I understand it, this file, because it is one of the patient files concerning the patient about whom there's been recommendations made already, the original file, I gather, Queensland Health doesn't physically have. So, what they have produced today is a photocopied file, and there are some problems with the quality. My instructing solicitors have made some inquiries to see if a better document can be retrieved.

COMMISSIONER: Yes. The original file is with another Government department.

MR DIEHM: Yes, in Brisbane, I understand.

WITNESS: I have trouble reading that, I'm terribly sorry.

MR DIEHM: I appreciate that you would. Could you confirm firstly, doctor, that in the photocopy bundle, that page I have shown you is the next one following the document which was tendered just before we went to lunch, the one setting out Dr Patel's diagnostic opinion?-- It follows the one I read this morning, but there's no date and not anything else on the page-----

It would appear to be the second page of-----?-- It would appear to be that.

Doctor and Commissioners, I can have a copy of that same page put up on the screen so that-----

COMMISSIONER: I might look at it before it goes up to see if we can make any sense of it. Dr Miach, let's see if we can work out between us what the recommendations say. Recommendation 1, would that be "check haemoglobin-----"?-- "On Thursday", "If below 9, transfuse". "Get complete blood work". "Type and cross four units of blood".

Certainly none of those recommendations seems to be a recommendation about surgery?-- Surgery on the 17th - is that the 17th of the 5th or 12th of the 5th?

MR DIEHM: 19th, I suggest. That, in fact, was the date that surgery occurred - was the 19th of the 5th. Could I refer you to the first line of that page? Aren't the first two words "plan oesophagectomy"?-- I can't read it, but that's probably what it says.

All right.

COMMISSIONER: Doctor, you are probably a lot more familiar at reading medical notes than I am, but my experience is that when you have a word "plan" like that, that is the surgeon's own note to himself or herself as to the course of action which is proposed to be taken?-- It looks like it. I mean, I haven't seen this and it certainly wasn't discussed with me.

Yes. This is not the format in which you would expect recommendations or an opinion to come to you from a surgeon?-- No, on a thing like this, if this is what, in fact, he proposed to do, the thing is to actually discuss it in great detail, you know, man to man. This is what happens always, even minor things, in fact. This sort of thing, in fact, you would expect to discuss it in great detail, sort of man to man.

As best as we can make out what it says, it seems to indicate the surgeon, who we know to be Dr Patel, has already worked out a plan for himself and is putting in train steps to proceed towards surgery on the 19th of May?-- That appears so on this thing here, yes.

So, that wouldn't be consistent with Dr Patel having, as it were, come up with a set of recommendations or opinions to come back to you and discuss?-- No, I mean, he saw - from what I can glean from these two pages was, in fact, he saw the patient, decided by himself what to do without reference to anybody else. I didn't know about this, and he surely didn't discuss it with me.

MR DIEHM: There will be another document I will come to that will highlight that point, but whilst you have answered the Commissioner's question that this wasn't what you were expecting, in the sense you would have expected an opinion to come back to you, perhaps for discussion-----?-- That's right.

-----for some agreement about a management plan, nevertheless, for the opinion, albeit one that also turns into a clear plan

that is put into action, it would not be unusual to have the opinion written in the clinical notes and that would be the means of communication back to the referring doctor; is that right?-- Either that, or, as I say, man to man, personal.

Yes. Either of those two possibilities?-- Mmm.

COMMISSIONER: If that was so, you wouldn't expect to see something like this where he has already got a plan of action and putting in train steps to perform surgery?-- Certainly not.

That extra page will form part of the existing Exhibit 98.

MR DIEHM: If a better copy can be obtained, we will provide it.

COMMISSIONER: Of course.

MR DIEHM: Dr Miach, I said there will be another document which will shed some light on what it was that Dr Patel was doing, and I ask for this document - two pages as it is - to be put on the imager, the top page first. Now, perhaps you need to see the full document, but you might be able to tell, just from what you can see, this is a consent form, proforma document from Queensland Health, for a procedure to be performed in a hospital?-- Yes.

It appears, obviously enough, to relate to the patient we are concerned with and, indeed, we can see under "Condition and Procedure", oesophageal cancer is diagnosed and, in fact, Dr Patel appears to call it an oesophagogastrectomy. An oesophagogastrectomy, presumably that's the same sort of procedure we are talking about?-- It is, yes.

Now, if that document can be taken to the bottom and then the second page put up?

COMMISSIONER: What's the additional word up at the top right-hand side from - is that "jejunostomy"? Do you know what that is?-- It says, "Oesophagogastrectomy - abdominal left neck incision and abdominal left chest incision".

D COMMISSIONER VIDER: Jejunostomy - up there?-- That's drainage of the jejunum. There's a hole in the jejunum that comes out on to the skin.

MR DIEHM: The doctor appears there to set out the risks as we can see there on the top right-hand side of the page. Would it be fair to say the way the risks are listed are in the descending order of seriousness?-- That's reasonable.

Perhaps then the second page of the document can be put up, and we might need to go to the bottom of it to see anything that's been filled in. We can see that that is - consent has been completed by the patient and by the surgeon both on 10 May 2003, the same day as Dr Patel's opinion, as it were, expressed in the notes. Now, that document, I suggest to you,

would ordinarily be part of the patient's records?-- It should be.

Yes. The next document - sorry, Commissioner, if that document can be tendered as well?

COMMISSIONER: An interesting thing about this document - I'm sure it is not the reason for which you have raised it - is under the subheading, "G. Patient Consent", one of the paragraphs reads, "I understand that a doctor other than the consulting surgeon may conduct the procedure." That gives the impression, at least, Mr Phillips was told either by Dr Patel or somebody else that Dr Patel was a surgeon - consultant surgeon. All right. The generic consent form for Mr James Phillips dated 10 May 2003 will be Exhibit 99.

ADMITTED AND MARKED "EXHIBIT 99"

MR DIEHM: Now, Dr Miach, tell me if you need me to show you a document, because I can, but I suggest to you that the operation was, itself, performed on the 19th of May 2003?-- I don't need the document. If that's the date, that's fine.

Doctor, the next document I want to show you is this one, which is on the screen now, and limited information as it has, does that document tell us that the patient was admitted as a surgical patient at the hospital on the 12th of May 2003?-- That's - that may be, but that, in fact, doesn't say that. That actually says maybe there was a pre-admission clinic, and, you know, he may have come into the clinic and, you know, had an explanation given. So, I'm not sure whether that means he actually had an admission to hospital.

Thank you. I am off on a frolic of my own, it would seem. I won't tender that document, Commissioner. Now, Dr Miach, if that advice was given by Dr Patel, albeit not in a way in which you would have expected, but recorded in the patient's notes on the 10th of May, and there is in the notes as well that consent, apparently completed on 10 May, the operation occurs on the 19th of May, given this patient's renal needs, you must have been seeing him on a number of occasions between those two dates?-- He would have actually come in for dialysis. If he was at home, he would come into the hospital three times a week for dialysis, he would come into the hospital, he would be dialysed and, in fact, he would go home. You know, I routinely see dialysis patients in a clinic. I'm thorough, but there's no reason to suspect I would have seen this. I don't know. But sometimes in the scheme of things I don't see dialysis patients when they are stable for weeks at a time, and, you know - so, it is possible I would have seen him, but in fact it is quite likely that, in fact, I would not have been aware of any of this.

If Ms Hoffman is right and you were involved in the

pre-operative work-up for this patient and the team effort arranging for this patient to have surgery, it must have been the case, musn't it, that you would have - if you hadn't been told otherwise - been looking at the file to see what sort of surgery he was going to have?-- If I was told. If I was told. But as I mentioned this morning, I mean, I had never seen that consent form, and, in fact, I hadn't seen the discussion - I wasn't aware of what Dr Patel told James Phillips or his family. I was involved with it. Sometimes I don't sort of see charts for weeks at a time, so it is not inconsistent at all that, in fact, I may not have been aware of this at all. Someone may have told me, but I doubt it.

Dr Miach, it had been suggested that the view of those clinicians who favoured this procedure being performed was that this patient had - if he didn't have the operation - no chance of surviving; if he did have the operation, some, albeit perhaps small, but some chance of surviving; what do you say about that view?-- It depends on your perspective. I mean, if someone has this type of cancer, you are quite right, if you don't do something about it, then, in fact, the chances of survival is zero. It depends what you are talking about - if it is one week, two weeks, a month. It depends on quality of life. It depends on all sorts of things. To go to theatre in this condition, in fact, would be consistent with - you know, with not surviving at all.

You would say he had no chance of surviving if he had the operation?-- I would never say no. I don't think you can say that. But the chance of having this sort of operation in someone like this gentleman would not have been great. I can't give you a percentage. A surgeon, for example, might. But, in fact, it would not have been great.

COMMISSIONER: He also had a chance of winning Gold Lotto, but you wouldn't-----?-- It is possible, so would I, but that's not coming either.

MR DIEHM: I want to ask you some questions, if I may, about the patient Marilyn Daisy. Since you gave your evidence in Brisbane, have you looked at the file for her?-- I'm trying to remember. I mean, I have so many files I can't remember. Maybe I have, maybe I haven't. I don't know.

If you did, it is not something you recall or formed any different view about than the evidence you gave in Brisbane - about what her course was?-- I can't remember looking at files for any specific reason.

All right. Now, it is your understanding, is it, that this patient, having had her amputation, remained an in-patient of the Bundaberg Hospital until such time as she went to Brisbane to see Dr Jenkins?-- I'm not sure of that either. It is done in the Renal Unit. We stabilise people. If we can have an access which works and works well, we keep treating them, but a lot of them go home. We don't keep them in hospital as in-patients. This lady may have been an in-patient all along but she may have gone home. It is possible. I haven't

refreshed my mind on that. But what happens is, in fact, if people have renal failure, they get dialysed. If they are stable and well, they go home and they come back three times a week.

This patient, do you recall, lived quite some distance away from the Bundaberg Hospital?-- This lady came from Gayndah, but, in fact, she moved into town and she was living, I think, close to town, about five or 10 kilometres out of town, and, in fact, she's trying to move into town now. I think she had moved into town at that stage. Exactly when she did, I can't be specific.

Thank you. Now, in the case of this patient concerning her treatment, you say that you were completely unaware that she was going to have the amputation done before it was done?-- What was decided about amputation - I'm not sure whether, in fact, she needed one, you know, eventually at some stage. But when she came into hospital and had it done, I was completely unaware that she was there, that's correct.

You were unaware that she was there and unaware also that she was going to have the procedure before-----?-- I wasn't aware she was in the hospital. I wasn't aware she was going to have a procedure, that she had the procedure. I discovered her some days later.

Do you know whether any of your staff were involved in the arrangements with respect to her - leading up to her having the amputation?-- That was a surgical procedure. My staff are medical people, so I suspect they knew nothing about it. They probably would have told me, in fact, if she was to be admitted.

They probably what?-- They probably would have told me if they were aware she was being admitted, but, in fact, it was a surgical issue, so I'm fairly certain that she was admitted under the surgeons without any knowledge of the medical side of the hospital knowing.

Now, Dr Smallberger, is he one of the doctors in your unit?-- One of the physicians, yes.

Do you know whether he had - you would have thought if Dr Smallberger had been involved in the arrangements for this patient to undergo the operation, you would have known about it?-- He's a physician.

Yes?-- He's a physician. Sometimes he tells me what he does, sometimes he doesn't.

But she was your patient, wasn't she?-- She was a renal patient, but, in fact, she may have been seen by other physicians in the past.

Yes. Can I ask you to look at this document, please? Now, that's a clinical note concerning the patient Marilyn Daisy. Where it says "Medical Ward Review", that means it is a review

done in your clinic?-- No, that's what's called a PHO review. It is actually done in the hospital at the out-patient clinic but it is done under another - it is not my clinic, it is somebody else's clinic.

Thank you. Now, you see where, in the second lot of highlighted information, it says "L" in a circle, "BKA". Does that mean "left below knee amputation"?-- That's right.

It says "planned", picking up on what was discussed earlier. Does that mean it is intended to have that surgery?-- That's correct.

And it is, in fact, intended to have that surgery to optimise renal function and to exclude significant CAD. What does CAD mean?-- Coronary artery disease.

Go to the bottom of that page-----

COMMISSIONER: Before you do, towards the top of the page, the first asterisk point, what's the "CRF"-----?-- That's chronic renal failure.

And that's someone's note that that condition was being managed by you?-- It is by Dr Miach. What's that word there? What do you think that is? "Managed by Dr Miach"? Yes, I had been managing it. That's right.

MR DIEHM: Down the bottom of the page, please? The initials that appear at the bottom of that page, is that Dr Smallberger?-- It looks like his writing.

Commissioner, there will be more documents. Perhaps if I can start with this one and tender it.

COMMISSIONER: Yes, of course. These will all be related?

MR DIEHM: Yes.

COMMISSIONER: Exhibit 100 will comprise all of the documents that are about to be tendered relating to the patient Marilyn Daisy.

ADMITTED AND MARKED "EXHIBIT 100"

COMMISSIONER: Exhibit 100 is the out-patient notes of the 24th of August 2005.

MR DIEHM: Thank you. Now, again, if you need to see the top of the document, doctor, to confirm that it relates to the same patient, please say so, but otherwise it appears to be another review on the 7th of September 2004 in the same unit we spoke about before?-- Yes.

Again, it is Dr Smallberger's writing, is it?-- Yes.

And we can see again in the highlighted section there's a reference to a "P" in a circle - that means "planned", does it?-- Maybe.

"BKA" - below knee amputation - "soon"?-- That's right.

I can't recall now if there's anything more. Go to the bottom of the document, otherwise over to the second page, please. Again, if there's anything you see, Dr Miach, that you think should be commented upon, then please say so?-- No, that's fair enough.

Can we look at the second page, thank you? Now, again, we see a reference to a "BKA" again. Does that - "After BKA consider" - you may or may not be able to shed light on the words that follow?-- That's a Beta-blocker.

A beta-blocker?-- It is a drug.

That is something to relate to managing her heart problems?-- Beta-blocker is used to manage blood pressure and heart as well.

That is Dr Smallberger's signature at the bottom?-- It is.

Thank you. That can become part of the exhibit, thank you.

COMMISSIONER: The next component of Exhibit 100 is the out-patient notes for the 7th of September 2004.

MR DIEHM: If you can look at this document, then, too, please? Now, this is a letter coming from the hospital dated 7 September 2004. It would appear to be addressed to the patient's general practitioner at Gayndah. Do you accept that?-- Sure, yes.

Again, I will give you the opportunity, with the assistance of the Commission staff, as this document can be slowly scrolled - and then my interest in it is right at the end. I don't want to deny you the chance to see anything for comment.

COMMISSIONER: Dr Miach, the third paragraph seems to have a description of the complications of diabetes. Does that seem to accord with your understanding of her condition?-- That tells you she actually has proven coronary artery disease. She has had at least one heart attack, and the scan she had there was to actually show that her heart wasn't functioning as well as it might, and - but, in fact, there were areas of the heart that weren't functioning well, but her overall functioning was reasonable. I think I noticed in one of the previous things that, in fact, the ejection fraction which is a measure of cardiac function, I thought there was mention of it, in one of the earlier documents, being 45 per cent.

COMMISSIONER: It is. The notes of 24 August have "LVEF", which I assume is "ejection fraction", "45 per cent"?--

That's right. This one says 58 per cent.

Does that mean there's been an improvement?-- It looks like it, but that may be an error within, you know, the - allowable error within the actual test itself.

Just again, if we can scroll down a little bit back to the paragraph that's presently at the top of the page, if we can expose the whole of that paragraph, there's a description of her chronic renal failure, diabetes and so on. That seems to imply, to my reading of it, that her diabetic and renal conditions weren't dramatically problematic at that time?-- It depends on a number of things. I would actually have to see the renal function preceding that, because in fact one of those - creatinine .35 in someone with diabetes and of her age and sex, that would be severe renal failure. It's down - I can hardly - can you lift it up? Thank you. "Diabetic nephropathy has caused chronic renal failure" et cetera. Creatinine 0.35.

MR DIEHM: If I may just interject in case this is of assistance - and you may or may not be able to remember, but is it the case that this lady had had some toes amputated in the year preceding?-- Yes, looks like it. That's right.

So that would be suggestive that her diabetes wasn't under particularly good control?-- Well, it says there - in fact if you scroll it down, can you put this - that's it. Up on the top thing, the haemoglobin A1C was 6.6 per cent. That actually is not too bad. That's actually quite good. That's probably better than most diabetics. That gives you an index of what the diabetic control has been over the previous two, three, four months or so. So that is not a sugar level. It actually gives you an idea of what control had been like.

All right. If we're finished with that page we can go to the second page. Again we can see this is correspondence from Dr Smallberger, and he refers to the intention to follow her up during hospitalisation for her below knee amputation, as well as after rehabilitation?-- That's correct.

Thank you. I tender that document.

COMMISSIONER: Yes, the two page letter of the 7th of September 2004 from Dr Smallberger to Dr Fernandes will be added as part of Exhibit 100. I think that's the easiest way to do it.

MR DIEHM: Thank you. Again I'm interested from my point of view in the highlighted section which actually, to be complete, I'd suspect goes beyond the highlighted section, so we should start perhaps at that entry of 20 September 2004, and when you're ready we can scroll down through it?-- Can you scroll up?

The reference to "WR Smallberger", does that mean that the patient was seen by Dr Smallberger?-- "Ward review" - that stands for "ward review Smallberger". That usually means that Dr Smallberger would have been there.

"BP satisfactory for pre-op"? Blood pressure satisfactory for a person who is about to undergo an operation, is that what that means?-- That's right, 140 on 60. That's right.

It would seem pretty clear from that note, would it not, that Dr Smallberger had in mind that this patient was about to undergo an operation?-- It looks like it.

I tender that document, Commissioner.

COMMISSIONER: Progress notes for the period 19 September to 20 September will be included as part of Exhibit 100.

MR DIEHM: Thank you, Commissioner. Doctor, if I ask you then to look at-----

COMMISSIONER: Sorry, Mr Diehm, this seems to be a page from an ongoing set of, I assume, ward notes or clinical notes of some sort.

MR DIEHM: Yes.

COMMISSIONER: Presumably the previous page shows that the patient was admitted as a surgical patient, that's right, and-----

MR DIEHM: Commissioner, I think the way the notes are collected there are patient notes - this witness might be able to comment. The surgical note we'll come to in another place, and I'll insert that at an appropriate time.

COMMISSIONER: It's just that looking at this page we have, on the 19th of the 9th, "Patient relaxed. Sleeping". Blood sugar levels given, observations and so on, which seems to suggest that that wasn't the first day the patient arrived in the ward. There's presumably an immediate preceding page showing the patient-----

MR DIEHM: There are a number, Commissioner. I've been selecting certain pages out.

COMMISSIONER: I accept that, and I make no criticism, but does it appear from that the patient was admitted to the surgical ward under Dr Patel, or isn't that clear?

MR DIEHM: That is more than I can say presently, Commissioner. It's not a document I've found.

COMMISSIONER: All right. Is that what you'd expect?-- No, I think it's a very good point. I think it would be important to find out who this patient was admitted under. She would have been admitted under a consultant, and that would be identified in the chart. It's identified every time a patient comes into hospital. It will actually tell you who the patient was admitted under.

MR DIEHM: I'll see if I can have that document turned up in due course, Commissioner, before I finish the cross-examination of the witness. The next document I wanted to take you to appears to have two pages involved. Now, the first of those entries, which I think should read "22/9/4. SB", and is it Dr-----?-- Sanjeeva.

Do you know that doctor?-- That would be a junior doctor. I suspect that it would have been a surgical JHO/PHO. I don't think we had a Dr Sanjeeva working with us at that time, but I might be wrong.

The patient has been reviewed by that doctor. If we can scroll further down, please. On 22 September we have a note there with three names, apparently for a ward review, Smallberger, Aung and Boynton?-- That was the team, the medical team. Dr Aung is a PHO who was working with Dr Smallberger at that stage, and Dr Boynton would have been an intern.

Again because I've shown you this note, it actually continues over the page, but it certainly appears from that note that the medical team, at least as early as 22 September 2004 - and bearing in mind, as we'll come to, the operation was performed on 20 September - was visiting this patient in the unit, and can I just say to the Commission, the documents I've had access to do not include the renal notes for the patient.

COMMISSIONER: Yes.

MR DIEHM: There's at least been a review, do you accept, Dr Miach, on the 22nd of September?-- Yes, I do.

If those pages can be made part of the exhibit as well.

COMMISSIONER: Two additional pages of inpatient progress notes will be added to Exhibit 100. They cover the period 22 September.

MR DIEHM: The next document on the screen - perhaps if we can have the top part of it as well, by the way, while we're there. It appears that Dr Patel reviewed the patient on 23 September. Then the next entry down, 23 September 2004, 9.35 in the morning, another ward review by those three doctors from your medical department?-- Yes.

We can actually see there that the second entry three days post the amputation shows there's been an acute deterioration in the renal failure, acute confusion and drowsiness and so on?-- Yes, but if you go back to the previous date you will actually find there's a comment on there saying "creatinine .8", and that is a marked deterioration in renal failure the previous day. Her renal function when her creatinine was .35 - and I apologise for - her renal function at that stage would have been very poor, but in fact when it got up to .8, she would have lost more than 50 per cent of whatever renal function she had existing. So in fact that's correct, but in fact you have to refer to the previous thing that actually saw that she was doing that.

Okay. So what happened is that the Department of Medicine doctors detected on 22 September that there'd been a deterioration in her renal failure?-- They documented that, but they made the point on the 23rd that there's acute

deterioration.

Further deterioration does that perhaps mean?-- Probably what it means, but it says "acute deterioration".

I tender that page as well, Commissioner.

COMMISSIONER: Progress notes of 23 September will be added to Exhibit 100.

MR DIEHM: Then, doctor, this page, if I may.

COMMISSIONER: Just before we go on to the next page, can we put up the top half of the page we were just looking at. Reading that from my uneducated viewpoint, I would have thought that that's a fairly positive set of notes from Dr Patel, "Patient drowsy. Eating and drinking well. Complaints of pain. Vitals stable. Stump checked" and so on. It seems to be-----?-- Yes.

-----quite inconsistent with the immediate preceding note and the immediate following note which seem to suggest that this patient is on death's door?-- Well, I agree that it says "as seen by Dr Patel". That's not his writing, so I think that his PHO or one of his junior staff would have written it, but the "patient drowsy" would have been of some concern to me. "Complaining of pain. Stump checked. Remove drain" - the "drowsy" would have been of some concern to me.

Yes.

MR DIEHM: To say that the patient is drowsy, is that an indication that the patient is well or unwell?-- Unwell.

COMMISSIONER: I guess the other importance of this is it's a pretty clear indication that whatever involvement the medical department team had in the management of this patient, it was clearly clear that the surgical department was responsible for this patient in terms of the amputated stump?-- Exactly. As I was saying this morning, Commissioner.

MR DIEHM: And, Commissioner, in selecting the notes I have, I wasn't meaning to give a suggestion otherwise.

COMMISSIONER: No, no.

MR DIEHM: I think I had come to another document. Dr Miach, this entry being 23 September 2004, the first entry would appear to be yours?-- That is my entry in my writing and my signature.

Is this the occasion which you've spoken about in your evidence in which you came to see this patient?-- Must be.

That follows what, quite apparently, have been continuous visits - a number of visits by other doctors from within your unit for this patient?-- That's right.

So to the extent that your evidence might have led someone to infer that this patient had been left unattended, uncared for with respect to the management of her dialysis until you came along and found her in this condition in the ward, that's wrong, isn't it?-- That referred to surgical reviews, but I wasn't aware that in fact she'd been seen by the medical unit. It certainly wasn't communicated to me. I saw her for the first time on the 23rd of the 9th.

What is also apparent from the documents that I've shown you is that even if you hadn't been personally informed that this patient was to undergo this procedure, it was known by a staff physician in your department, obviously having an intimate involvement leading up to the operation in the management of that condition, that this operation was going to happen?-- It appears that way from the documents that you've shown us, yes.

Thank you. Commissioner, I should have added that last document to the exhibit.

COMMISSIONER: The final segment of clinical notes for the 23rd of September will be added to and form part of Exhibit 100. That now completes Exhibit 100, I take it.

MR DIEHM: It may do. There might be one further document, if I could have a moment, the one that you asked about.

COMMISSIONER: Okay.

MR DIEHM: Doctor, if you could look at this document, please. I don't know whether you need to see the top of the document to get a heading of it. That's as much as there is. But if you look down just a little bit further, please, into the document, we see in - some of the typed words are hard to read, but above where "Outpatient Department" is typed in, that would be the heading for "Admission Source". To the left of that we have the date of the admission, 16th of September, then underneath the date, the unit patient admitted to, "surgery", and the treating doctor is "Patel"?-- That's correct.

That's the document that you were talking about before that would shed light on where this patient was admitted to. Commissioner, that copy has been taken from Queensland Health's copy, so I'd like it to be part of the exhibit, but perhaps it can be photocopied first.

COMMISSIONER: Yes, indeed. That page, when it comes back, will be added to and form part of Exhibit 100.

MR DIEHM: Thank you. Commissioner, I'll have the document shown to the witness as a matter of fairness to him, but I have now a better copy of - it's double-sided, but of Dr Patel's opinion. Doctor, you've had a chance to read that document?-- Yes, I have.

I don't specifically have anything to ask you about it, but is there anything specifically you want to say about it?-- No,

no comment.

COMMISSIONER: I think that can go back to Mr Diehm.

MR DIEHM: I think that can perhaps become the exhibit, Commissioner.

COMMISSIONER: To replace the page that was virtually illegible. That was part of Exhibit 98. Dr Miach, that admission form that we were looking at before, I guess the critical thing from our viewpoint - I realise that Mr Diehm has his own issues that he needs to follow up, but from our viewpoint that makes it perfectly clear, doesn't it, that the patient was the responsibility of Dr Patel?-- Absolutely.

And in those circumstances there would be no excuse for Dr Patel's not continuing the management of the patient until the wound had been properly-----?-- Absolutely. As far as the stump was concerned, absolutely.

That is added to and forms part of Exhibit 100.

MR DIEHM: Thank you, Commissioner. Commissioner, I did say before that that was it as far as Exhibit 100 was concerned. I have some more documents concerning this patient, but they are on a discrete topic, so it's probably relevant to make a new exhibit anyway.

COMMISSIONER: Yes.

MR DIEHM: If you can look at this document, please. Doctor, again this is a note made apparently by Dr Boynton, one of the doctors in your department, but relevantly it appears that the patient was asking for what's described as "gate leave". Does that mean leave to leave the hospital temporarily?-- Just temporarily. She wouldn't be discharged. She would leave the hospital with someone and then come back.

And there's a reason there, a personal reason. A family loss is given as to why that is sought on her part. If that can be - if I could tender that document, Commissioner.

COMMISSIONER: That will be Exhibit 101.

ADMITTED AND MARKED "EXHIBIT 101"

MR DIEHM: As part of that same issue - again the highlighted section in particular I wanted to draw your attention to, because it appears that there's still this issue for the patient from a social point of view, and it's said, is it not, that the patient was very keen to be discharged or she would self-discharge to organise her affairs at home, and that it was explained to her the problems associated with that, including - perhaps you can help us with your experience as to

what the first of those problems appears to be as mentioned in that note?-- Euvolemia. That means, basically, fluid status. People who have kidney failure, they can't retake fluids, so they may be dehydrated or they may get overloaded if they drink too much. That's what that means. Some problems with the stump, pain, bleeding, infection, those sorts of things.

Because again, accepting you're not a surgeon, this is still fairly early post-surgery. One would imagine that the stump is still-----?-- This was on - it's about two weeks.

Then the plan as set out thereafter includes a reference to a PermCath with Dr Gaffield, and then "tomorrow, surgical review of stump, Dr Patel's team", and then also some reference to the vascath as well?-- This lady - just to explain, this lady needed dialysis so she had a temporary catheter called a vascath, which I would have put in, which is usually a tube inside the groin. The reason I think that there was some nervousness about letting her go home early was because in fact she had this tube still in her leg, and that can cause problems. We tend to leave these vascaths in until we have a PermCath in because - in fact surgery sometimes has been so erratic at Bundaberg Hospital, surgeons will say, "I'll put it in tomorrow morning", but then they cancel for whatever reason and then in fact you don't have anything. You don't have a tube inside the leg and you don't have a PermCath, so in fact the patient is in danger at that stage. That's what that means.

If I can tender that document as part of the exhibit.

COMMISSIONER: That will form part of Exhibit 101.

MR DIEHM: Look at this document, please.

COMMISSIONER: I know you told us this morning, doctor, that there's no standard length of time for removal of sutures. This is the 4th of October, about two weeks after the operation?-- Yes.

Are you able to indicate whether that is about the time you'd think about removing sutures for an amputation?-- Yes, it is. I don't have much to do with sutures and amputation, but there was a recent patient, as I mentioned. That's approximately the time - two to three weeks - that they get removed, but as I also mentioned, if the tissue is what's called ischaemic, if it is not likely to sort of heal very well, then the surgeons may decide so keep them for a little bit longer. But the usual time, from my understanding, my knowledge of the situation, is sort of somewhere between two and three weeks.

And is that decision-making process something you would expect to see recorded in the progress notes, that the stump was reviewed, a decision was made to leave the sutures in for another seven days, or something like that?-- If there was an intention to leave them in I would have expected some comment to be made about that.

Yes?-- But as I've mentioned a number of times, decisions as far as stitches, sutures in an amputation stump, that's left to the surgical team.

Of course.

MR DIEHM: Would you look at this document, please? I'm sorry, if the document that I just had on the screen can become part of the exhibit. I didn't refer to it, I'm sorry. I'm sorry, I am reminded, your Honour - I distracted myself. Perhaps if we could go back to the last document that was on the screen, please. My juniors on my right are reminding me that I neglected these things. Now, with respect to what you have just been discussing, on the 4th of October 2004 there appears to have been a review of the stump by a Surgical Principal House Officer. Thank you. If that can become part of the exhibit and the next document can be put on please?

COMMISSIONER: With small area stump breakdown, is it, wound breakdown?

MR DIEHM: Lateral edge of wound?-- That's correct.

MR DIEHM: So there was some puss come into the wound?-- It says "no puss", haemoserous discharge. But it says "zero puss" so that there's no puss there.

Thank you. Yes, I don't need to refer to that next note now, thank you. If that document can become part of the exhibit and the next one put on because this follows from the Commissioner's question just a few moments ago. On the 28th of September 2004, patient was seen by Dr Patel, said to be, "Doing well. Seen by the medical team as well. Transfer Medical Ward. Stump healing well. Nil concerns surgically. Will follow-up in Outpatients Department. Continue physiotherapy Outpatients Department two weeks." That's the sort of thing you were talking about, that you would expect to see a plan with respect to when-----?-- That's exactly right. It also says patient was in the Surgical Ward until the 28th of the 9th, so she was transferred to the Medical Ward about eight days after she had her surgery.

Yes, thank you?-- One of the things that it doesn't say there is about sutures.

Yes. Thank you, doctor.

COMMISSIONER: That will be added to Exhibit 101. I will put it at the front of 101 so the pages are in chronological order.

MR DIEHM: Thank you, Commissioner. Now, if I can show you this document, please? It would appear, doctor, the social concerns of the patient. I'm not being at all critical of her, that her family circumstances finally took effect, didn't they, because it appears from that note that she was to discharge herself from the hospital against medical advice?-- That's correct. It's - an RNO put that entry in.

Thank you. Commissioner, I might be a few minutes sorting a few documents.

COMMISSIONER: We will take the afternoon break in that case.

THE COMMISSION ADJOURNED AT 3.05 P.M.

THE COMMISSION RESUMED AT 3.24 P.M.

PETER JOHN MIACH, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Mr Diehm?

MR DIEHM: Thank you. Just before I move on to these documents, can I have back on the screen what is, I think, the first document of Exhibit 101, which is the 28th of September entry.

COMMISSIONER: The Admission?

MR DIEHM: Yes, the Admission. If we can just see what's at the top of it, please. Doctor, are you able to make out what the top note is referring to? Is that a nursing entry, is it?-- It is a nursing - it's got RN there, so it's a nursing note. It's, "10 o'clock at night continued".

Thank you. It was something I thought it said that it didn't say, so if that could be returned. I will put a further document on the screen. These would continue to become part of the exhibit, Commissioner, they relate to the same matter. Doctor, I'm interested in having you look at the entry recorded 12th of October 2004?-- Could you lift that up, I can't see it.

If we can see more of that?

COMMISSIONER: Can you scroll all of the way up?

CLERK: That is the full document, Commissioner.

COMMISSIONER: It's just a blank page.

MR DIEHM: There's a line ruled through it. Doctor, what that means, does it not, is that an appointment was made for the patient but the patient didn't attend?-- Usually that's what they suggest. It's usually "DNA", "Did Not Attend", but that's what that suggests.

Thank you. If that could become part of the exhibit?

COMMISSIONER: Yes, that will be added to Exhibit 101.

MR DIEHM: Doctor, if you could then look at this page. This would be a page in the notes, it seems, devoted to entries for dressing review. Some problems with the stump, it would seem. But there we can see before the time of Ms Daisy's visit to Dr Jenkins in Brisbane, she had three attendances for reviews of the dressing presumably of her stump?-- Presumably, yes.

All right.

COMMISSIONER: The first of those is the 12th of October, which is the same date as the Surgical Ward Review that you were suggesting wasn't in attendance.

MR DIEHM: Yes.

COMMISSIONER: It seems she found her way to some sort of surgical examination on the 12th of October.

MR DIEHM: I was about to explore whether he could shed any light on that. Doctor, do you know where dressing reviews are carried out?-- Yes, they're done in the Outpatients' clinics. They're usually done by senior nurses, but there's usually a surgeon there. But they're mainly done by nurses. If there was a ward review, which is a Surgical Ward Review, that would have been by a surgical PHO in the clinic or by a surgeon himself. But these entries relate to nurses who actually do routine dressings on wounds.

Thank you. If that page can become part of the exhibit, Commissioner?

COMMISSIONER: Yes, that will be added to Exhibit 101.

MR DIEHM: Doctor, finally, two pages that I will ask you to look at in sequence. Now, the first of the entries on these pages seems to be a surgical note. Do you know that name?-- That is a PHO.

In the Department of Surgery?-- Surgical note, yes.

And there's a sketch there of the stump?-- Yep.

Apparently showing the stitches, would you agree?-- It depends on how the PHO does his depiction, but that would suggest stitches.

Yes?-- They're not mentioned that I can actually see.

And when you're ready to you can scroll down the page. Again, can you tell me whether you can pass comment about that? There's a suggestion the wound would be reviewed in two days' time?-- That's correct, "Hopefully these areas will granulate and heal without further surgery."

And the 16th of October, a further review by the same PHO?-- Yes, it is, it's got his name there, "review in three days".

And - thank you. If those documents can become part of the exhibit then?

COMMISSIONER: Now, according to these documents, if you put them together, the patient then had a stump review on the 12th of October, the 14th of October and the 16th of October, the 19th of October and the 28th of October, which takes us up to over a month after the surgery and she still has stitches in; does that seem right?-- Well, again, I keep repeating myself. It seems strange to me. Stitches are usually removed long before then and the letter from Dr Jenkins when in fact he wrote suggested exactly that. But looking at those notes suggest to me that, in fact, sutures hadn't even been thought about in those notes.

There is nothing to suggest it is there or nothing to suggest that Dr Patel reviewed the patients?-- Well, no, but his PHO - or the dressing clinic, in fact it would have been left to them, but they may not have realised that the stitches were still there.

Yes.

COMMISSIONER: Those four pages will be added to Exhibit 101.

MR DIEHM: Commissioner, I can announce that's the end of the notes that I intend to deal with in respect of this patient.

COMMISSIONER: Yes.

MR DIEHM: Doctor, the long and the short of it is - and they speak for themselves in this regard - but it would seem that to the extent that there might be criticisms made about the management of that particular patient in terms of inaction at times of reviews, there were a lot of other people involved in that process, it seems, doctors and nurses, who were responsible for such failure?-- I would agree with that, but I would also say that as far as two things are involved, as far as her renal failure was concerned, she was admitted without any knowledge from the Renal Unit, including myself, and three days later, three or four days later, whatever, she was quite ill. That's the first thing. The second thing, as far as the sutures were concerned, in fact she had a lot of reviews, but the sutures were still there in the end and that's actually what happened to this lady.

Doctor, you say that she was admitted without the knowledge of the Renal Unit?-- Yes.

And she became unwell in those few days after the operation. She was being - albeit Dr Patel presumably was the doctor ultimately responsible for her condition - she was being seen on a regular basis by a physician, amongst other doctors, within your Department of Medicine, wasn't she?-- She was. She was seen by the doctor who actually organised her admission. This lady had severe kidney failure. I didn't know she was there until she was very, very sick. So that's correct, that's what the notes suggest, that another physician, in fact, had seen this lady.

Doctor, I just want to touch briefly on P34 before moving on to another topic. It's the oesophagectomy patient. It would be right to say, would it not-----

COMMISSIONER: This is Mr Phillips?

MR DIEHM: Yes. That for that surgery, the oesophagectomy to have proceeded, there would have had to have been at least an anaesthetist involved in an assessment of the patient and, indeed, in particular, an assessment of whether the patient was up to undergoing the surgery that was proposed?-- There was a pre-admission clinic, which I think is in one of the exhibits, and the anaesthetist or underlings frequently do that, or they generally do that, whether it's an anaesthetist themselves or people who work for them. But that's correct they - patients usually are assessed by the anaesthetist in that situation.

And it's something that they're in the ordinary course conscious of and thinking of right up until the point of time that they put the patient under for the operation, isn't it?-- Well, they see the patient some days or a week or whatever beforehand and, in fact, then they know the issues involved.

Yes?-- Usually if there are issues involved they are usually referred to other consultants looking after these patients. For example, if this gentleman was on dialysis then, in fact, staff from the Renal Unit, including myself, would normally be consulted.

Doctor, the catheter ought - if I can move to that? You said in your evidence in Brisbane that it was very likely that that audit would have been done before the end of January, which was the time that you left for your trip to England?-- That's correct.

And you say that you gave the audit, which became Exhibit 18, to Dr Keating either before or after you left on that leave but probably after you returned?-- That's correct.

You said - I'm sorry, I will withdraw that. You were unable to recall whether you said anything specifically to Dr Keating about the document at the time that you gave it to him?-- I don't think I said very much at all, but thinking about it - and this - my recollection of that period is not perfect. But almost certainly the reason that, in fact, that I came and I gave him that audit was because, in fact, there was a

preceding meeting with it and that had to do with the meeting that I was about, that I was in the process of organising to have this Baxter Program set in place. What I actually did, I spoke to the surgeon involved, I spoke to other people and I would have also spoken to Dr Keating about that. It is very likely, and I think that's actually what happened, although my recollection isn't great, that, in fact, I spoke to him. I went up to see him to let him know that, in fact, I was considering instituting this Baxter Program and it is very likely that, in fact, he would have asked me why and I would - and, you know, the reason - part of the reason was, in fact, that the Tenckhoff catheters, they were not being done to my satisfaction, and as always I would have been asked, "Well, where's the evidence?", and that is the reason that, in fact, I would have come back and gave him the evidence and left. That's very likely I've - I've got a vague recollection of it. It's not very clear in my mind, but that's what would have happened, because I made a point of speaking to the people who would have been involved in this whole Baxter Program because I wouldn't set it up if people were against it. So I made the original contacts, the original discussions, and then I wrote some of the letters organising the actual meeting and setting the program in place.

Doctor, as a result of this conversation, best as you can recall it, or as you have relayed it, a meeting was eventually set up, was it not, at the Friendly's Hospital with a view to discussing the Baxter Program?-- That's correct.

Now, was that some time after this discussion that you had with Dr Keating about the catheter problem?-- It must have been. But, again, my recollection isn't perfect. I can't remember the dates, but it would be logical to me that, in fact, if I was speaking to the surgeon involved, if I was speaking to the company representative involved, if I was speaking to other people, that I also would have spoken to the Director of Medical Services. I also let the Director at Hervey Bay know about it. I can't remember whether I specifically rang him, but I certainly would have sent him a copy of the letter I wrote. But in my own hospital, in fact, I would have almost certainly gone and discussed the thing and let people know what I was contemplating doing.

Doctor, it remains the case though, you can't recall the detail of what it was that you told Dr Keating when you gave him the document?-- Not very much. I can't recall. Not very much. It's very likely that I just walked in and just gave him the document and said a few words, maybe, "This is what you were asking," and left. I can't - I don't think I would have actually said very much to him at that stage. But, as I say, preceding that, the day before, or one or two days or the same day, in fact, it is likely I would have had a discussion with him about this whole issue.

Do you say that the - well, I'm sorry, I will pause. Do you say it was likely that you had a discussion with him about the issue before that day, before the day you gave him the audit report? Again, you can't recall what it was that you

discussed in that earlier case?-- I would have discussed the Baxter Program.

Yes, thank you. Dr Miach, the document that you gave to Dr Keating, do you suggest that it of itself fully explains the problems that you were experiencing or had experienced with Dr Patel with the placement of the Tenckhoff catheters?-- That document, in fact, describes specifics. It gave names, dates, what the problem was. So, in fact, it was a self-explanatory document. I would have been happy to sort of sit down with anybody and explain it in very great detail.

You speak of a complication rate with respect to Dr Patel's placement of these catheters of 100 per cent. Does the document tell us that it is a 100 per cent complication rate for Dr Patel in placing these catheters?-- There was six patients and they all had problems.

Can the witness see Exhibit 18, please, or perhaps if it can be put on the screen, Commissioner? I'm sorry not to give advanced notice in respect of that.

COMMISSIONER: Mr Diehm, I'm not sure why we are going to this, but it says at the bottom, "x6 Peritoneal Dialysis Catheter Placed 2003". Six out of six complications. Is there something more than that that we need to look at?

MR DIEHM: Commissioner, I - yes, there is. I do need to explore these matters. Dr Miach, the Commissioner has drawn attention to something at the foot of the page of this document that note - it says, "x6 Peritoneal Dialysis Catheter Placed 2003. Now, is that the part of the document that tells us that these were the only catheters of this type placed during 2003?-- They're sequential catheters from August to October. Before that, I can't - I can't remember who was placing them in. Sorry, before August - before August - between August and January 2003, I can't tell you how many catheters were placed, were placed in patients. Those datum are available.

Do you know if there were any others placed by Dr Patel?-- I don't think so. I think that's a sequential list of - I know that because, in fact, there weren't that many surgeons in Bundaberg capable of doing these things and he was the only one that, in fact, was doing them. So I specifically sought him out in the early part of 2003 or the latter - the second half to do these things. So I don't think - I'm sort of fairly certain there was nobody else who was putting them in at this stage.

All right. It is that note down the bottom that's the part of the document that tells us that these are the only six that Dr Patel did in 2003.

COMMISSIONER: Mr Diehm, do we have waste time on this? I mean, if Dr Keating's going to say that he asked to have Dr Miach - whether this was six out of six, 100 per cent, or six out of 60, that's something I'd expect you to put to Dr Miach. But, you know, the man's answering a charge of all general practices in the hospital. He gets a document showing 100 per cent complication rate. You seriously want us to spend time quibbling over whether or not he was told it was 100 per cent?

MR DIEHM: Commissioner, I would hope and expect that I would get some indulgence with respect to the matters that I'm pursuing. I pursue them for a reason.

COMMISSIONER: All right. Keep going then.

MR DIEHM: Thank you. Dr Miach, I do just want to make this absolutely clear. Is that the part of the document that tells us that these are the only six that Dr Patel did in 2003?-- As I have repeated, as far as I'm aware, these are all the catheters that he did in 2003, but the data is available, that can be checked up. I doubt whether or not there were any catheters that were done by him before that, but I could be wrong.

Doctor, I'm actually asking you something discrete from that at the moment. It doesn't matter whether there were any others or not for the purpose of my present question. Is it that line down the bottom of the document that tells the reader that three of the six - so it's six out of six?-- They are the ones.

And it's that line down the bottom that tells us that the six that are described up the top are the six that were done?-- Absolutely.

Thank you. Now, that document, you would say, is a document that tells a tale of significant problems with respect to Dr Patel performing these sorts of procedures?-- That's correct.

Because, as the document shows, with each of the patients involved there was a complication, a problem?-- That's correct.

Now, again, just so that I can understand what it is that you say, the document conveys in terms of the problem, because there are a number of different headings there that may be of interest in this respect - obviously there is a column that is headed, "Catheter Problem.", so presumably that's one of the concerns that there is with respect to catheters, and we get given a date in four of the instances of that catheter problem occurring?-- Okay, yes.

Is that right, sorry?-- There are four dates there, yes. There are six dates and four dates. "Catheter Problem" - under, "Catheter Problem" there are four dates. I agree with that.

Obviously in the, "Outcome", in the sense that it's adverse, is part of the problem, it's the result presumably of the problem?-- That's right.

But the column, "Catheter Position", I gather from your evidence this morning that also is a problem of itself?-- That's right.

So, whereas migration is a problem inside the patient-----?-- Yep.

-----the catheter position is a problem on the outside of the patient?-- That's correct.

And that's because, amongst other things perhaps, of an increased risk of infection for the patient?-- That's correct.

Because of the position?-- That's correct.

It should be downways?-- Absolutely.

Thank you. Now, doctor, you would say, do you, that reading that document tells us that the surgeon who's named in the document, Patel, is not competent to be performing these procedures?-- Well, with a 100 per cent problem rate I would suggest, yes, because when I stopped this and someone else did it, there were the same number of patients, there were no complication rates.

And it wouldn't matter if there were only five patients, for instance, so that the first five that had the catheter problems or first five that had the catheters placed, that they had these problems, you'd still say that's sufficient evidence that this man is not competent to perform this procedure?-- Well, it goes back to experience of what you are actually used to. After sort of seeing catheters placed in for decades, when you get six in a row which gives problems then it tells me this is a problem. If I find five in a row I would have thought the same. If there are four in a row it would have told me the same. I kept it going for sort of - for quite a few to actually make sure there was an issue, because all of these procedures, in fact - inherent in them, in fact, are complications. One of the major problems with peritoneal dialysis is the fact complications arise. But when you had six in a row, that was sort of untenable, in my mind. There was a problem.

As you say, a five in a row is untenable as well?-- As far as I'm concerned, yes.

And four in a row?-- Probably.

The last of the catheters placed, Dr Miach, would appear to be, would it not, P19, the 3rd of December 2003?-- I am just looking at the dates. That looks like it, yes.

All right. And the other thing I wanted to ask of you is this catheter position. That is something that is obvious on a physical examination of the patient?-- It is.

And do you consult with the patients after they have had this procedure performed yourself?-- Yes, I do.

And you examine the patient?-- Yes, I do.

And does that examination involve observing the catheter position?-- Usually. I observe the catheter position mainly to see if there's any redness, any ooze, any discharge, any infection or sort of - the position. I usually do this in conjunction with a lot of nurses, that is, involved in - trained in peritoneal dialysis.

All right. How soon after the procedure would you see the patient?-- Oh, well, initially if the catheter's placed properly, in fact it's - has good a bandage about it - we have a protocol, changing the bandages. I may not see it for a week, two weeks.

All right?-- So that's not routine that I would actually see the catheter when it comes back. I may see it earlier, may sort of see them a lot later.

Yes?-- I may not see them until they come to see me in the clinic so I can review the whole clinical situation.

By the time of the placement of the catheter in P19, you must have been aware, were you not, of considerable problems with Dr Patel placing the earlier catheters in these patients?-- Well, I knew the complications, I knew that there were issues, I knew that they weren't working, I knew that they weren't draining.

By the look of the document we can see that you would also specifically presumably have known of the migration problem in P8, because that problem apparently arose on the 19th of September 2003?-- Yes.

You would also have known of the infection in the catheter position in patient P24, that having occurred on the 4th of November 2003?-- It's likely, yes.

What do you mean "slightly"?-- It is likely that I would have.

I'm sorry, I thought you said "slightly"?-- No, it is likely I would have known, because if there's an infection there that - in fact, myself or my staff would be consulted for antibiotics, for swabs and the rest of it, so it is very likely I would have known about it, yes.

Thank you. And you would also have known about the impaired outflow drainage in P45?-- Extremely likely, yes.

And with respect to P8, you would have known that the catheter had been placed in an upwards position?-- Probably, if I would have examined the patient, but, as I say, sometimes I don't see these catheters until weeks after they are put in. We tend to leave them alone to make sure that they seal and they - that they are kept clean. So we don't - I don't routinely go and see them and sort of dismantle them to have a look at exactly which way they are placed. I mean, I assume that they are placed correctly.

Doctor, that, in this particular patient's case, is some two and a half months after the migration problem has become known of, isn't it? So, in other words - P19?-- Yeah.

We are talking about catheter placement on the 3rd of December?-- Yeah.

In P8 there was a migration problem on the 19th of September?-- That's correct.

So it's highly likely, isn't it, that by the time of P19's procedure you knew that P8's catheter had been placed in the upwards position?-- Catheters migrate sometimes. You don't know whether the catheter's migrated until you start using it, and if you have a look there, in fact, the place - the catheter was placed on 15th of August and on the 19th or the 9th, approximately a month later, in fact, the problem was identified, because that's - that's when the catheter would have started to be used.

Yes.

COMMISSIONER: One instance of migration in itself wouldn't create a concern?-- No. I mean, it does happen. It does happen. It depends on - it's not unknown. I mean, that's one of the recognised complications, but one, two, three - three's too much.

MR DIEHM: Doctor-----

COMMISSIONER: Well-----

MR DIEHM: Sorry, Commissioner.

COMMISSIONER: No, go ahead.

MR DIEHM: My question, though, was that given that a problem of migration had become known by the 19th of September, it is improbable that you did not learn then or soon thereafter, if you didn't know before, that the patient's catheter had from the external point of view been placed in the upwards position because you would have been involved in dealing with the patient because of the problem with the migration?-- I'm not - I'm not sure what you are getting at. If you just sort of explain that to me again?

Okay?-- There's two issues involved. One is migration, which is actually picked up after you start using the catheter, and the other one is inspection of the exit site, which you can sort of observe at any time.

Doctor, I'm trying to see if we can establish when it is likely that you would have known in a case of the patient P8 that the position of the catheter externally was upwards, and what I'm suggesting to you and you have told us is that usually you would expect to see a patient after the catheter was placed, a week or two after it was placed, and see the catheter itself, but sometimes not?-- That's correct.

What I'm suggesting to you is that given that there was a problem with this patient in the form of migration identified on the 19th of September, it is impossible to believe that you had not learned well before the 3rd of December that the catheter in that patient was placed in the upwards position?-- I think you are making an assumption that, in fact, the upward position, in fact, was responsible for the catheter migrating.

I'm not, doctor. I am not. I am simply asking you if that helps you telling us whether you were likely to have known of the catheter being in the upwards position before the 3rd of December?-- It is possible.

In the case of P8?-- It is possible.

It's likely, isn't?-- It's possible. I don't - I mean, I can't tell you when, in fact, I examined this patient's catheter exit site. As I say, sometimes I examine them a week, sometimes two weeks, sometimes a month.

That's not-----

COMMISSIONER: Sorry. I think the implication from Mr Diehm's question, though, is this, that if on the 19th of September it was observed that the catheter had migrated, there's a likelihood that at about that time you would also have looked at the placement of the catheter?-- It's very likely, Commissioner.

So it's quite possible that on the 19th of September or thereabouts you noted that this catheter had been placed in an upwards position?-- It's extremely likely.

Yes?

MR DIEHM: Thank you, Commissioner. The third patient on the list, I think, is P24, not P29. I assume that's meant to be P24. In any event, we know that's the third patient on that catheter list. We have got a date of catheter problem, 4th of November 2003, and you have mentioned already in your evidence that given that was an infection in the catheter position, that would have been something you would have known about, you would have been consulted about. Now, in knowing that and being consulted about that, you would have learned at least at

that point in time, if not before, that the catheter position in that patient was side-upwards?-- It's very likely.

Thank you. If we can look at the case of P31. That may be more difficult for us to talk about because we don't have a date of catheter problem with that patient. But given that this catheter was inserted on the 19th of September 2003, whilst you can't say with certainty again, there is a good chance that you would have known that that catheter had been placed upwards before the 3rd of December 2003?-- It's very likely.

Thank you. And in the case of - we will leave out P30 because the problem there appears to have occurred on the 16th of December and it's only a little over two weeks before that the catheter was placed. But in the case of P45 we have got a problem that again you have already said you would have known about at around the time it was discovered, the impaired outflow drainage. The date of that problem is the 18th of November 2003. So, apart from knowing about the catheter problem there described, at around the 18th of November 2003, if not before, you would have known that the catheter in that patient had been placed in the sideways position?-- Very likely.

So, we can tell from all of that that by the time P19 goes into surgery - and it's on your referral, isn't it, that P19's going in to have procedure done by Dr Patel?-- I usually organise them, yes.

By the time P19's doing that, it would seem that we have got at least four patients that you know of - they are responding with a catheter problem as described in that document and, indeed, where you know of the problem with respect to the catheter position, four out of four by that point in time, wasn't it, Dr Miach?-- That's right.

The four out of four, that, as you said before, would have been enough to tell you that this man was incompetent to perform this procedure. Is that right, doctor?-- I agree with what you say, yes.

And what did you do about that? What was your immediate response to that situation, doctor?-- The position of the catheter on the abdominal wall is important, but as is evidenced by one patient, who in fact had a catheter pointing upwards, he still - it's still working, it's got problems, but it's still working. I can't remember - I can't be sure whether I - I synthesised in my mind that all of these exit sites were, in fact, abnormal. I would have seen them but I wouldn't have instinctively sort of said, "Well this is the third catheter that has done this. This is the fourth catheter that has done that." So, I - you know, so what you are saying, I think, is correct, but I don't think I would have synthesised it that way. The catheters were put in, they look here - the direction was sort of abnormal. Sometimes they work and one, in fact, is still working.

Doctor, I think I can help you, in answer to my question. What you did is you sent P19 to Dr Patel to have another catheter put in.

COMMISSIONER: Mr Diehm, I think it only fair for me to say that at this stage the trend of your questions is obvious. I would expect from a counsel of your experience that you would not be attacking Dr Miach in this way, except on explicit instructions. It's, therefore, right, is it, for us to assume that Dr Keating has instructed you to launch this attack on Dr Miach?

MR DIEHM: Commissioner-----

COMMISSIONER: Is that right?

MR DIEHM: Commissioner, I can answer that question this way.

COMMISSIONER: Please do.

MR DIEHM: I have as counsel, as you know, Commissioner, a reasonably broad discretion as to the way in which I ask questions and what questions I ask, and in fact it's not for my client to tell me what questions to ask.

COMMISSIONER: Indeed. But by the same token, it's not for you to launch such an attack without your client's instructions.

MR DIEHM: Commissioner, I don't have instructions and I have not been - I have not been acting outside the scope of my instructions in asking the questions I am asking.

COMMISSIONER: Well, I am going to adjourn for five minutes so you can take appropriate instructions, but I want everyone at the Bar table to understand that one of the issues that's clearly being raised is this shoot the messenger attitude, and if it comes to our attention that anyone from the Director-General of Queensland Health down has given instructions for a witness like Dr Miach to be attacked, then that will be an appropriate foundation for us to make findings at the end of the proceedings.

MR DIEHM: Commissioner-----

COMMISSIONER: I will give you a five minute break to get instructions.

MR DIEHM: May I raise something before we do rise, Commissioner?

COMMISSIONER: Say whatever you like.

MR DIEHM: Thank you. Commissioner, this is not - my questions are not a shoot the messenger situation and, with respect, that is not a fair observation about this situation.

The second thing I wish to raise about the matter is that my

client was subjected in Brisbane to a rather grueling and vigorous series of questioning-----

COMMISSIONER: Yes.

MR DIEHM: -----no less than what I have just been asking of Dr Miach, in my respectful submission, and the situation must be that parties who are the subject of allegations at this Inquiry are entitled to defend themselves.

COMMISSIONER: Of course, you will have every opportunity to put to Dr Miach your instructions. I will give you the opportunity to confirm those are your instructions since you say you don't have specific instructions to do that.

MR DIEHM: Thank you, Commissioner.

THE COURT ADJOURNED AT 4.05 P.M.

THE COMMISSION RESUMED AT 4.10 P.M.

PETER JOHN MIACH, CONTINUING CROSS-EXAMINATION:

MR DIEHM: Commissioner-----

COMMISSIONER: Ready to proceed, Mr Diehm?

MR DIEHM: No, actually. I was going ask for further time, if I may.

COMMISSIONER: Yes, yes, by all means.

MR DIEHM: I'm sorry.

COMMISSIONER: Yes.

MR DIEHM: Thank you.

COMMISSIONER: Adjourn. You let us know when you are ready.

MR DIEHM: Yes.

THE COURT ADJOURNED AT 4.11 P.M.

THE COMMISSION RESUMED AT 4.20 P.M.

PETER JOHN MIACH, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Yes, Mr Diehm?

MR DIEHM: My instructions would be to ask the questions that I'm asking.

COMMISSIONER: That's fine, then. There's no need to explain. You have got your instructions, so you can continue.

MR DIEHM: Commissioner, though, it is a matter of concern to my client that it appears, from what you have said, that there will be some adverse consequence for him if he persists through me in asking those questions.

COMMISSIONER: Well, he gives you instructions, what consequences flow from that is a matter for us.

MR DIEHM: It is a matter for him, Commissioner, in the sense, with respect, that what you have said gives rise to an inference, in my respectful submission, that if he seeks to challenge the evidence of those who make accusations against him, that he will have some sanction visited upon him.

COMMISSIONER: Not at all. That's, with respect, a completely inaccurate statement of the situation. You have been going now for - what is it, about three hours? There has been no attempt to prevent you from challenging adverse evidence, and you have unrestricted right to do that. The question is whether there's any merit in the line of cross-examination which is taking place now which seems to be - involve the implication that Dr Miach is somehow personally responsible for referring patients to Dr Patel for surgery in light of the previous adverse outcomes. If your instructions are to do more than merely protect your client's interests and to suggest that Dr Miach is somehow culpable, then that's a matter for you. You pursue those instructions if they are the instructions you have.

MR DIEHM: Commissioner, that's not the purpose of my questions.

COMMISSIONER: If that's not the purpose, then I'm gratified to hear that.

MR DIEHM: Dr Miach, the question that I asked you was whether what you did with the knowledge of the outcomes for those four patients was - and, indeed, four out of four that you could know the outcomes for at that point in time - was to send another patient, the last one on the 3rd of December, to Dr Patel for the procedure to be performed?-- I don't think, with all due respect - I don't think it works like that. I

don't actually have a little tick box and say, "Well, one cross, two crosses, three crosses, four crosses and you are out." It doesn't work like that. I mean, I see a lot of patients and, in fact, I look at catheters. I don't count them. I sort of - I observe them. So, in fact, it isn't, you know, a sanguine decision that, in fact, I'm going to go to three or four and then I'm going to stop. That's not the way it works. So, the suggestion that, in fact, that I would have sent anybody else to Dr Patel knowing that there was a 100 per cent problem rate at four catheters is not the way I would put it. It has been put to me, for example, that, in fact, six is not enough.

All right. Do you agree with that?-- That six is enough?

That six is not enough?-- Six was enough for me.

It was enough for you. But you told us before that four would be enough?-- Well, four as far as the catheter position is concerned. Four or six, that's a major difference in this sort of situation? I'll suggest to you that, in fact, it isn't. Certainly six is more than enough for me. If I had nothing else to do but sort of just look at the number of catheters that were coming out the wrong way in the abdomen, then, in fact, I may have stopped at four, but that's not the way physicians, including myself, practise.

COMMISSIONER: Dr Miach, let's take a hypothetical situation. Let's say that on the 2nd of December, the day before patient 19 had his catheter inserted, you were presented with a chart like this one, but omitting, obviously, the line relating to P19, because you couldn't know what was going to happen to him, and omitting the line relating to P30, because his problem hadn't yet become apparent, so if you were given this sort of chart with the four failures on it, would you have then referred patient 19 to Dr Patel for surgery?-- Probably not, but this chart, in fact, wasn't available until months later - one or two months later - and, you know, I don't have a computer in my brain sort of telling me that three patients have had catheters going sideways and one had migrated two weeks later. I mean, it doesn't work like that. Certainly if I would have had this chart, then, in fact, I would have been more circumspect about that, but I knew the situation wasn't adequate and, actually, as I mentioned before, I actually spoke to Dr Patel about the whole catheter program. I mean, I did six. Maybe I should have done five. Maybe I should have done seven. I don't know. Then I stopped.

Well, following the point that has been made, in relation to P19, was there at that time someone other than Dr Patel whom you could ask to insert the catheter?-- No, not in the hospital. Again, in fact, Dr Brian Thiele, who inserts catheters for me now, he left the public hospital. I can't tell you when exactly that was, but my preference would be, in fact, to have asked another surgeon. I asked another surgeon in the hospital. His name is Gaffield. I remember sort of speaking to him and he said, "Look, this is not the sort of thing I'm used to. I prefer not to do them." So, I respected

his wishes. The other surgeon is a urologist who also did general surgery. I also asked him. He wasn't prepared to do them for the same reasons. There was nobody else in the hospital. I attempted from Hervey Bay, which I also look after - I attempted to get some of these Tenckhoff catheters inserted in Brisbane. That didn't work either because the Director of Surgery in the Royal Brisbane Hospital said, "Look, it isn't a difficult procedure." In fact, he wrote me a letter about a specific patient I referred to him. He said, "It is not a difficult procedure. Do it yourself." So, you know - so, these were done, but I had the impression as time was going on that, in fact, I wasn't happy, but I didn't have this chart in front of me and I didn't sort of go home at night and sort of tick all the complications that these patients had. So, in fact, I think it is quite reasonable that I actually asked Dr Patel to do a couple more. But when, in fact, things got out of hand, then, in fact, I had this done and I made the decision. So, I don't think it is - as far as I'm concerned, I don't think it is sensible to sort of say, "Well, you had four failures. You go ahead. Why did you do that?" I don't accept that.

If, on the other hand, you were a Director of Medical Services and your Director of Medicine came to you with this sort of chart, what would your attitude be in that hypothetical situation?-- This was months later.

Yes, of course?-- I would have certainly read it. I certainly would have discussed it with him. I did it for a reason. I gave it to him for a reason. It is not that I had nothing else to do. I perceived a problem. This is why I did the audit. I perceived a problem. I know in the Bundaberg Base Hospital, in fact, everybody wants evidence all the time. "Show me the evidence." And - well, I gave him the evidence. Simple as that.

And he told you-----?-- Nothing happened. He took it. I didn't hear from him. Sort of months later in October of 2004, in fact, it was suggested I didn't give it to him. I gave it to him again. Again, nothing happened. I gave him - unrelated to peritoneal dialysis catheters - I gave him a copy of the letter you have there from Jason Jenkins. Nothing happened. So, in fact, you know, I produce evidence, I perceive a problem, I produce evidence, and, in fact, I behave appropriately.

Yes, Mr Diehm?

MR DIEHM: Dr Miach, you made a decision to cease using Dr Patel for any surgical procedures in your unit, didn't you?-- In the Renal Unit, but I also advised - I also advised the physicians about surgery and their patients, and it certainly applied to me that if any other surgery of a general nature - in fact, I sent it elsewhere, and that was from approximately January - December/January 2004 before I left.

What was the trigger that made you make that decision?-- The trigger was a whole compilation of things. You know, I had a

whole - a whole lot of issues, a whole lot of communications. I had diagnostic problems. I had sort of what I regarded as inappropriate decisions. So, it was an amalgamation. It was a conglomeration of issues. But the one that sort of triggered it and that I decided was it, in fact, was a patient that actually died after having a PermCath inserted.

Yes, all right. Here's one of the ones on the list on the - perhaps if that can be put back on the screen?-- What's his number?

I think I'll be able to tell you when I can see the document, doctor. He is, I think, P30?-- Okay.

So, that was the final trigger. That's on the 16th of December 2003?-- That's right.

Doctor, in answer to a question from the Commissioner, you said that there wasn't anybody else available to do this procedure for you. Wasn't Dr Thiele a VMO at the hospital until January of 2004?-- I already said that, in fact, he was a VMO there. I didn't know when he actually left, and you obviously know that. Dr Thiele is a vascular surgeon. He used to do one session - operating session at the hospital. He couldn't do everything. He did his own surgery. He did his own vascular surgery, whatever it was. Whenever he had time - in fact, I would go and specifically ask him to do a fistula for me, but he couldn't do everything. He actually made - did me a service. He did me favours by operating on some of my patients. But peritoneal dialysis, even though he does them very well, he wasn't doing those.

Before you sent P19 to Dr Patel for that sixth catheter placement, had you made any inquiries about other options available to you with respect to having Dr Patel perform that procedure? I'm sorry, I might need to rephrase that to make sure I have got my point across. Had you made any inquiries about alternatives to using Dr Patel for the performance of that procedure prior to sending that patient to him?-- This particular patient?

Yes?-- No.

Doctor, when you send a patient to a particular surgeon, I gather from the flavour of your evidence - and, indeed, your ultimate decision not to use Dr Patel anymore - you take some care in thinking about whether or not that surgeon is one who is suitable for performing the task that you are referring the patient for?-- When I stopped sending people to Dr Patel?

Sorry, what I'm driving at, doctor, is before you sent P19 to see Dr Patel for that procedure on 3 December, you would have given thought to whether or not you thought Dr Patel was up to performing the procedure?-- I had been giving thought repeatedly over months and months and months. I had been observing things. I had been observing catheters, I'd been observing PermCaths, I'd been observing misdiagnosis, I'd been observing perspectives, I'd been observing all sorts of

things. Specifically, if you are asking me when I sent this P19 for surgery whether I specifically tried other - tried other avenues, no. What other avenues were there? Royal Brisbane Hospital?

You hadn't made that inquiry of the Royal Brisbane Hospital?-- I made that inquiry previously about another patient who came from Hervey Bay and, in fact, they told me, in fact, "We are not going to do it here. We don't have the time. We don't have the capacity." I can't see much point my banging my head, sort of asking the same question again to a surgeon down in Brisbane, so-----

But you decided after the death of P30, you still had the same problems. You still had catheters that needed to be placed, you still had no other options, as you perceived it, with respect to where those placements would go, but you still decided not to use Dr Patel any further?-- Well, there were other options. So, I think to correct you, there were other options, because, in fact, what patients need is they need dialysis. The first dialysis that was ever used was, in fact, haemodialysis, so there's always another option. What I did, in fact, was the obvious option: if you are going to stop doing peritoneal dialysis catheters, you change automatically over to haemodialysis. It is a much more complex issue, much more work involved, many more surgeons involved, and so there is an option.

But those options weren't ones that you thought you should avail yourself of, clearly enough, at the time you referred the patient P19 to Dr Patel. You were still satisfied at that moment in time that Dr Patel was up to performing the procedure that you were asking to be done?-- As I've explained before, these patients sort of progressed. I had the feeling - I didn't have this chart in front of me. I didn't keep my own audit. I had the feeling that things weren't quite right. So, sure. I mean, what you are saying is correct. I didn't sort of - before sending patient P19 for surgery or referral, I didn't seek specifically any other options at that stage, that's correct. I made the decision at the end of December, early January that, in fact, that's it - you know, there's no more surgery done by Dr Patel on my patients.

All right?-- You have got to sort of start somewhere. You know, if I would have said that P19 was the trigger point, you would have gone back a date prior to that.

Dr Miach, this document that is on the screen, Exhibit 18, is that the only form of document that there ever was with respect to these statistics or this information with respect to peritoneal dialysis catheters to your knowledge?-- That's the only document I've ever seen.

And you say that this was a document that you gave to Dr Keating some time prior to the meeting at the Friendlies Hospital?-- Almost certainly that's what happened. Again, I can't remember the exact date, as I've mentioned a number of

times now.

If I suggest to you that this document that's on the screen came into existence on the 20th of October 2004, you would say that can't be right, because you gave it to Dr Keating months before that?-- Absolutely. Absolutely. I think this document, in fact, was available on the 10th of February, because on the 10th of February there is an entry in one of the diaries of the Renal Unit that some of the nursing staff went to see the acting Director of Nursing and they actually gave him this document - this is what I'm led to believe.

COMMISSIONER: Although you weren't there?-- I wasn't there. I was in London.

For example, for all you know, it might have been an earlier version of this printed off the computer?-- It could have been. I don't know. I was a million miles away. But I assume that this is the only document that was produced. I can't be specific that, in fact, there's a - an extra box has been filled in over months. I mean, I would suspect that when this document was produced, there were a number of documents that were work-in-progress. You know, they were developed and they were filled in and they were cancelled out and they were checked and they were rechecked, and this is the document that was, in fact, produced. So, whether there were other documents, I don't know, but this is the document that I worked on.

MR DIEHM: Sorry I haven't pre-organised this, Commissioner. I will try and get better into the habit of it. Could the witness see, please, Exhibit 69? Does that document look at all familiar to you?-- It seems to be a version of the document that, in fact, was up a second ago on the screen.

Did you say it seems to be another version of it?-- It seems to be a version of it.

A version?-- The patients seem to be the same. There's six of them. It looks to me, that, in fact, it is incomplete. That, to me, for what it is worth - and I might be totally wrong - is a sort of document that you would actually produce when you are - you are working towards getting something more definitive. I have never seen that, but that doesn't surprise me that it exists.

Right. Have you seen that document before?-- No, I haven't.

Thank you. That and the earlier document may be returned - Exhibit 18. I have finished with those documents. Commissioner, I'm moving off the topic of the dialysis catheters, but can I say again, lest there be any misunderstanding, I know, Commissioners, you have heard what I have said, but for others, there will not be a submission made by my client that Dr Miach was guilty of any wrong-doing by referring that final patient for the insertion of a catheter. That was not the point of the cross-examination.

COMMISSIONER: I'm grateful to hear you say that and I'm sure Dr Miach appreciates that assurance as well.

WITNESS: Thank you.

MR DIEHM: I now want to ask you questions about the change to the rostering system that was the subject of your evidence in Brisbane, both orally and in your statement. You were concerned that there had been a change made to the on-call rostering early on in Dr Keating's time as Director of Medical Services which you thought was compromising patient care. Now, you have had discussions with Dr Keating about this matter in the past?-- I have, yes.

And, indeed, when the system was introduced, there were discussions about the change and the reasons for the change?-- Absolutely.

You are aware, are you not, that the changes were brought about to implement a review that was done with respect to staffing arrangements for medical practitioners at the hospital conducted by a Mark Mattiuissi in 2001?-- Yes, I was. Significant about that document is, in fact, no-one in medicine was actually included in the review.

All right. You are aware that Dr Keating implemented that system because he was asked to do so by Mr Leck?-- I'm not aware specifically that he was asked to do that by Mr Leck, no.

Are you aware the reason, from the hospital management's point of view with respect to implementing the systems, was because the system, as it existed previously, meant that RMOs - Resident Medical Officers - were, at times, rostered such that they were working for 24 hour or longer periods of time straight?-- I'm not aware of that. The rostering system, in fact, was decided to be actually run by the administration part of the hospital. Everybody knows that there is a major shortage of staff and that is one of the consequences of it. The facts of the matter are the fact that the previous system had three PHOs - Principle House Officers - in medicine and still has that. The previous system, in fact, worked, and this system was introduced unilaterally - unilaterally. Without any referrals to me or to any other physicians, it was instituted, and I was annoyed by it and, in fact, I was quite direct about it, because, in fact, I felt that patients were suffering, and I can tell you how.

Well, you-----

COMMISSIONER: Please do, doctor?-- Well, the reason is that I would expect in a sort of hospital - any hospital - and I have worked all over the world in hospitals - that, in fact, if someone that's sick comes into a hospital, one would expect - the community would expect that the best possible available doctor fields and looks after and manages, diagnoses that patient, and, in Bundaberg, the best possible medical person as far as medicine is concerned is the medical PHO. Now, in

other hospitals, in fact, they are what's called Registrars - they have much more experience, much more knowledge - but in Bundaberg, in fact, the best possible person who fields an acute patient is a medical PHO. That was scrapped unilaterally. So, if someone here ended up in hospital last week at 11 o'clock at night, instead of seeing a - they had a heart attack or any acute medical problem, instead of seeing the best possible doctor to treat them, they would have seen anybody, and that, according to me, was counterproductive as far as patient management was concerned.

Did you convey these feelings to Dr Keating?-- Absolutely.

MR DIEHM: Dr Keating asked you to provide details of instances where you thought the changed rostering had impacted on patient care?-- There was a meeting - there was a Medical Staff Advisory Committee meeting shortly after this - this roster system was introduced. I was very direct at that meeting. There were a number of patients that I brought up. Those patients - in fact, I can't remember the specific details of them, and if you were to go through their charts, I'm sure you would find some discrepancies with what I'm telling you - but some of those patients - in fact, some with acute surgical problems were admitted under the physicians and some with acute medical problems were admitted under the surgeons, and as the months and years went on, in fact, I observed repeatedly, you know, unusual things that were going on. I didn't clerk them. You know, I didn't sort of get up in the middle of the night, 6 o'clock in the morning and sort of - but they happened routinely, which you would expect to happen.

COMMISSIONER: How many examples did you bring up?-- How many could I?

Yes, at the time, when Dr Keating asked?-- When the Medical Staff Advisory Committee meeting was on, in fact there were a couple that were sort of acute. As the months - and as it went on, in fact, there were repeated instances. No-one knew about them. I mean I knew about them. What was I going to do with them? You know, I can sort of draw up audits, I can draw up complaints. I can tell you that when you do that, in fact, you are sort of told, "Go and write" - "Go and sort of get me some more evidence." The facts of the matter, are, in fact, in a - you know, after sort of practising medicine for a long time - in fact, I know what's needed. This is the reason they appoint me. This is the reason they pay me. To put a system in place which, in fact, doesn't make any sense to me or any sense to any other physician - and these complaints, in fact, came to me from all sorts of people - mainly the physicians. The PHOs were also quite alarmed. The situation used to arise, in fact, in the middle of the night, half a dozen patients used to be admitted. You would find them on the ward. Some of them were misdiagnosed, some of them had, in fact, no idea what was going on and the PHOs and the consultant that came on in the morning actually had to readmit them all again, and then you are told to sort of - that your length of stay is long. The whole thing was quite - that

irritated me intensely, I must confess.

MR DIEHM: Dr Miach, I must suggest that, in fact, the system introduced was supported by most of the senior medical practitioners?-- Not by me.

Not by you?-- Not by me in medicine.

Most of the others?-- I don't know about that. It was certainly supported by the surgeons. It wasn't supported by me and it wasn't supported by the doctors who work for me. If "most" means obstetricians, surgeons, that's fine, but I'm talking about medicine.

The system didn't apply to obstetrics, did it?-- No, it didn't. I don't know what you are referring to when you say "most". It certainly - the surgeons were certainly very happy with it.

The system, as it were, that was introduced was that the on-call RMO would remain on duty until 10 p.m. and after then would be called out for any serious problems that needed to be attended to?-- You are talking about an RMO or a PHO?

An RMO?-- RMO - what's that? Is that sort of a Resident Medical Officer? A JHO? An intern? What exactly is an RMO?

As I understood from other evidence, RMO and JHO are the same thing at the Bundaberg Base Hospital?-- Maybe that's so. I know them as JHO - as PHOs.

All right. And the system, as introduced, is such that when those doctors who are on-call need further assistance because of the complexity of the patient, they are at liberty to contact one of the consultants?-- Absolutely. I also do a consultant roster, and, in fact, there's always a consultant all the time, but if you know the system, in fact, what happened is, in fact, the consultants were - by de facto, they would turn into PHOs or Registrars, and no consultant is going to do that. You actually put a young doctor there and you will cop-out, if that's the right word. The cop-out, if that's the right word, is you sort of say, "If you can't cope with it, you call the consultant." That actually makes the consultant a de facto PHO or Registrar, and no-one is going to cope with that. I was a Registrar 25 years ago. I'm not going to do it anymore, not even in Bundaberg.

COMMISSIONER: Doctor, while Mr Diehm is getting instructions, about now we would normally be rising for the afternoon. I realise that it is a pretty arduous thing being in the witness-box all day, and if you would prefer that we adjourn now, I would be happy to do so, but you may prefer to keep going and get this over and done with?-- I would prefer to keep going and get it over and done with.

Thank you. Yes, Mr Diehm?

MR DIEHM: Can I indicate I'm getting close to finishing?

COMMISSIONER: Yes.

MR DIEHM: Dr Miach, I'll touch upon this issue because you may not know any detail about it. You have made reference in your evidence in Brisbane to Dr Thiele and the desirability of getting him in to the hospital again as a VMO. If Dr Keating had been making attempts prior to his standing down from his position to arrange that with Dr Thiele, they are matters you should know about?-- Depends what you are referring to. If you are referring to a situation of offering Dr Thiele a session once every few months to do some vascular work in the hospital, I can expand on that. If you are referring to anything else, I'm not aware of it.

I think you have already given some evidence about that issue, have you not?-- About the vascular thing?

About the offer to have him attend every few months, I think it was, you said?-- Yes, I have given you evidence about that. Totally inadequate what was proposed.

I shan't take that matter any further. That will be a matter for Dr Thiele and Dr Keating, no doubt, to address in due course. Dr Miach, you also gave evidence about an approach that you made to both Dr Keating and Ms Mulligan, as I recall it, concerning an idea you had to have a renal PHO appointed to the hospital, somebody to work under you in the renal unit. Do you recall what I'm talking about there?-- That's been something in my mind for quite a long time. Specifically what you're referring to you'll have to refresh my mind. I can't specifically remember going to see both of them. I think I've only spoken to Linda Mulligan once, I think, if I'm not mistaken.

Let's leave Ms Mulligan out of it. Do you recall what you were talking about in your evidence in Brisbane - and if you don't I can take you to the transcript to help you - about meeting with Dr Keating concerning that? And in fact this is the meeting in which you say he responded to you something words to the effect of, "You've got to understand, Peter, this is a business, not a hospital."?-- Yes.

Do you recall now what I'm talking about?-- I know the meeting, yes.

What I want to put to you about that is that Dr Keating did not use those precise words, though I can't put to you the precise words that he did use, but that what he endeavoured to convey to you - the effect of what he endeavoured to convey to you was that if you had a proposal of this kind, you needed to come along with more detail about the proposal, in effect a plan about how it would all work, because there would be implications for the hospital's budget. They would need to look at your plan in the context of the whole of the hospital's services to make a decision about whether or not the money could be found to operate what you were proposing?-- Well, if - you brought up this meeting. I'll tell you what the meeting was about. The meeting in fact was a meeting that sort of was attended by four people. It was attended by Dr Keating, myself, the Nurse Unit Manager, Robyn Pollock, and also Linda Mulligan. The purpose of the meeting, as far as to the best of my recollection, was to try and formalise a relationship, a nexus between Bundaberg and the Fraser Coast. There was a proposal to formalise what in fact I'd already been doing for quite a long time. When a patient got sick with kidney disease, I frequently transferred them to Bundaberg, I managed them there once they were stabilised, and I sent them back. So in fact I was working both in Bundaberg and I was seeing patients from Hervey Bay, and the unit has increased. There are two units now. There were always two units, always, but in fact they're reasonably sized units now. There are a lot of patients that we manage, and I said, "I agree with the approach, but if we do that, we need some help. We need some help", and I didn't come up with a proposal. I didn't even know what the meeting was, but I said, "It's sensible, but in fact you need some help." I'm aware of the workforce issues which I've spoken to Dr Keating about a number of times, and the only point I made is in fact, "I agree with it. I think it's a good step forward for the

community, for the Coast, but I need some help", and the PHO may have come up. In fact we need more than a PHO. We need another nephrologist in this area. The chance of getting that is pretty poor, but certainly a PHO. In fact I'd commenced negotiations, asking questions, of one of the large renal units in Brisbane about that, and they agreed with me, but you know, once you bring up a PHO it costs money, and this is when that statement was made. Not only was it made once, it was made twice, because I couldn't believe my ears, and in fact I said, "Could you repeat that", and in fact it occurred twice. So I know what I'm hearing.

Doctor, you might recall that I put to you a context of what Dr Keating was saying to you?-- I understand the concept. I think it's a good concept.

No, a context of what Dr Keating was saying to you?-- Well, that may be so. I don't dispute that. I don't deny that, but you know, all of the stuff that was being said, I understand. The thing that stuck in my mind was the comment that - about the "business" business.

The phrase that you-----?-- The phrase. That's what stuck in my mind.

COMMISSIONER: Have you ever yourself had to prepare a business plan to go to management to say, "Here's my business plan" to get an extra member of staff or something like that?-- A business plan is an interesting concept. I mean, I know, for example, business plans in Queensland as far as the progression of renal services in fact, they're always made by bureaucrats. That's what they are. I don't know what a business plan is. I know what I need. Someone else can do a business plan. I pointed this out to Keating. "If you want to do a business plan, that's fine. You've got plenty of administrators that can do it. Give it to me, I'll correct it and I'll give you the facts." For me to spend hours, days doing a business plan, going to records - look, you can't do it. I'm not going to work at night. A business plan is something that always was brought up. I for one wasn't about to do it. Someone else should have been doing it.

MR DIEHM: Also, you gave evidence about a statement that was made to you by Dr Keating, you say, words to the effect, "What goes around comes around." This was after the controversy had blown up?-- Sure. That's correct.

Now, you thought that he was attempting to threaten you?-- That's my impression.

You certainly weren't threatened though, were you?-- Absolutely not threatened at all. In fact to be quite - not flippant, but jocular about this thing, it made me laugh, quite frankly.

Doctor, aside from anything else, what would have made you laugh aside from anything else is that there was no reason for you to be threatened, was there? You'd not done anything that

would warrant, in the best of circumstances, a threat to be made to you?-- As far as I know, no.

Dr Keating wasn't suggesting that you had, was he?-- No, he wasn't. He came to see me - which is quite unusual - we sat in my office and we discussed things. I mean, obviously the whole issue about what was sort of appearing in - that was the major issue. I wasn't quite sure what was on his mind. I had a feeling. I had a feeling what was on his mind, but I wasn't quite sure. We discussed amicably some of the issues and the rest of it, and then the statement came out. It came out of the blue. What I said is in fact, you know, "The way you and I see things are very different", or something to that effect. I mean, I regarded it - if you want to synthesize it, if you want to examine it, if you want to analyse it, it could be regarded as a threat, but it didn't threaten me at all. Someone asked me about it, so I told them. I've never felt threatened by anybody at the hospital, I must confess.

Can you tell me what, if anything, you can think of it was that made you suppose that the comment was directed to you?-- We were the only two people in my office.

Undoubtedly, Dr Miach, that means he was saying it to you, but that doesn't mean that the comment is directed at you, if you like, does it?-- Well, who else would it be directed at? He was talking to me.

Well, it's the sort of comment that people make from time to time in conversation talking about third person, isn't it?-- Well, who knows. I mean, comments are made and they're not intended to be made. Exactly the same as in your opening comments earlier this morning about one or two slips of the tongue, you know, that I actually commented to the CMC. It was late at night with a headache, tension, stress. Those things are said on the spur of the moment. They don't mean anything. If that was what was intended, that's fine, but that's the way I took it. I may have been wrong.

And doctor, finally - I promise you - Dr Qureshi. You made mention in your evidence in Brisbane that you were filling out some forms at some stage with respect to his performance. Is that something that's done for all junior doctors?-- Yes, it is. I do it all the time. In fact when I get back to work I'm going to do two more on two other people. It's done all the time.

Was there something special being done for Dr Qureshi as part of a performance management program for him, do you know?-- My recollection of that is that in fact issues came up with Dr Qureshi. My recollection is that in fact I had filled in a form on him previously, but I was given another one, a more comprehensive form to fill in, which is what I did.

Was the more comprehensive form a different form than what you usually had for-----?-- They change. They change in the Bundaberg Base Hospital. In fact there was one form that we used until quite recently, but now in fact there's another

form that's used. I mean, people develop and produce forms. That's one of the things that happens in the Bundaberg Base Hospital.

Thank you. That's all I have. Thank you.

COMMISSIONER: Thank you, Mr Diehm. Who is next?

MR ASHTON: Commissioner, I have no questions. I'm ordinarily next. I have no questions, but I feel obliged, with respect, to say that that's not to be taken as an acquiescence in the intimation that you earlier gave to Mr Diehm and me and my colleagues at the Bar table. That's something as to which I'll need to take instructions.

COMMISSIONER: Well, I think I know what you're referring to. I thought - and no doubt you would be in a position to take me to the relevant case law and so on at an appropriate time - I thought it was well settled that in proceedings where the standard of proof is balance of probabilities rather than criminal proceedings where it's beyond reasonable doubt, that if counsel are instructed to, or the Tribunal of fact can infer that counsel are instructed to attack a witness without a foundation subsequently being established for that attack, that is something which a Court can take into account in making findings of credit.

MR ASHTON: Well, respectfully, Commissioner, I don't wish to engage on that matter. I'd prefer to have the opportunity to consider the implications overnight.

COMMISSIONER: Of course. Of course. Consider the implications, and if you wish to persuade me otherwise as a matter of law, then of course I'll listen to what you have to say. But I would have thought it's quite elementary, that if that sort of attack is made, then the client on whose behalf it is made bears the consequences.

MR ASHTON: Thanks, Commissioner

COMMISSIONER: Mr Macsporran?

MR MACSPORRAN: I have about five minutes worth, not again because of your earlier comment, but because this witness has hardly touched upon my client in his evidence.

COMMISSIONER: Yes.

CROSS-EXAMINATION:

MR MACSPORRAN: Dr Miach, my name is Allan Macsporran. I appear for Linda Mulligan. Right at the start of your evidence this morning you raised the question of a perception you had that the reporting system was inadequate?-- That's correct.

Do you recall those remarks you made?-- Yes, I do.

And speaking very generally, as I understood your evidence, you were saying that the problem with it was that reports that were made might go into the system and might not be actioned, or not actioned efficiently enough?-- They might have been actioned. All of them might have been actioned, except that we never knew. We never had any feedback.

That was the other comment. There was no feedback, as you called it?-- I don't know what happened to them. Maybe all of them were actioned. I don't know.

Firstly, the reporting system - if we talk about it in such terms generally - is designed to enable the management - if we use that term generally - to act upon issues and correct problems. Is that so?-- That is so.

And management rely upon the actual reporting of the event?-- That's correct.

That can be done by way of documentation. Is that so?-- That is so.

Or it can be done, as in your case on one occasion, orally, directly to the management person responsible. But in either case the incident, whatever it is, is in fact reported?-- That's correct.

It is then with management to do something about it if they see fit or can?-- Sure.

Now, then you talk about feedback. There are two aspects to that, I take it. The first is an acknowledgment that the complaint has been received by the management person?-- Yes.

And secondly, presumably you mean feedback about what has happened to the complaint?-- That's exactly what I mean.

And the feedback that comes may depend upon the person in management who the report is made to. Is that so?-- Yes, it is.

If, for instance, it's a medical issue and there are reports, the complaint is made to a nursing stream management person. What sort of feedback would you expect from the nursing stream management person?-- Just say that again? If in fact a complaint has to do with someone in medicine-----

Yes, and the nursing stream takes the complaint?-- Well, if it relates to a doctor or someone - you know, a doctor specifically, and if someone complains about him, whoever complains about him in fact should take it through its own stream. If a nurse complains about a doctor then in fact it should go through Nurse Unit Manager of the ward then up to the appropriate nursing administration. If it has to do with a doctor, I mean, I would expect that there would be some feedback or some communication or some understanding that in fact if it has to go to a doctor it would come to the medical part of the thing. It would go to the Director of Medical Services, it would go to the Director of Medicine, but it should actually also go to the medical aspect of the institution of the hospital.

Yes. Taking the example of my client, Linda Mulligan, who was, as you know, the District DON, if it was a complaint about a medical practitioner, she would forward it on, presumably to the Director of Medical Services, for instance?-- That's what I would have expected.

And her feedback to the complainant would be firstly acknowledgment that she has received the complaint and forwarded it on to the Director?-- Yes.

And any information that came back to her from that source about what had been done. Is that so?-- That's so.

Possibly perhaps also, if nothing had been done or there'd been no feedback to her, she might pass on that fact, that is, "We haven't heard anything further. It's being investigated."?-- It's a bit of a tortuous argument. I've been here for hours. Could you explain to me just exactly what you're getting at?

Yes, I'm getting to this: if my client, as an example, Linda Mulligan, receives a complaint from a nurse, for example, about a doctor's conduct - it might be a clinical competence issue - her duty would be to forward the complaint on to the Director of Medical Services?-- Because it applied to the doctor.

Yes?-- That's what one would expect.

Yes?-- Out of courtesy, I suspect that the Director of Medicine or the responsible physician, whoever works with this doctor, would also be informed of whatever is going on.

Certainly. And then the question of what feedback you would expect from my client to the complainant. You would expect her to acknowledge receiving the complaint firstly?-- Yes, I would.

Expect her to say the complaint had been forwarded on to the appropriate authority, being in this case the Director of Medical Services?-- Sure.

And then ultimately, perhaps, if she got some feedback herself, to relay that to the complainant?-- I think that's a reasonable proposal. I think that's fine. I mean, as long as in fact - if there's a complaint about a doctor, as long as it's handled appropriately - it would be handled from the Director of Medical Services, perhaps getting the Director of Medicine involved and perhaps the physician, but certainly there needs to be some understanding, some feedback of what actually happened to that complaint.

That's feedback to the person who made the complaint?-- To the person, but also to the people - I mean, there were complaints of doctors who worked for me - and I think I know what you're referring to - who in fact I only discovered them days after they occurred.

Yes?-- And, you know - I mean, maybe that's the way it should be, but it's a bit inappropriate. I mean, the doctor works for me. I mean, he's doing something unusual and yet I don't know about it.

No, you said that you found out in that case some days later?-- Absolutely.

You'd like to have known sooner?-- Absolutely.

But the fact is you were ultimately informed and took-----?-- Well, I think who informed me was in fact the Nurse Unit Manager of the ward. I think she actually let me know what was going on, that she had a complaint, and then - in fact I'm always on the ward, so she let me know about this particular case.

She let you know directly?-- Yes, she did.

But that wasn't by way of documentation, I take it?-- No, it was just - the documentation in fact had been done, I assume by the nurses, and had gone up their stream. She let me know just verbally on the ward that in fact there was an issue with the particular doctor, what the issue was, and in fact the appropriate steps had been taken.

I suppose you don't really know whether she had in fact lodged the form. You hoped-----?-- No, I don't.

You hoped she had?-- I don't know. I don't know what forms were filled in. I would have assumed in fact a complaint was made and it was lodged and forwarded appropriately.

Again dealing with my client, Ms Mulligan, did you have much to do with her?-- Very little.

Can I ask you this: is it the case that you have no information that suggests that on any occasion she failed to appropriately deal with complaints actually given to her?-- No, I can't say. I know nothing about it, so I certainly can't confirm that.

Thank you.

COMMISSIONER: Thank you, Mr Macsporran. Ms McMillan?

CROSS-EXAMINATION:

MS McMILLAN: Dr Miach, I appear on behalf of the Medical Board. I'm interested in just clarifying some procedures and also some complaints processes, so if you understand my function in regards on behalf of the Board. I just wanted to clarify one matter and, Commissioner, could I please see Exhibits 100 and 101? Those are the patient notes in relation to Marilyn Daisy. I'll just show it to you first rather than putting it up on the screen, Dr Miach. Where I've opened that on Exhibit 100, you will see - I think it's in Dr Smalberger's writing. It says - you have it in front of you, I think, Dr Miach, the document.

CLERK: And the Commissioners, as well, can see it.

WITNESS: The document that's on the screen, is that the one you're referring to?

MS McMILLAN: Yes, and it's a document - and the record of the date is the 23rd of September '04?-- Yes.

I don't have it in front of me, but from memory-----

COMMISSIONER: It's right here, I think.

CLERK: No, only you and the witness can see it at the moment, Commissioner.

MS McMILLAN: You have special privileges, you see, about these things.

COMMISSIONER: Put it on the screen so everyone can see it.

MS McMILLAN: I'm content to be corrected if I'm wrong?-- Would you like me to read it?

Yes. Does it say words to the effect that "renal review as soon as possible" - or "ASAP" I think it actually says?-- That's right.

Is that the 22nd of September?-- That's on the 23rd of September.

I think was it that day or the next day that in fact you reviewed Ms Daisy?-- I can't remember, but-----

I think from the notes that Mr Diehm took you through, that in fact it was around that date that you then reviewed her for the first time yourself?-- That's right.

So does that assist you at all as to why you might have been brought in, so to speak, at that time?-- Because she was sick.

Well, yes, I understand that, but we have, it seems - I think you agree that Dr Smalberger had been reviewing her, and there's a note, it seems, by Dr Smalberger, "Renal review ASAP"?-- Correct.

Clearly you're senior to Dr Smalberger. That's correct, isn't it?-- Yes.

Does that perhaps assist in terms of a chronology as to why you then saw her, if not that day, the next day?-- Dr Smalberger's extremely competent-----

I'm not making any assertions he's not?-- -----but he's not a nephrologist. When I see certain figures, certain biochemistry, it means something to me which may not actually mean - and I note on the previous evidence of one or two hours ago that in fact this term which we call creatinine, which is actually a measure of kidney function, had got markedly worse, markedly worse.

Yes?-- But that, I think, was the previous day. If I were to see that level, in fact I would have sort of acted immediately. A lot of people may not have.

Dr Miach, I'm not making any assertions about Dr Smalberger's competence?-- I'm not sure of the question you're asking.

The question I'm asking you is you seem to be introduced, so to speak, into the picture of her care at that date?-- That's right.

You indicated you had not seen her post-operative - pre-operative, post-operative prior to that date?-- That's right.

There is a note there from Dr Smalberger, "Renal ASAP". Might that explain why you came into the picture then and there in terms of her worsening condition?-- Absolutely.

Perhaps you were reviewed, you being the senior practitioner?-- When that statement is made and when this review is made of sort of someone like Marilyn Daisy, that, in fact, that means, in fact, the Renal Unit is called. You know, that's what that means, in fact, renal review as soon as possible. You know, they would have called me. Now, I don't know exactly when they called me, when I turned up, but I suspect it was fairly quickly, being aware of this patient.

COMMISSIONER: But it wasn't, as Ms McMillan says, because you were senior to Dr Smalberger, it was because this was a renal issue and you were a renal specialist?-- That's right. I mean, I'm senior to the physicians who work there, but they have complete autonomy, provided, in fact, they do their work well and, in fact, I keep an eye on things. I don't intrude on their practice. They're consultant physicians. But this was a specific issue in severe kidney failure.

MS McMILLAN: You understand that I'm just trying to understand the chronology of perhaps why you became involved at that point in time, you see?-- I'm quite certain he would have told his juniors that were on doing the ward round with him to let me know.

Yes?-- Almost certainly that's what happened.

Perhaps if I could just have that exhibit back. I want to change topics then, thank you. Now-----

COMMISSIONER: Have you finished with those?

MS McMILLAN: Yes, I have, thank you.

COMMISSIONER: Thanks.

MS McMILLAN: Paragraph 84 of your statement. Do you have it there with you, Dr Miach?-- Yes, I do.

Page 11. You have been asked some questions about this and this patient's name has not been published, so I will refer to him as P31?-- Yeah.

Now, I've now got a copy - or I actually have the original

file. Now, your statement doesn't record a specific date for this surgery and it's obviously a voluminous file. Now, you will obviously find the surgery a great deal more quickly than I will. I will open it at a page which I'm assuming from your evidence might well be the surgery that you're speaking of, but could you please correct me if I am wrong?-- Sure. No, that's something else.

Is it?-- You are referring to a patient with a cardiac problem.

Yes, I'm referring to one where?-- No, this is where - this is the wrong episode.

Right.

COMMISSIONER: Ms McMillan, I think it's about an hour and 20 minutes since our last break, so we might take a five or 10 minute break, give Dr Miach an opportunity to look through the file. If that suits you, Dr Miach?-- Absolutely.

MR BODDICE: I wouldn't want the sun to go down without a response, Commissioner, to your request this morning. Commissioner, I have sought instructions. As I understood the question this morning, there's really two aspects to it. The first is: did anyone at Queensland Health release a copy of the report to Mr Thomas or provide him with information; and, secondly, if so, why before the Commission?

COMMISSIONER: The answer to the first speaks for itself. I mean, obviously Mr Thomas got it from somewhere and we don't have it and no-one else has it, so it must have been Queensland Health.

MR BODDICE: Well, my instructions are these: a section of the report was provided to a number of persons on the 23rd of June, that each of those persons who received a copy of it have been spoken to and they have provided instructions that none of them have spoken to Mr Thomas about the document or provided him a copy of it, and that the final report was provided to a number of persons yesterday afternoon and that no person who received that document has spoken to Mr Thomas about it or provided him with a copy of it.

COMMISSIONER: I always suspected that Mr Thomas has got it from the department, and that's the only way he could have found this information out is from Queensland Health when no-one else in the world knew about it. You've told us what your instructions are.

MR BODDICE: You've asked for instructions and I'm just conveying our instructions.

COMMISSIONER: Yes. In any event, I understand it's the Premier's intention to direct that it be released this afternoon. I've got a copy from the Premier that was to enclose - a letter from the Premier that was to enclose a copy of the report, but due to communication difficulties between

Brisbane and Bundaberg we don't actually have the report yet. I propose though to give it an exhibit number, Exhibit 102, and the staff of the Inquiry will ensure it is put on the website and made available to the parties and any other interested persons as soon as physically we have a copy available for distribution. So Exhibit 102 will be the Premier's letter of the 29th of June 2005, together with a copy of the report of Review of Clinical Services at Bundaberg Hospital.

ADMITTED AND MARKED "EXHIBIT 102"

COMMISSIONER: Now, was there something else you wanted to say?

MR BODDICE: No, thank you, Commissioner.

COMMISSIONER: And just so that there is absolutely no misunderstanding, my comments this morning were not intended as criticism of the journalist concerned or anyone else. I admire their skill and ingenuity in getting access to this material. I am still greatly disappointed that someone from Queensland Health thought it was more important for Mr Thomas to have the information than for us to have the information. But that's how it's turned out. That will be Exhibit 102. We will now take that 10 minute break.

THE COMMISSION ADJOURNED 5.20 P.M.

THE COMMISSION RESUMED AT 5.31 P.M.

PETER JOHN MIACH, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: If you will excuse me just a moment, Dr Miach. It seems that there's a complication with processing the report to get it onto the website, because the report itself is 150 pages long and contains a large number of patient names. What we propose to do in the circumstances is to make copies available to the press and the media in an electronic format which will contain the names, but it will continue to be the subject of the directions previously given that names are not to be mentioned in news reporting, either press or electronic, without the permission of the patients or the patient's family, or next of kin in the case of a deceased patient. Meanwhile, the Inquiry staff will be working into the night to produce a copy which has the patient names

replaced from the current copy and that will be put on the website when available. So far as journalists are concerned, if they wish to obtain a copy they should speak to the Secretary and arrangements will be made to provide that either in disk or by e-mail, or it may be efficient just to - more efficient just to speak to Mr Thomas, who seems to have these things much quicker than we do.

I myself have only seen the first 11 pages, which is the Executive Summary. The critical issues from that Executive Summary seem to be that on analysis of 221 clinical records, Dr Woodruff has concluded that there were eight instances where Dr Patel exhibited an unacceptable level of care contributing to the deaths of patients. It is said that there are another eight instances where Dr Patel may have exhibited an unacceptable level of care and those eight patients died.

On the other hand, Dr Woodruff makes the point that in a comfortable majority of cases examined, Dr Patel's outcomes were acceptable and that there are some instances where Dr Patel retrieved patients from dangerous situations caused by other practitioners prior to his involvement in the patient's management.

A Risk Management Framework is discussed in the Executive Summary and a number of recommendations are made, which I will - I won't read all of them into the record because they are extensive, but they conclude with recommendations at a broader level that Queensland Health should: ensure there are comprehensive processes for recruitment and assessment of Overseas Trained doctors prior to their employment in Health Service Districts; that it should develop a comprehensive strategy to address the serious medical workforce issues affecting safety and quality of health services, delivering practical assistance to Health Service Districts, requiring comprehensive review of case models, conditions of employment and flexibility; thirdly, develop and implement an orientation process for key executives; fourthly, facilitate further review of the anomaly of a Medical Board of Queensland General (non specialist) Registrant with specialist level billing provider number; fifth, develop objective mechanisms for monitoring the ongoing clinical performance of medical practitioners to determine whether their practice is within acceptable standards, which may include periods of supervised practice or formative assessment; sixthly, that Queensland Health should work with the Bundaberg Health Service District to develop peer clinical networks with a focus on clinical performance, service improvement, benchmarking and shared learning; seventhly, develop, implement and support statistical process control and "cusum" methodologies to assist with monitoring individual clinician performance and clinical services in key clinical areas of practice; item 8 is review the indicative range of procedures described within the Surgical Complexity section of the Clinical Services Capability Framework document to ensure greater homogeneity of complexity of the listed of procedures; item 9 is to provide input into the review processes of the Australian Council of Health Care Standards (ACHS) specifically consideration to

amend the current clinical indicator reporting and benchmarking to enhance validity and clinician acceptability; 10, further develop the Measured Quality Program to provide risk-adjusted and statistically valid performance data for outcomes of clinical service; 11, provide comprehensive training and support in clinical incident and complaints management to Bundaberg Health Service District which would include standardised Root Cause Analysis methodology; and, 12, ensure that the European style date format or sets as "long date" and removes the user definable characteristic of this field in GroupWise to reduce confusion in the future.

I have already indicated that the review will be Exhibit 102. I have also been provided with a copy of the Press Release issued by Mr Beattie, indicating that he and Health Minister, Mr Nuttall, have instructed Queensland Health to make the implementation of these recommendations a high priority.

Yes, thank you. Ms McMillan?

MS McMILLAN: Yes, thank you, Commissioner. Dr Miach, if I can bring you back to Patient 31. You've had some limited opportunity to have a look through that file. Have you found the operation in question, Dr Miach?-- Yes, I have.

What date is that, Dr Miach?-- 17th of August 2003.

All right. Now, can you tell us from that file, was the operation carried out of an urgent nature?-- It was.

Right. Was there an anaesthetist involved?-- Yes, there was.

Can you tell us from the file who that was?-- I'm trying to get a printed name. Dr Carter.

Yes. And Dr Carter is a doctor employed by the hospital, is he not?-- Yes.

He's a fairly senior doctor, is he not?-- Yes, he's the Director-----

What position does he hold?-- He's the Director of Anaesthesia.

Was he in attendance, as far as you can recollect, when you went into theatre on that occasion?-- There were a number of people there. I think he was.

All right?-- But I - I'm certain that he was, but I can't remember talking to him or sort of - I'm sure he was.

All right. Commissioner, I want to tender only those flagged pages from the file. Rather than pull apart the file, could I perhaps arrange for copies to be made just of those pages that Dr Miach has isolated? It's a two volume file.

COMMISSIONER: All right. Dr Miach, have you marked with stickers the pages that you regard as relevant?

MS McMILLAN: Yes, I have had Dr Miach flag them.

WITNESS: Yes, there is one, two, three. There's a sticker on here that says that that's also done, but they're the three there.

MS McMILLAN: Doctor, if I can just ask you, paragraph 86, the issue about the patient not being properly anaesthetised, that clearly, is it not, an issue about the anaesthetic properly being administered, is it not?-- Looking at the notes there, the surgical record, all that I can see are, in fact, it was an intravenous sedation. That's what he says there.

That's, I take it, not a general anaesthetic as you described this morning?-- Completely different. It's completely different.

It's different. Did you take up with Dr Carter the difference in what you perceived to be normal practice, having the general anaesthetic, as opposed to the anaesthetic that you observed in the notes there?-- I came in late and I actually left early. I can't recall whether I specifically discussed the issue with him. I made some comment. I can't recall - I made some comments in theatre and I don't know if he specifically answered, but I had the impression that in this particular patient the way to go was not with a general anaesthetic but with sedation. I didn't understand it. Subsequent to that, I don't recall bringing it up with Dr Carter.

In terms of having looked at those notes now, do you have any particular comment to make about Dr Patel's skills exercised during that surgery - apart from the anaesthetic issue - I'm asking about the skills?-- I was there and I actually had a look. My impression - and, in fact, it's just an opinion from a physician - was that, in fact, he was fairly - fairly rough and not as meticulous as most of the surgeons that I've been involved with.

Can you expand upon what you mean by "rough"?-- Well, the patient was obviously uncomfortable. There were instruments working sort of high up into this region here, the epigastrium as we call it. You know, there were tensions, there were forceps pulling on tissue. It was just my general impression, and it's only a impression, it's one man's opinion, is that in fact the ones that I had seen were a much more controlled affair. There was much more systematic, much more control. It was effective but it appeared - it appeared sort of unduly "rough" - in inverted commas - to me.

Right. In essence then, the surgery, both the way it was carried out and the lack or perhaps the type of anaesthetic used, was certainly surgery the totality which concerned you?-- Well, it did. I mean, I just refreshed my mind looking at the operation notes. As well as doing a pericardiectomy, as we call it, also a PermCath was inserted at the same time.

Yes?-- Now, the PermCath insertion, in fact, that's also done under a general anaesthetic. So, you know, this gentleman had two reasons to be sort of properly anaesthetised, both a pericardiectomy and also the insertion of a PermCath.

That being so, did you, for instance, generate anything like an Adverse Event Form, or anything of that nature?-- No, I didn't. No, I didn't. This - this was a surgical procedure.

Yes?-- It was done sort of by surgeons, anaesthetists, the whole theatre staff. I just sort of walked in, had a look and walked out.

Yes?-- But, no, I did not initiate an Adverse-----

COMMISSIONER: Whose decision in relation to surgery of that nature - perhaps you don't know the answer to this - but is it the anaesthetist's decision or the surgeon's decision whether to administer a full anaesthetic or a sedative?-- I may be wrong, but it's the anaesthetist but usually done in conjunction with the surgeon. The surgeon operates and the anaesthetist anaesthetises. So my impression would be it would be the anaesthetist who would be involved in that.

But one would expect then the anaesthetist to consult with the surgeon as to what sort of procedure it is in making that judgment?-- He may have done that, but, you know, what's written on the note, on the chart - in fact, it actually mentions what procedure was going to be done. In fact, there were two procedures, if I'm not mistaken, just reading it briefly, one was a pericardiectomy and the other was the insertion of this PermCath.

Was there anything in your reading of the notes to indicate why the patient would not have been fully anaesthetised? Was there some heart complication, for example, or blood pressure, or something like that that would have put the patient in jeopardy if he had been given a GA?-- The heart was under control, because this patient, in fact, had a pigtailed catheter, had a catheter inside his pericardium, so fluid was draining away so it was safe from that point of view. So the heart was working quite reasonably. I don't know why a general anaesthetic was not given. Maybe there were reasons. Maybe there were discussions before I came in. Maybe there were discussions with the patient there. But I don't know in my own mind why an anaesthetic was not given.

MS McMILLAN: There's nothing in the notes that indicate to you why that would be the case?-- Well, I've had a cursory look and I've looked at the surgery thing and I haven't seen anything, but I'm happy to go through them again in more detail and sort of see. But from my experience, in fact, this sort of procedure is usually done - in fact, is always done under a proper anaesthesia.

Well, can I put it this way: if there was a particular reason why you were not administering a general anaesthetic, would

you expect to see that, for instance, in the anaesthetic record; for instance, a note why it was being done that way?-- I would have expected so.

And you looked at that page and is it correct to-----?-- I just had a look and there were three pages that sort of had some writing on, the first one, the last one, and the one in the middle appeared to be blank, but that's - but maybe it's been misfiled. Maybe it's been filed somewhere. Maybe I haven't had a good look.

All right. Perhaps when it comes back you might just want to check that. Can I just move on to the - another copy. Now, Dr Qureshi, you have been asked some questions about him, but at paragraph 131 you said you conducted a test of him to determine his clinical competence. That's at page 18 of your statement. Do you recollect that?-- Yes, I do. I do recollect that.

And you indicated he failed that test completely?-- That's correct. That's correct.

Now, in terms of your view, then, about him, did you do anything with those so-called test results?-- They were given to me by medical administration. I filled them in and sent them back. I should mention that this particular doctor had issues in a number of other areas of the hospital.

Yes?-- They weren't happy to work with him in the Accident and Emergency Department. He moved up to the Intensive Care Coronary Care Unit. They weren't happy with him there, and then he came to the Department of Medicine. I wasn't happy with him either.

Doctor, if I can stop you there. The test that you administered, are you saying it was an official test given to you to administer to him?-- Yes, it was a specific form which was given to me.

Can you identify it? What's the form called, are you aware?-- It's - oh, I can't remember the exact - but it's a common form that we currently use. It talks about regrading people one to five, or six, or whatever it may be, you know, extremely bad to excellent, you know, one to five and whatever it is, and then, in fact, you would have clinical competence, clinical knowledge, theoretical skills, communication, being able to take a history, examination, interpretation of pathological results, those sorts of things. But that form was available and that's the one that I filled in.

Then what did you do with the form after you-----?-- I gave it to medical administration. I probably would have given it to one of the secretaries who works in medical administration.

Is this this Executive that we have heard about at the hospital?-- Yes, it's in the Executive. The medical administration is the Executive.

Could you just give that file to doctor - all right. Once you have done that, perhaps - Commissioner, could the witness just see those three pages again, please?

COMMISSIONER: Well, have we got - I am not sure whether - we have got more than we need.

WITNESS: I'm sorry, what were you asking me?

MS McMILLAN: I wanted you to just clarify any issues about the anaesthetic, whether there was any indication there why

there wasn't a general anaesthetic administered on that occasion?-- Sure. IV sedation, and then in fact that sort of describes the operation. The perioperative record is here. Pericardial window and insertion of PermCath, left side. Removal of pericardial pigtailed catheter on the right side. Perma - removal of - the catheter was already in site in the pericardial sac. This is - this is the nursing notes, the perioperative record for the nursing. The first I can see is-----

You just need to slow down?-- Sorry. "ESRF", which stands for End Stage Renal Failure, and underneath that it says "pericardial infusion RSA". Not quite sure what that means. It's got - I don't know what that is, "IV" or "NE". And then there's a signature there which I think is Dr Carter's. That's all that's on that record there. And on the post-operative orders, there's nothing on that one there. The Day Surgery Post-operative Record, there's nothing on that, and then that's a surgeon's report which is - which is there.

All right. Thank you. So there's-----?-- I can't see very much mention of anaesthesia. It may be on some other part of the chart, I don't know, but on here there isn't-----

All right. Thank you. All right. Now, just to briefly go back to Dr Qureshi, so that test you gave effectively to a secretary, I understand, in the administration part of the hospital?-- That's what I would have done. It usually came to me via the secretaries who work for Medical Administration. So I filled it in and, in fact, I gave it back to them but that would have gone back to Medical Administration. That's where they all automatically go back.

Did you make any particular complaint about Qureshi yourself to any other person, talking about issues about competence?-- What verbal or - I mean-----

Verbal or in writing?-- In writing was these assessments, that's the writing aspect of it.

Yes?-- It was sort of quite explicit there what - how I considered him, what the issues were. In day-to-day working, in fact, almost certainly with the other physicians, in fact, I would have mentioned it. I can't specifically remember but there's probably not much - in my mind I would have done that.

Again from your description of him, both - clinically was the real issue with Dr Qureshi, correct?-- That's correct.

From what you understood in a number of areas in the hospital, including your own?-- That's correct.

And, secondly, from your statement you understood there were issues about - sexual harassment issues-----?-- Yes.

-----in relation to him?-- Yes, there were.

Right. Without elaborating on those, did you at any time

think that you should take those matters further, given that obviously there was quite a substantial problem about Dr Qureshi and from what you understood he was obviously still operating within the hospital?-- Well, they were taken to the appropriate - the appropriate - the complaints came mainly via the nurses.

Yes?-- And then they went up through this channel up there to the Executive.

Yes?-- I found out about them, as I have mentioned, sort of some time later.

Yes?-- Once this issue came up then it was brought to my attention that in fact there were two or three - one or two other patients and perhaps also one or two staff who had unwelcome advances too. But all of these complaints, in fact, as far as I am aware, were written down. They were actually going to an appropriate - through the appropriate stream.

Okay?-- So, when I discovered that, in fact, the complaints had already been written and had already been forwarded - so I personally didn't sort of write any more.

COMMISSIONER: Doctor, you were asked by Ms McMillan about the other complaints you made. I understood from your evidence back in Brisbane that you also told Dr Keating that you didn't want Dr Qureshi in your section of the hospital?-- Yes, yes, yes, I did. I can't specifically remember when, but it was very obvious. I mean, I sort of said I didn't want him.

Yes?-- I heard reports about him from various areas of the hospital, but he ended up in the unit. I remember sort of specifically saying, "This man is of no use to me up here. In fact, he may be counterproductive." I remember making statements, "If you want to have him here, if you want to pay him, that's fine, but - you know, put him somewhere where it's not on the ward", and I think I may have mentioned - I sort of said, "Put him in the library. Let him read a book", or something.

MS McMILLAN: This was to Dr Keating, was it, or do you recollect who it was to?-- To the best of my recollection, it was Dr Keating.

All right?-- To the best of my recollection.

Well, did you receive a response, if you spoke to him, that was satisfactory to you about-----?-- No, I did not.

Given that-----

COMMISSIONER: Sorry to interrupt there. I think again what you told us in Brisbane was that the police then turned up to-----?-- Yes.

-----arrest Dr Qureshi before those issues were resolved?-- Yes. Well, Dr Qureshi kept on working, he kept appearing on

the ward, and my understanding is there were other issues in the community with Dr Qureshi, and I didn't see the police myself but they arrived, in fact, but Dr Qureshi disappeared.

Yes?-- He'd left, he'd gone somewhere, I don't know where.

So when Ms McMillan asks you whether there was, as it were, any outcome to your complaint to Dr Keating-----?-- No, no, there weren't. The only outcome was that the police turned up.

Yes?-- Maybe from other - from another area-----

Yes?-- -----in the community.

MS McMILLAN: Thank you, Commissioner. The issue I then want to move to is in your view you weren't getting the satisfactory response from Dr Keating both about Dr Patel and it seems Dr Qureshi; correct? In your view?-- Yes.

You talk about the Executive meetings and you said you did not raise your concerns at these meetings. Paragraph 142, "I already conveyed my concerns to Dr Keating who was my immediate supervisor." I will just ask you why it was if you weren't getting a satisfactory response you didn't, for instance, raise it at that sort of meeting, that sort of forum?-- That's - that question is - has been asked a number of times. I mean, it's - how best to answer that? I mean, this issue came up, I think, earlier on in evidence at - I suggested that or I said - I must have said that in fact certain things shouldn't be mentioned at one of the Clinical Science Forums. You have to understand that I'm a physician and I'm looking after medicine. You know, for me to actually "publicly", inverted commas, sort of send up reports, other minutes which are distributed widely to the Executive and to the hospital, for me to actually come up and sort of say that, you know, I stopped Dr Patel operating on my patients, if - you know, I wasn't sure of the ethics of doing that, the correctness of doing that, whether in fact I was doing him a disservice. I was looking at what I was going to do, the way I perceived things. I mean, I wasn't aware that those issues were also occurring elsewhere and I wasn't about to - you know, to publicly say that - you know, that I decided he wasn't going to operate on my patients. Effectively what doctors do - in fact, there are plenty of surgeons out there and plenty of physicians, in fact, quietly or understating you don't use. You know, you don't sort of report them. I mean, surgeons - I have known surgeons in the past, I have known physicians, I have known all sorts of people in the past that I wouldn't use. That's my decision. To actually flag that and put it, in inverted commas, "publically", I was a bit nervous about that. Provided I had concerns and provided I actually spoke about them to the appropriate people, I thought that was enough. So that's a longwinded answer to your question.

D COMMISSIONER VIDER: Dr Miach, just further to that, then, would this be the first occasion in your professional life

that you have conducted a thing like that peritoneal catheter audit to demonstrate your concern about patient outcomes from services given by another doctor?-- I'm trying to remember 30 - 32 years of experience. Certainly as part of normal medical practise, as part of normal quality assurance, quality control, monitoring, and the rest of it, these audits - these charts, in fact, are developed. We do it. But the specific reason-----

Yes?-- -----then, no.

Mmm?-- But, you know, where I was working before I came to Bundaberg was somewhat different to here.

COMMISSIONER: Ms McMillan, just to keep the record straight, there's six pages from the medical records relating to patient P31 and the surgery performed on that patient, which will be Exhibit 103.

ADMITTED AND MARKED "EXHIBIT 103"

MS McMILLAN: Thank you. Thank you. I've concluded what I wanted to ask Dr Miach. In fairness, I would seek that he have some time, perhaps not now, to finish looking at the file, because in fairness perhaps there was, for instance, an allergy to an anaesthetic of that nature and it would perhaps be best if that was just excluded, and obviously Dr Miach hasn't had time to completely consider the file.

COMMISSIONER: I am reluctant to ask Dr Miach. He's made a lot of time available to the Inquiry and I am reluctant to ask him to take homework away with him. You know, if someone's going to raise that issue, I think-----

MS McMILLAN: I don't know. I'm not raising it as an issue. Perhaps-----

WITNESS: After it's finished, I am happy to sit here with you and go through everything, if that helps you in any way.

COMMISSIONER: Doctor-----

MS McMILLAN: I will take some instructions.

COMMISSIONER: Yes, thank you. Mr Farr?

CROSS-EXAMINATION:

MR FARR: Thank you, Commissioner. Dr Miach, my name is Brad Farr. I am appearing for Queensland Health. Can I just pick up on something that you said just a moment ago where you said that you weren't sure if you wouldn't be doing Dr Patel a disservice if you made a report questioning his clinical competence. I think I have paraphrased that accurately. Do I take it from that comment that you, even as time progressed, still had some doubts in your own mind as to just the degree of his competence?-- That's correct.

And that doubt continued, as I understand your evidence - please tell me if I'm wrong - that you had formed a view in relation to at least certain aspects of his abilities, those which touched upon what you did, overlapped your field; that's correct?-- That's correct.

But do I take it as well that you weren't able to form the view that he might have had problems in other areas about which you had no personal experience?-- Well, the logical extrapolation of what you are saying is, in fact, that he would have had problems in other areas. I specifically didn't know that.

Right?-- I applied the way I spoke, the way I behaved to the patients and the situations that I was involved in.

Right?-- I didn't sort of go outside that. I had other things to do, as I keep sort of saying. I am a physician and I'm not sort of the overseer surgeons, especially senior surgeons. I made my views known. But, no, I didn't go outside to actually do more about it. I mean, I protected the patients that I felt needed protection under my control and I warned people but, in fact, outside that I didn't go.

So the end result is that even as time progressed there was at least some degree of doubt in your own mind and you took steps that you considered to be appropriate-----?-- That's correct.

-----in your own circumstances. Now, can I refer you to something that you said in your evidence-in-chief a few weeks ago, and I will just ask if you still hold the sentiment. But you were asked a question about - well, you were asked if you could suggest anything that can be done within the administration of Queensland Health generally that would attract VMOs or people like yourself, that type of thing, and you gave a very lengthy answer. But just in part of it you said this, speaking of the Bundaberg Hospital, there was a gorge or a chasm between the administration part of the hospital and the clinical part, and then you went on to offer your opinion that there has to be an amazing cooperation and goodwill between the administrative part of the hospital and the senior clinician, whether they be surgeons, clinicians or whatever they are for it, the system, to work to its optimal effect?-- My sentiment would remain there.

Okay?-- I firmly believe that sort of more involvement of clinicians in the running of the hospital, in fact, is advantageous. The administrators aren't doctors and doctors aren't administrators.

Sure?-- A combination of both of those things, I think, would be beneficial. That was the - my comments there. I still agree with that.

All right. And you would agree with me, would you not, that the best systems in the world, in whatever field of endeavour, can be useless if the people that are to use them don't use them correctly or don't use them at all?-- That's correct.

COMMISSIONER: I think that's - could be called a truism.

MR FARR: It's a truism. I am sure it is. The communication lines between the administration and the clinicians is a two-way street. I take it that you are referring to both communication from administrators to the clinicians and vice versa?-- Absolutely, yes, I do.

You have asked - been asked questions and you have spoken already of a matter which might provide some degree of an example where that ideal fell short of where one might hope it would be. That was in relation to the issue of the request that you received from Dr Keating to change the protocol relating to the peritonitis treatment?-- That's right.

Now, just so that I make sure that I have understood your evidence correctly, you were requested to change the protocol. You accept that Dr Keating, given that he was your line manager, was entitled to make such a request of you. You don't dispute that fact, as I understand it. Before you answer that, can I make the next part of the question this, which might make it easier for you, you also accept that you have the right to yourself question that request and dispute it if you think appropriate?-- That's correct.

So he has the right to ask it, you have the right to-----?-- Sure.

To question it?-- Sure, sure.

In such circumstances, I dare say what you would hope and what most of the people would hope would occur is that there would be a discussion about whatever the issue might be, a meeting of minds, if you like, where the issues are canvassed, and that ultimately whatever might be the best patient outcome is the system which is put into place. You would agree with that?-- I would agree with that.

Would you also agree that the worst case outcome would be to have just simply no discussion about it whatsoever to such an extent that one party might not know what the other party is doing? You'd agree with that also?-- I would agree with that, yes.

And you have told us in evidence that upon receipt of that request you ignored the request and that you had no contact with Dr Keating in relation to it?-- That's correct.

And I don't mean to be critical of you, but with the benefit of hindsight, that would seem to allow at least for the potential position that, for instance, Dr Keating might not have even known that his request had not been put into operation?-- I see the point. The request, according to me, was so unusual, it was so strange, that I found it very difficult to actually answer it. I mean, we are talking about a protocol which is used internationally. If they - if they want to exercise change of protocol they should have actually looked up actually what the protocol - where it came from, the thing. To write to me to change a protocol because some PHO had made a mistake had nothing to do with the protocol. The protocol is perfectly adequate.

All right?-- So for me to actually get a request to change a protocol when there was no reason to change a protocol - in retrospect, in fact, I think you are correct. It would have been more productive for me to actually have gone and seen Dr Keating and sort of said, "Look, this is a bit strange. I'm not going to do it." So I agree with that. And-----

COMMISSIONER: Dr Miach, there are two things that quite fundamentally concern me through all of this. One is it's expressed to be a request in the memorandum you were sent, and you have agreed with Mr Farr that Dr Keating had the authority to make a request of it. I suppose in that sense anyone can make a request, you don't need any authority at all, but in terms of clinical decisions I should have imagined that you as the senior clinician in medicine weren't answerable to anyone for clinical decisions. You couldn't have a bureaucrat, even one with a medical degree, telling you how to conduct clinical matters?-- Well, it was a bit more fundamental than that. I mean, this was a protocol that had to do with the specific and very, very specific area of specialised area of medicine, renal disease, peritonitis. I mean, for someone to ask me to change a protocol when I knew in fact it was perfectly adequate, that's quite - quite unusual, quite strange. But then to actually send me a copy of a letter from another doctor who is a specialist in his own right-----

Not a letter from another doctor, a letter from a firm of solicitors attributing something to a doctor?-- Well, you know, I mean to be quite frank, and it's getting late in the day, but, I mean, I regarded that letter as quite an insult, quite frankly.

Yes, and you-----?-- I sort of - I was quite irritated for a while and I cooled off and went about it. I just sort of thought it was a joke, I thought it was an insult, and I didn't think that, in fact, this particular occasion, in fact, warranted an answer. I got other correspondence from Dr Keating and to my recollection I always answered that.

MR FARR: Just in relation to the joke or the insult?-- Yes.

Were you aware - you were given at least the reference of Dr Whitby, who was someone that you had heard of, as I understand it?-- I didn't hear of it. I made inquiries when I read the name, who he was, and I found out pretty quickly who he was.

Did you, therefore, find out that he was the director of infectious diseases at the Princess Alexandra Hospital?-- I knew that he was an infectious disease specialist in Brisbane.

Have you heard of the Centre for Health Related Infection?-- In Brisbane?

Yes?-- Not specifically, no.

You don't know of him being the director of that body as well?-- No, I don't. No, I am sure he is. But that - that name - there's a lot of specialists, a lot of names, a lot of units down there.

I appreciate that?-- I'm not from this part of the world so I was unaware of exactly who he was. Then I found out and I knew he was an infectious disease specialist.

All right.

COMMISSIONER: Mr Farr, where's this taking us? I mean Dr Miach made his own judgment about the matter. He was obviously the person to make it. What does it matter whether he contacted someone in an entirely different medical field?

MR FARR: It's important, Commissioner, because you have spoken on a number of occasions of systemic failures.

COMMISSIONER: Yes.

MR FARR: Here we have an example of an individual who does not follow a system, and I will take the doctor then-----

COMMISSIONER: That's bizarre.

MR FARR: -----to the problems.

COMMISSIONER: There's no question here of system. This is a Director of Medical Services who sends a copy of a solicitor's letter and purports to tell the head of medicine that he should be doing what the solicitors say rather than what he's learnt himself in 35 years of experience as a specialist.

MR DIEHM: With respect, that's not what the document says at all. The document is merely a-----

COMMISSIONER: A recommendation, a request.

MR DIEHM: The letter from the solicitor that you refer to makes it sound the way we put it, that is the solicitor's

recommendation. It is, in fact, the recommendation of Dr Whitby. They are merely communicating that.

COMMISSIONER: Well, you know, you're challenging Dr Miach as to why he didn't speak to Dr Whitby. If Dr Keating was so worried about it, why didn't he speak to Dr Whitby? Why didn't someone get a report from Dr Whitby and provide this to Dr Miach instead of blaming the man who's on the front line, having to look after patients, who gets this, I think, quite extraordinary request from the Director of Medical Services, does his research, looks up the references, sees that what he's doing is in effect consistent with international standards? Why should he be doing anything more?

MR FARR: Firstly, Dr Miach has already given the answer. Dr Keating might not have even known that the change of protocol - protocol was not implemented.

COMMISSIONER: It's apparent that he didn't.

MR FARR: It's apparent to us now because he wasn't told that, but the evidence is that Dr Keating might not have known that because he was never conveyed that information.

COMMISSIONER: But is anyone going to suggest for a moment - is there anyone here in the courtroom that's going to say that - or anywhere else - that's going to say that the decision made by the specialist who's in the witness box at the moment was not the best decision to be made in the interests of patients?

MR FARR: Well, I understand that if that evidence is required, yes, we can obtain that evidence.

COMMISSIONER: Who's going to say that?

MR FARR: I have been provided with some instructions to date from the Director of Medical Services.

COMMISSIONER: From whom?

MR FARR: Royal Brisbane Women's Hospital.

COMMISSIONER: From whom?

MR FARR: A Dr Richard Ashby.

COMMISSIONER: Dr Richard Ashby is going to say that-----

MR FARR: I am not suggesting he would be the one, but what I was going to put to this witness is whether he is aware, however, of certain features as a demonstration simply - I am not blaming this witness. That's not-----

COMMISSIONER: You sound like you are.

MR FARR: All I'm intending on doing is showing that systems have been put into place, they can fail.

COMMISSIONER: This isn't a system. This is a letter from the Director of Medical Services including a copy of that letter from that firm of solicitors.

MR FARR: With respect-----

COMMISSIONER: Is there some system at Queensland Health that that's how they give clinical directions?

MR FARR: Well, if you pardon evidence from the Bar table, the policy that we have been discussing has been the policy at the Princess Alexandra Hospital, the Royal Brisbane and Women's Hospital for some years.

COMMISSIONER: Dr Miach wasn't taught there. He has received a letter from solicitors saying you should do it that way.

MR FARR: That's why I'm not for the moment blaming Dr Miach.

COMMISSIONER: Okay. Well, you have made the point that he was sent a letter from Dr Keating, he thought it was nonsense, and treated it as such. Where do we go now?

MR FARR: Well, it was designed to be a demonstration, as I have indicated.

COMMISSIONER: Those facts have been demonstrated. What else do you want to demonstrate?

MR FARR: I don't know that I need to take it any further, but I will think about that.

COMMISSIONER: Okay.

MR FARR: With respect, Commissioner, it is quarter past 6 in the evening.

COMMISSIONER: Yes.

MR FARR: It is a difficult time to cross-examine anyone, and I'm endeavouring to keep my cross-examination as short as I possibly can on relevant issues.

COMMISSIONER: Thank you, Mr Farr. I do appreciate that.

MR FARR: Thank you. Can I ask you this on this topic, and if you do not know about this, please say so, but the protocol related to the drug Gentamicin. That is an antibiotic, as I understand it?-- It is.

Do you have any knowledge of it being linked to deafness?-- Yes, I do.

All right. And did you have any understanding-----?-- Deafness - in fact, it affects the middle ear. Not so much deafness, but lack of balance is what the problem is.

Do you understand it can be both balance and deafness?-- It is mainly balance.

And do you understand that the protocol is directed at that issue?-- Yes, I do.

And did you understand, even though I have just given evidence from the Bar table - and please say if you didn't - but did you understand this protocol you were asked if it existed already existed in large hospitals?-- No, I didn't, but I know what protocols exist in other large hospitals, I know what other protocols exist in other large international hospitals. I know this protocol has been promulgated and has been passed and been discussed in a lot of other centres internationally, and it is modelled on that. I think it is important to realise if you want to be very specific about Gentamicin, you have to understand how the drug is used. Even though it sort of says in some protocols that you can use the drug for one week, two weeks, and some protocols say three weeks, the vast majority of nephrologists don't use it that way, mainly because they understand that, in fact, it has got problems, and you use it initially in people with peritonitis because it is a broad-spectrum antibiotic and until you know what the germ is, you use it. Once you have the germ identified, you stop it. So, the vast majority of people, in fact, only get Gentamicin for a few days. Every nephrologist in practice knows that. For what it is worth, there are international protocols that suggest you can use it up to three weeks. There are specific guidelines for Gentamicin. We actually do blood levels. That's not the panacea. That's not the solution to everything. But everybody knows the issues with Gentamicin and - but that's the way it is used. So, even though it says in a protocol you can only use it for two weeks, you don't use it like that. It is used a lot less than that.

COMMISSIONER: Dr Miach, just picking up Mr Farr's point, if Dr Keating had chosen to leave his office and come down and see you and say, "Look, I got this letter from the solicitors and I've made some inquiries and I found out that at the PA they use a different protocol from that which you were using.", would I be right in thinking you would hear him out?-- Absolutely. In fact, I would look at the PA protocols, I would look at the Royal Brisbane Hospital protocols. I mean, there are protocols in other very large

hospitals in Australia that are used; also international protocols. But I have an open mind. I don't think I know everything. I would have sat down with him, and I would have explained to him - so, there's no doubt, in fact, I would have heard him out and I would have looked at everything and I would have explained everything, and if things needed to be changed, then, in fact, I would have. But as far as Gentamicin, this particular issue that was brought up was because of a mistake from a PHO. It had nothing to do with protocols.

MR FARR: Gentamicin, as I understand it - correct me if I am wrong - is not an antibiotic that is used solely for renal patients. It is a broad-spectrum antibiotic?-- It is an antibiotic used in all sorts of situations.

Would you agree with this proposition: that health providers around the world, if you like, have the lofty aim of trying to reduce the variation in medical practice in any given area, the logic being that the reduced variation will ultimately be of greatest benefit to the patient?-- Sure.

And to reduce the number of adverse outcomes?-- Sure.

You would have, as I understand it, witnessed over the years that you have been at Bundaberg, for instance, Queensland Health attempting to - whether successfully or not might be a different question - but attempting to at least recognise those principles in many different areas?-- Yes, we follow it in a number of areas in Bundaberg Base Hospital. We are married to a number of hospitals, a number of systems which do exactly that. We concur with and we screen and we compare our results routinely in all aspects of renal medicine, in all aspects of cardiac medicine - or I should say in people with coronary artery problems and also in stroke patients, in patients who have a cerebrovascular event, but also internally we do that to make sure we achieve those things.

Certainly.

COMMISSIONER: May I ask the attendant to put this - since we are talking about this protocol change, put this up on the screen, the first page? Doctor, if you look at it in the text - just move it up a bit, please - "Copy of recommendation made to Bundaberg Health Service". It says, "You are requested to implement the suggested changes in order to help reduce the likelihood of recurrence." Was the protocol change suggested in any way relevant to reducing the likelihood of recurrence?-- None at all. The problem was a mistake. You know, you can actually change a protocol 700 times, but if you make a mistake, you make a mistake. It is as simple as that. Changing this protocol, in fact, wouldn't have actually - it wasn't - it had nothing to do with addressing the problem. The poor junior doctor made a mistake. That's what it was.

If it was put on the basis that Mr Farr is now putting to you and it was not put on the footing that it was to reduce the likelihood of reoccurrence, but it was to bring practice at

Bundaberg Hospital in line with practice at the PA and Royal Brisbane, I assume you would have had a different reaction?-- Absolutely. I would have got the Royal Brisbane protocols. They would be different. I mean, any unit that sort of deals with renal disease has its own protocols and they are all different. Fundamentally they all have the same approach, but the nuances, the fine-tuning, in fact, would be different. You know, it doesn't mean to say that the protocol we use is better or worse and the ones that Royal Brisbane Hospital use - it is exactly the same to sort of say, for example, a protocol that's used at the Royal Melbourne Hospital is inferior or better than what they use in Brisbane. All they are is they are different.

Thank you.

MR FARR: And this being a good example of the point that I was asking you about originally, the effect of your evidence is, as I understand it, that the letter you received from Dr Keating could have been far better worded, so that the communication from him to you in that regard was inadequate, and you have already acknowledged that your response, in hindsight, was probably also inaccurate?-- There was no response at all.

All right. If I can move on to the topic of adverse event reporting? Are you aware of what the system is at the Bundaberg Hospital presently?-- In the last one or two weeks? The whole thing is being revamped at the moment.

Since November last year?-- The thing-----

I don't need to get the detail, I'm asking if you are aware of the system?-- There have been some changes. I'm aware of those. The specific details of those I'm not, because as I've mentioned repeatedly, I don't sort of routinely fill in adverse event forms. Other people do that.

You would agree with me, though, that - I take it your knowledge of the system extends this far: that it is designed to provide a central register, if you like, of adverse events throughout the hospital?-- Yes.

I dare say you would agree with that as being an admirable-----?-- I do. I agree with that totally.

Having a central register would allow, again, for a uniform approach to problems that might arise with some degree of similarity, for instance?-- That's true.

Or prevent duplication of effort from different areas of the hospital, or allow for comparison from both within the hospital or from outside or go into statewide figures to be compared nationally?-- Sure.

There is a lot of advantages to it?-- I agree with that.

And once again, of course, the system is only as good as the

people using it?-- I agree with that.

I think we spoke of that originally. If you don't know sufficiently about the system, then please say so, but we understand - and I think we are yet to hear evidence on this topic - but we understand that one of the tenets of the current system is that it is a no-blame approach; that this adverse reporting is not for the purposes of blaming someone or getting back at someone; it is simply for the identification of an issue to ensure that it doesn't occur a second time. I take it that you would agree with that being a very, very sensible approach to this?-- I agree with that completely. I'm not sufficiently conversant with the minutiae of how the system works, but the proposals and the comments you have made, I agree with them 100 per cent.

Excuse me a moment. Can I ask you this, again on a different topic: you, in your evidence-in-chief some weeks ago in Brisbane, spoke of - in fact, I think a suggestion was made to you in a question by the Commissioner that overseas trained doctors being something akin to bonded slaves, in that they have to work for a particular hospital, if you like, for their visa to remain current?-----

COMMISSIONER: Sounds like my turn of phrase.

MR FARR: That wasn't meant as a criticism, I might add.

COMMISSIONER: No.

MR FARR: Can I ask you this: is it your understanding that a good overseas trained doctor - a good, competent overseas trained doctor is worth his weight in gold to Queensland Health?-- Absolutely. 100 per cent.

And because of the shortage - the world-wide shortage, we hear, of doctors, it would be in everyone's best interest to hang on to the good ones?-- Absolutely, yes.

If a competent, good overseas trained doctor were to make a complaint about a matter, have you - firstly, can I ask you this: have you any knowledge of an overseas trained doctor - a good, competent overseas trained doctor having their employment ceased and hence their visa ended because they have made a complaint?-- Personally, no, but I've never been involved in areas of need or overseas doctors under the sort of - I have been involved in the last few years, but personally, no, I don't.

COMMISSIONER: Do you know of doctors who have been in fear of that sort of action?-- Well, it is a subtle thing. I mean, when this issue became current, there are a couple of very, very good overseas doctors who work in Bundaberg who work for me, and they offered their support, because they knew that I was involved in all of this, and they offered their support 100 per cent. The advice that I gave them - I sort of said, "Stay out of it. Just stay out of it.", not because I thought that they would be reprimanded or anything else, but because

my perception since I have been in Queensland and Queensland Health is that's what they should do. I sort of said, "Look, they can't do anything to me.", not that I think they would, but I said, "If they don't like you, they can do something to you."

MR FARR: So, you were acting really in their interests out of an abundance of caution, if you like?-- Absolutely.

And I take it from the way you have just worded that answer, that whilst they were your perceptions, you acknowledge that they might not necessarily be correct perceptions?-- They are my perceptions. I may be wrong.

All right. Thank you?-- They are my perceptions.

All right. Now, look, I know that you have been questioned on this topic, but I think I should put this to you as well, but it was in relation to the changes in the rostering system that you have already been asked about. Can I also make a similar suggestion to you that Mr Diehm made: the majority of senior medical officers support the change, and I know that you have already answered that question, but I'm just putting it for the record?-- Not in medicine. In fact, I mean, I'm in the process of reinstituting the system that, in fact, existed prior to the - to this recent change, because I think it is in patients' interests. I think patients deserve to have the best possible medical treatment when they get sick.

Thank you. That's all I have.

COMMISSIONER: Before there's any re-examination, there are a couple of things I wish to raise, Dr Miach, and it goes back to the first point - I know it was 9.30 this morning when you started giving evidence - but I referred, perhaps to your embarrassment, to the reports that appeared in the newspapers a couple of weekends ago. What has come to our attention is this from a draft of the review of clinical services which is now Exhibit 102. From a draft of that, it appears that three of the four Queensland Health people who are conducting that review, in the course of doing that review somehow took it upon themselves to get access to personnel files of the medical staff at Bundaberg, including your own personal file. Can I ask, firstly, whether you were informed that Dr Mattiuissi and his colleagues were going to be rifling through your personal file?-- No.

If anything emerges from that draft that they discovered going through those files - the fact that you were not strictly registered in Queensland as a specialist - did any member of that review team inform you of that discovery when they became aware of it?-- No, they haven't. When was that done?

I don't have the dates in front of me. Mr Andrews might be able to assist.

MR ANDREWS: No, I can't, Commissioner. I don't have a copy of the draft with me.

COMMISSIONER: There were two periods when they came to Bundaberg and looked at the documents, and I don't have the dates in front of me, but I think one was in early May and one was either at the end of May or early June?-- I wish they would have told me. I mean, I rectified it the day that I discovered that there was an irregularity. No-one told me.

How did that come to your attention that there was an irregularity?-- It was actually on the Queen's birthday weekend. I was actually walking down on the beach and the press liaison officer rang me that she was contacted by a reporter from The Australian, I think, asking whether I was registered as a specialist. I said, "Of course I'm registered as a specialist. I've been registered as a specialist all over Australia for 30 years. The HIC Insurance Commission recognises me as a specialist, also a nephrologist." I said, you know, "What do they mean?" I didn't know what they were talking about. Then it came to light the following morning and it sort of irritated me. The whole issue, in fact, is that I originally registered in Queensland in 1992, and I kept my registration going. Now, I registered when I was still in Melbourne, and I filled in all the forms diligently, I delineated all of my qualifications, then that was screened by the Director of Medical Services in Rockhampton. He filled in his own form - and I actually have copies of them here - so he knew exactly what he was appointing me as, he knew exactly what sort of registration I needed, and he didn't do anything about it, and once, in fact, that mistake on his part was made, in fact it was perpetuated, because, in fact, I never - I just kept renewing my registration. I actually spoke to the Medical Board of Queensland on several occasions recently and I tried to explain to them - I asked them - they used terms like "systems failure", "administrative oversight" and "a bit of an embarrassment". They also told me, in fact, that the system has changed in the last - since the mid-90s when sort of - they were aware that when specialists came up from other states, in fact they found themselves in the same situation that I've found myself in, and now it is the routine, they tell me, to actually inform people that if they have specialist degrees for specialist practice in Queensland, they need to register properly. Queensland and South Australia are the only two states that actually hold a specialist register. I'm a specialist in Victoria. My registration in Victoria is a general registration. I have a copy of it. My registration up here was as a general registration and I thought the administrators who were processing my documents had, in fact, some idea what they were doing, but they didn't.

My concern for the moment is what, if anything, Dr Mattiuissi and his colleagues did to bring this to your attention?-- Nothing. Nothing at all.

Do you know, apart from what I've informed you now about Mattiuissi and his colleagues having access to your personal records at Bundaberg, whether anyone else has had access to those records?-- I don't know that, but I believe that they are filed in the Director of Medical Services office. In

fact, when I was filling in the - to register myself a couple of weeks ago, my file was taken out of that - those cabinets. So, they are filed up there. But I'm not aware whether anybody has seen them.

All right. It would, of course, be only an assumption that if there was any connection between the discovery made by the Mattiuissi review team and the fact that this came to light in the press on the Queen's birthday weekend-----?-- It is an interesting connection. I wasn't aware that anybody had gone through my files.

Are you aware of anything that you have said or done in your role at Bundaberg Hospital other than the evidence that you have given to this Commission of Inquiry that would cause any of the bureaucrats within Queensland Health to wish to leak to the press the outcome of their review of your personal files?-- I would be just guessing, Commissioner. I mean, you know, I think I tend to speak my mind. I go to committee meetings and I say what I need to say and sometimes it isn't received as well as it might, but, no, I don't particularly know, but who knows. But I haven't - I would have never made that connection, quite frankly.

Any questions arising out of that?

MS McMILLAN: No. Commissioner, can I take it I don't need to get any instructions from my client about the specialist point? I take it there's no adverse inference drawn against my client in relation to that?

COMMISSIONER: No.

MS McMILLAN: Thank you.

COMMISSIONER: Does anyone have anything arising out of that evidence? Any re-examination?

MS GALLAGHER: No, Commissioner.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: Look, before you go on, Mr Groth, in his usual incredible efficiency, has turned up the relevant dates for me. It seems that the review of your personnel files by the team - and we are speaking here about Dr Mattiuissi, Dr Wakefield and Dr Hobbs - Dr Woodruff had nothing to do with this aspect of it - but the review of your files by those three occurred on one or other of two visits to Bundaberg between the 19th and 22nd of April, and the 9th and 13th of May. Does that assist at all in any of the matters we have canvassed?-- I would be very interested to know if they discovered whether my registration wasn't - but, no - I knew that they came up. They interviewed me - Dr Mattiuissi and - I was with Dr Woodruff - they interviewed me some time in Bundaberg around about that time, but that's all I can say

about that.

Yes, Mr Andrews?

RE-EXAMINATION:

MR ANDREWS: Dr Miach, please cast your mind back to the second half of 2003. I'm aware from the peritoneal catheter placement audit that there were at least six patients you were seeing in whom Tenckhoff catheters had been placed. How many other patients were you seeing in that half of 2003 who would have been recipients of Tenckhoff catheters?-- The six in the latter half - they were it. There were no other ones. They were new catheters. Now, in fact, I had seen people who had been on established peritoneal dialysis for months or years beforehand - I would see those - but as far as introduction of new catheters, they were it.

COMMISSIONER: I think Mr Andrews' question, though, is what was the total number of patients you were dealing with who had had those catheters inserted at some time, not just during that period, but how many patients did you have that-----?-- Those six plus patients who actually had - who were undergoing peritoneal dialysis?

Yes?-- The exact figure changes all the time, because people on peritoneal dialysis, they come and they go, but I guess in Bundaberg - and I also look after people in Hervey Bay - I guess in Bundaberg there would have been half a dozen other ones, I think, but I could be out a couple either way. There's another sort of half a dozen to 10 in Hervey Bay.

You made the point earlier that you really hadn't, in your own mind, synthesised the fact that this - this was in answer to questions from Mr Diehm - that there were four patients who had had their catheters put in by Dr Patel and all four of them were problematic, so you then went ahead and had another patient done, and I think the point of Mr Andrews' question is how many others were you looking at from time to time - how many other catheters did you have in place?-- Well, as I say - in fact, from my memory of people who were on established peritoneal dialysis at that stage in Bundaberg, it would have been about half a dozen, but as I mentioned before, I didn't have - I didn't do the audit - the audit wasn't available when I was asking for these catheters to be put in, so I didn't have a tick sheet in my mind, for example, "Three catheters put in, three problems with the catheter coming out sideways, the fourth one the same; want to pull out." It doesn't work like that.

MR ANDREWS: I have no further questions.

COMMISSIONER: Dr Miach, thank you for your time and thank you particularly for staying back late to help us move things

along. You are excused from further attendance. You will recall that Ms McMillan-----

MS McMILLAN: No, I won't press that, thank you.

COMMISSIONER: Well, you are excused, then, from further attendance with our very sincere thanks for your assistance?-- Thank you very much.

COMMISSIONER: 9.30 in the morning?

MR ANDREWS: Yes, please, Commissioner, and I expect that it will be Mr Messenger.

COMMISSIONER: Yes.

MR ANDREWS: His evidence.

COMMISSIONER: We are adjourned then until 9.30 tomorrow.

THE COMMISSION ADJOURNED AT 6.41 P.M. TILL 9.30 A.M. THE FOLLOWING DAY