Transcript of Proceedings

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SIR LLEW EDWARDS, Deputy Commissioner

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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 01/07/2005

..DAY 17

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THE COMMISSION RESUMED AT 9.35 A.M.

COMMISSIONER: Just before I forget, ladies and gentlemen, I would like to record our thanks to Carl, who has been our attendant this fortnight and he has got to go back to his regular duties next week, so someone is going to have to fill his boots. Morning.

MS GALLAGHER: Before we start, just as a matter of today's evidence, Drs Smalberger and Thiele are members of the AMA.

COMMISSIONER: Yes.

MR GALLAGHER: On that basis I would seek leave to appear on their behalf.

COMMISSIONER: Certainly.

MR GALLAGHER: Thank you. Mr Morzone?

MR MORZONE: Yes, if it please, Mr Commissioner, I call Brian Leslie Thiele.

BRIAN LESLIE THIELE, SWORN AND EXAMINED:

COMMISSIONER: Dr Thiele, please make yourself comfortable. Do you have any objection to your evidence being video recorded or photographed?-- Not at all.

Thank you.

MR MORZONE: Is your full name Brian Leslie Thiele?-- It is.

You are an Honorary Fellow of the Royal College of Surgeons?-- I am.

You are also a Fellow of the American College of Surgeons?-- I am.

You are a Professor of Surgery, University of Queensland?-- I am.

You have practised and held appointments in the highest level in your profession both in Australia and the United States?-- That's correct.

Including in the United States as Secretary of the Society for Vascular Surgery?-- That's correct.

You have practised in the United States for 18 years, between 1976 and 1994?-- True.

You also held academic appointments in the United States, including the University of Washington from 1977 to 1983?-- Correct.

And at the Pennsylvania State University from 1983 to 1984?-- That's correct.

You practised most latterly at Pennsylvania State University Hospital-----?-- Correct.

-----before you returned to Australia, and there you were the Vice Chairman of the Surgical Department, the Head Vascular Surgeon at that hospital and responsible for more than 60 surgeons?-- That's correct.

You have been published over 100 times in Australia and the United States?-- That's correct.

And you have also authored a text on peripheral vascular surgery?-- That is true.

In 1994 you returned to Australia and to Bundaberg?-- Yes.

You were born and raised in Bundaberg?-- I was.

You are currently a vascular surgeon in private practice in Bundaberg?-- Yes.

And you visit the Friendly Society Hospital?-- Correct.

You've sworn a statement in this Inquiry. Are the facts true and correct-----?-- Yes.

-----to the best of your knowledge and belief? And are the opinions in that statement true and correct and opinions which you truly hold?-- Yes.

Attached to that statement or intended to be attached to that statement is a copy of your Curriculum Vitae, at least until you returned to Australia in 1994. That has been copied and we will distribute that in a moment, but I will otherwise tender, please, Mr Commissioner, the statement of Dr Thiele.

COMMISSIONER: The statement of Dr Thiele will be Exhibit 118 and that will be attached to that his curriculum vitae when it has been copied.

ADMITTED AND MARKED "EXHIBIT 118"

MR MORZONE: I now hand up, Mr Commissioner, a copy of the Curriculum Vitae marked BT1. Dr Thiele, when you returned to Australia from the United States in 1994, was it your intention to return to Bundaberg?-- Yes, that was really the only locality that I was interested in returning to.

Why was that?-- Well, I was born and raised here, my wife also was born and raised here, and in the words of others, you can take the boy out of the country but you can't take the country out of the boy. I did not desire to retire in the United States, I desired to retire in this country and I was desirous of retiring in the area in which I was born and raised.

You mention in your statement that you rang up Queensland Health to inquire about the availability of physicians. The Director of Medical Services at the Bundaberg Hospital was available and you became the Director of Medical Services at the Bundaberg Base Hospital in 1994?-- That is correct.

You remained there for five years until 1999?-- That is true.

In paragraph 6 of your statement, you make mention of the fact that soon after you arrived at the Bundaberg Base Hospital it became apparent that staff morale was very low?-- Yes, I think that was sort of my overriding first impression, which somewhat surprised me, and it was manifest in that there was a reluctance for staff to make eye contact with you as you walked around. There was a reluctance of staff to be cordial and bid you the time of day, and I didn't for one minute think that this was a problem peculiar to the people of Bundaberg, I felt it was much more likely to be an environmental issue.

You state in paragraph 7 that you, with the assistance of your wife, set about changing that. You introduced a number of regular staff functions and they're in your statement?-- Yes. Yes, we felt that it was very important to facilitate an environment within the institution to encourage people to be as good as they can be and have a very strong sense of selfworth and it was really with that in mind that there were numerous activities instituted which incorporated the involvement of all people who worked in the hospital. It wasn't only for medical staff, it wasn't just for nursing staff, but it included the tradesmen who worked there, it included the gardeners who worked there. These things included monthly staff barbecues, it also included -we reintroduced an annual fete held at the hospital. We reintroduced an annual staff concert where all people participated there. The auxiliary organisation recommenced. It had not - it had previously been in place but it had languished some time in the past and that attempted to raise money to provide some little things around the hospital which would make it visually more attractive. So - but all of that was really directed primarily to try to lift the general staff morale.

COMMISSIONER: Dr Thiele, I'm probably pre-empting something we're going to come to, but whilst you were doing all of this, were you also performing clinical services in the hospital?-- Yes, and I should say that initially I took this position and the understanding was that I would not be clinically active.

Yes?-- I think it was the second weekend that I was in

Bundaberg on a Sunday, a man arrived in the Emergency Department with a ruptured aneurism, which is the sort of problem that I deal with, and I had a momentary dilemma as to what I was going to do, because in general terms these people were either flown to Brisbane for treatment or they were attempted to be operated on here, and if they are flown to Brisbane probably half would arrive alive. So I thought, "I really don't have an option. I need to operate on this man." So I operated on him, he had a favourable outcome, and I really decided then that this was a service which could and should be offered to the people of Bundaberg. So I started performing clinical duties in especially vascular surgery.

And how did you - what proportion of your time was devoted to clinical duties rather than purely administrative functions?-- Oh, I probably spent 20, 30 per cent of my time in clinical activities and 70 per cent on the administrative side of things.

Can I ask you then - because there has been a lot of discussion during the evidence so far about the separation between administration and clinical services in hospitals, not just in Bundaberg but elsewhere in this State - what are your views of being the non-playing captain rather than being part of the clinical team in terms of the efficiency of fulfilling your role as Director of Medicine or Director of Medical Services?-- Well, I think that's a fundamental system flaw. I do not believe in this day and age that one can be a full-time medical administrator and at the same time be responsible for ensuring the fact that there are high quality clinical services being delivered. I think the flaw is that there is information provided to people in these positions which they assume gives them a good guide to what the quality of services is. But I think the fact that that doesn't work is manifest by the fact that we're here today, and I think that to a degree the administrative organisation has sort of made a victim of people who are in these positions where they've had an expectation that if they follow the rules and follow the dot points everything will be fine. And the fact is clinically you can't be sure that things are fine unless you go around and have a look and you participate. So part of the issue has to be this marriage between delivery of health services, quality health services, which is the prime function of the hospital, and then, secondly, the administration, and, in my personal view, the emphasis has been shifted to the administrative aspect of service delivery.

I guess the counter-argument that people would advance is that medical administration has of necessity become so complex and so detailed, particularly with the funding arrangements, the Medicare arrangements, all of the things that - all of the paper that has to be done to run a hospital, that it's too much to expect a person to be the administrative head of Medical Services and also to be a practising clinician at the same time?-- And I think that's a persuasive argument. I don't believe that's the way it should be. My own personal view is that I think there should be a Clinical Chief of Staff who is elected by the clinicians who has equal authority to

the Director of Administration of Medical Services. I think a Chief of Staff, whose primary function is to oversee delivery of quality clinical services, can do that and that's his job. But he should sit on the Executive with exactly the same authority as Director of Medical Administration.

Yes?-- So I would separate the Clinical Services from the Administrative Services but a Chief of Staff has to have equal responsibility. I mean, I think if you try to incorporate both responsibilities in the one person, I don't know of anybody living who can do it, and that's why my conclusion is that the only way you're going to have quality clinical services is if you have medical professionals who are making the decisions about it. I think the second advantage is that it brings to the decision-making table, wherever that is, directly the views of clinicians, where currently it's filtered through an administrative layer.

Are you in a position - do you feel qualified to comment on the same issues as regards the nursing silos, having a Nursing Superintendent or Director of Nursing Services who again is not a practising clinician?-- I believe very strongly in that. I mean, one of the other parallel reasons to do is there is an increasing expectation, even in hospitals of the size of Bundaberg, that teaching of medical students is becoming more important. The nursing curriculum is also changing, so nurse trainees will be spending more time in hospitals, and there has to be a mechanism instituted which addresses these particular needs too, and I think if you have a Clinical Superintendent, or whatever, of Nursing in a similar capacity to a Medical Chief of Staff, then I think the system would work much better, and to me the administrative side of the hospital should function to support, facilitate the delivery of clinical services, and to a degree it's assumed a life and momentum of its own, much of its activity I don't think have anything to do with getting quality patient care to patients or being able to assess if quality patient care is being delivered.

An analogy which someone has given to me, and it's perhaps not an entirely perfect analogy, is a maritime one where the captain of the ship still goes on the bridge and still exercises his skill as a seaman. You may have under his authority a purser who is in charge of running the ship as a business, but the person who makes the final decisions and the person who is in charge has to be a person who understands the operational issues that are fundamental to running a ship?-- Yeah, I think that analogy is absolutely correct and I don't think that fundamental aspect of leadership has changed in hundreds of years. I think people who work for and with you have the greatest respect for you if you demonstrate that you can function in their arena with the same abilities that they have, and one of the difficulties has been that clinicians can be rather notorious about their views of administrators and in many cases they don't give them their just due, but that's a reality. A surgeon is more likely to respect another surgeon than he is to respect somebody who is not a surgeon.

Mr Morzone?

MR MORZONE: Thank you, Mr Commissioner. Is the mind-set - you have referred in your statement to the mind-set of the administrator being different, can you expand on that while we are on this topic?-- Well, I - in a structure such as Queensland Health, there is a very strong culture of pleasing the boss, ensuring that the hierarchy is kept happy, and that's not an unreasonable thing to a degree. But, again, in my view, I think if you only expect to get good news from people, there's a natural human tendency for people when faced with a difficult problem or news that your boss mightn't like to either downplay the importance of it or not even report it. Now, if found out, that person will get a kick in the rear end for not being prepared to tell their superior. But the superior has to recognise that if you institute or impose a culture like that, that's the natural end product, people become less open and less reluctant or more reluctant to discuss real problems and real issues and increasingly the institution and organisation becomes inward looking and, in my view, that then results in a reduction in the quality of the running of the organisation. I mean, any healthy organisation has to welcome criticism because that's the means by which the organism changes and it grows. If you stifle criticism you are asking for trouble.

You mentioned before to the Commissioner that you undertook clinical services or provided clinical services within the hospital; you operated, what else did you do?-- I ran a clinic in the Outpatients' Department as well, yeah.

And was there a reason for selecting the Outpatients?-- No, I mean, that was just a method of my being able to see patients with potentially vascular disease problems prior to consideration of whether or not they needed an operation.

And did you do rounds at the hospital?-- Yes. I mean, I think that's the other aspect which is important, that my view is that quality medical health care is in part based on an environment of teaching and we institute - I instituted a weekly ward round in the Surgical Ward, which was a teaching round, directed to improving the knowledge of residents who were working there. But in association with Peter Anderson, who was Director of Surgery at the time, we also instituted regular weekly meetings of various types. There was a Mortality and Morbidity Meeting, there was a Clinicopathological Conference where all histological specimens were looked at within the context of the clinical situation in which they had been obtained, and we also facilitated the visitation to Bundaberg of other specialists from Brisbane to give educational talks to the staff and the view - the reason to do that was for the resident staff to recognise that if they came to work at the Bundaberg Base Hospital, their educational experience would be broadened and I saw that as a very important factor in recruiting quality resident staff, and I think that was manifest by the fact that about half of our residents at that time were Australian-trained doctors, and of the people who were

recruited from the Slade Organisation overseas, they kept i^. Telling us that residents who had worked at Bundaberg went back to the UK and told people verbally that it was a good idea to come to Bundaberg because their educational experience would be expanded.

COMMISSIONER: Doctor, would I be right in thinking there is another side to the coin of this provision of education at that clinical level and that is that's one of the attractions to Visiting Medical Officers to come into a hospital and be part of the educational process, that VMOs, as we have already heard, are paid almost nothing for providing VMO services but one of the attractions is to be part of the teaching and research situation in a hospital?-- Oh, yeah. I mean, there's absolutely no question about that and, I mean, the Hippocratic Oath reminds us of our responsibilities in the area of passing on knowledge to those who come after us, and one of the most enjoyable features for VMOs working in the public system is their exposure to both medical students and Residents who are in training programs where they have an opportunity to mould young people, increase their knowledge and see their careers blossom. There's no question about - not only that, the skill levels of people who are in training programs is much higher than people who are just general medical resident staff and that means that these individuals are more competent, they're taking care of patients post-operatively, they're more competent at assessing the seriousness of illness which a patient may present with within a Emergency Department, and the whole - the whole tenor of an institution which functions with that sort of an environment goes up.

MR MORZONE: You refer in your statement, latter part of your statement, from about paragraph 28 to 30, about a preference for Queensland Health to use full-time specialists over VMOs and you make mention in your statement of full-time specialists reducing the quality and quantity of health services. Can you explain that a little bit further?-- This is, I think, one of the fundamental differences in health care delivery in provincial areas compared to the metropolitan area. If you wish to recruit specialist staff into provincial areas, increasingly these individuals cannot function in isolation. They require the presence of other support services. It may be sophisticated radiology, it may be sophisticated pathology, it may be the presence of other certain specialists in the area, and many people don't feel comfortable about practising in an isolated environment where they have to do everything. In fact, those days are gone. So it's not just a matter of getting a specialist. If you try to utilise full-time VMOs, you may be able to recruit somebody initially, but in general terms the history or the track record of that is that these people tend to be itinerant, they stay for a few years and then they go. Then you are faced with the costs of rerecruiting every two or three years. This produces a major impediment to the continuity of delivery of quality services. But, secondly, it also impacts negatively on the institutions abilities to long-term plan because you don't know what your manpower situation is going to be, and so

I think if one looks at it in toto, the philosophy of utilising full-time medical staff in provincial areas doesn't work. I mean, there's more practical reasons why it becomes a problem as well. Where if, for example, in a place like Bundaberg there are two general surgeons, they're on call every second night and every second weekend. If you put into the roster two VMOs who do sessions, suddenly the call roster becomes one night in four and one weekend in four. So there's just some commonsense things that I think are really no-brainers and yet there's been a persistence in the view of employing full-time staff and I think part of it relates to a desire to control things.

If you have a full-time employee, he is answerable directly to you, and if he gives you a bit of a problem you can chastise him. If you have a system in which there's a flux of VMOs, some of whom might be renegades, it becomes a little bit more difficult because you have to deal with them.

COMMISSIONER: And if that full-time staff member happens to be from overseas who's practising under an Area of Need designation, your control is almost absolute?-- Absolutely, yes.

My attention has been drawn to advertisements from hospitals in cities not dissimilar from the size of Bundaberg in other parts of Australia, other states of Australia, where in advertising for a position like that which was filled by Dr Patel, rather than advertising a full-time position with a salary equivalent of maybe $200,000 a year, they advertise for two or even three positions for surgeons in the town on the basis that the surgeon will be paid, say, $80,000 a year for working two days a week at the hospital and have a right of private practice for the other three days a week. Are you familiar with Queensland Health adopting that sort of flexibility-----?-- No.

-----or that sort of strategy?-- No, and I think that's where - I mean, the public and the private systems may be able to run in parallel in the metropolitan areas, but in provincial areas, for health service to be optimised it has to be done jointly between the private and the public sector because that's the way in which you will have the broadest range of clinical services available.

And the best quality of medical service?-- And the best quality, so that the persistence with the philosophy of full-time staff, I think, is bound to fail.

And the other thing that was suggested to me is in that situation - if, for example, three surgeons are attracted to the town to work part-time at the hospital and part-time in private practice at the private hospitals, then if one of them does get up and leave you're only replacing one-third of the workforce rather than the entire surgical workforce with all of the delay and cost and inconvenience that involves?-- Absolutely, and I mean it becomes much easier to recruit people because young people who have finished their training in this day and age often have a significant financial burden to deal with as a result of their education. If they're coming to a city to practise, they usually come in sort of with no financial base to deal with, and there is some apprehension about, "Well, how much money am I going to earn initially when I set up practice? Because I don't know how many people are going to come in the front door." The concept of working in a public hospital and having a certain base income guaranteed when they first arrive is frequently the factor which convinces them to come. They have a secure base income. It may not be enough for them to completely live on, but it provides that base, and so the recruitment becomes a much easier process.

And a much better chance of attracting Australian-trained surgeons?-- Quality people, correct.

D COMMISSIONER EDWARDS: And also includes the quality of teaching to students and so forth?-- Yes.

Which is a necessary part-----?-- Yes. I mean, I just see the teaching and education activities, even in places like Bundaberg, as being fundamental to delivery of quality services.

And from reports, students seem to enjoy this a great deal as part of their teaching program. Has that been your experience?-- Oh, absolutely, and in fact when I was at the base hospital, we were accredited by the College of Surgeons for surgical training positions and we had registrars on rotation from Brisbane on a six monthly basis, and I can tell you that uniformly their commentary, when I had exit interviews with them about their experience, was they had had a great time. So it's not that places like Bundaberg aren't capable of providing the experience. They are. The tragedy is they're not utilised.

COMMISSIONER: Doctor, I know this is taking you a bit out of your field at the moment, but you talked about the distinction between metropolitan and rural hospitals. I guess, though, there are rural hospitals and there are rural hospitals. Bundaberg isn't Thargomindah or-----?-- No.

-----Cunnamulla?-- No.

Do you see any scope for what you're saying being extended to those quite small provincial rural parts of the State?-- Well, to be quite frank, I haven't thought a great deal about it, but I do believe that measures have to be put in place which clearly stamp on the front door of a hospital that their primary function is delivery of medical services, and to that end, that, I believe, would need some degree of re-organisation in probably most country hospitals. You talk about places like Thargomindah or Quilpie or whatever. I mean, clearly they are very, very different, and, I mean, it is becoming an increasing problem as medical services become more and more and more sophisticated. Where 30 years ago you could put a GP in Quilpie and he could more than adequately deal with 95 per cent of the needs of that town, not any more.

But certainly the arguments you're advancing would apply to all of - without being discriminatory about this - what one might describe as the major provincial centres throughout the State, places like Maryborough, Gladstone, Mackay-----?-- Absolutely.

-----Mount Isa, Toowoomba and so on?-- That's my view anyway.

MR MORZONE: In your statement you refer to having built up clinical services and a surgical department, and you just made mention of the department having obtained a grant from the

Royal Australian College of Surgeons as an institution for training?-- Yes, that was formal recognition by the College of Surgeons for us to be a training centre for surgical registrars.

What is involved in obtaining such recognition?-- Well, it has to be recognised that the surgeons who are responsible for supervising the work of the registrars are appropriately trained and qualified, that secondly, they will be exposed to a reasonably broad range of surgical activity, and that thirdly, there is an educational program - ongoing educational program which meets the requirements of the College of Surgeons, and so - I mean, that's where these two issues of education and quality service really dovetail. They're inseparable. And it was a result of the fact that we paid particular attention to the educational needs of staff that that recognition was given.

And you've referred to a flow-on effect in terms of training and also attracting further quality staff to the hospital?-- Yes, yes. I mean-----

Is that grant still in existence at the hospital?-- No. I mean, it's not really a grant. That's probably a misuse of the term. It's a recognition and, no, that no longer exists.

Do you have personal knowledge of what happened to it or how-----?-- Well, it would have been suspended because it requires really that there be at least two surgeons from the Royal Australasian College of Surgeons who are responsible for supervising the clinical activity of the resident staff.

You've also mentioned in evidence today in paragraph 8 of your statement the other initiatives which you undertook to improve the quality of clinical services. You make reference in the statement to educational presentations and regular clinical review conferences. Are they the matters that you are referring to this morning, or are they simply different?-- No, they're the ones I was referring to.

And do you know if they still continue to exist at the hospital?-- No. I mean, I know there are educational conferences, but there's not the intensity nor scope of educational conferences within the surgical arena that existed when I was there. Now, I don't know about the medical arena.

Did the Area of Need system exist when you were Director of Medical Services at the hospital?-- Yes, it had just started, and in fact we did use the Area of Need circumstance to recruit a Director of Anaesthesia from South Africa, a very good Director of Anaesthesia actually.

While I remember too, we've covered reference to the Visiting Medical Officers in your statement, but there was one mention in the last line of your paragraph 30, from memory, where, as well as referring to the difficulty of full-time specialists being itinerant and there being the stop-start provision of services and there being difficulty in long-term planning, you

make reference to the risk that "full-time staff specialists are likely to be brought down if care is not taken by the public system ethos". What do you mean by that?-- Well, I think that's manifest by the eventual resignation of Dr Charles Nankivell from the base hospital. Dr Charles Nankivell was a very highly qualified surgeon and the sort of person who philosophically suited working in the public system, was technically gifted, was an extremely caring individual, had excellent patient rapport, and for an extended period of time Dr Nankivell functioned almost singly at the institution. He did have some help, but he was faced with increasing amounts of call time every second night, every second weekend, plus clinical circumstances which put him in conflict with his view of what standard of care should be available to the public. That's what I mean about doctors who do have a sense of obligation, and they have an ethos about the quality of care, becoming eventually worn down by the continued imposition of practising in an environment which is trying to get them to practise at a standard less than what they're comfortable. Charles Nankivell is an example of that situation.

COMMISSIONER: Are you able to give concrete or specific examples of situations where a doctor like Dr Nankivell would consider the clinical environment to be substandard?-- Yes, I mean, during my tenure we had many discussions about the problems of upper endoscopy and colonoscopy of patients, and both he and Dr Anderson complained about the long waiting list for people who needed to have these investigations performed, and the long waiting times which lapsed before they were examined. The difficulty was that there were large numbers of these patients referred by the general practice community in the town to the base hospital because of some symptoms that needed investigation, but there wasn't the manpower to be able to effectively deal with the numbers showing up at the front door, and there was no way either of knowing whether one person's symptoms were more likely to indicate that there was a sinister cause versus another person where there was not a sinister cause. So they went into a progressive line and they would, on occasions, come across a circumstance where a patient with a potentially lethal problem had been waiting an unacceptable period of time. They felt personally very uncomfortable about that, not because of any repercussions which they personally might have had, but they fundamentally knew that this was not appropriate quality medical care.

Doctor, I'll ask you this question as a lawyer rather than someone with a medical background myself. My impression is that aside, possibly, from breast screening, endoscopy and colonoscopy are probably the leading forms of prophylactic medicine in the country for early discovery of cancer and early prevention of cancer developing into something fatal?-- That's a fair statement, yes.

It strikes me as almost criminally negligent to have patients referred by a GP to the hospital for that sort of prophylactic investigation and then put them on a waiting list?-- Correct.

MR MORZONE: In your statement you refer to the budgetary constraints which you felt as Director of Medical Services and ultimately the effects which it had on services, as you've just mentioned, and you've given other examples including an example of the establishment of CAT scan facilities?-- Mmm.

Can you explain that?-- Yes. When I arrived in Bundaberg - it is important to understand that in provincial towns like this, the base hospital is responsible for the delivery of certain core functions to all the community regardless of whether you are private or public, and one of those is trauma. If you're in a major vehicle accident in this town you have no option but to go to the Emergency Department at the Bundaberg Base Hospital. When I arrived the practice was that there was no CAT scanner at the Bundaberg Base Hospital. There was a CAT scanner at the Mater Hospital, and the standard of care for the management of trauma patients - major trauma patients is rapid, early CT scanning to identify extent of injury. The practice that was adopted was to utilise an ambulance, to put the patient in an ambulance, take them to the Mater Hospital with nursing and/or medical supervision, have a CAT scan at the Mater Hospital and then return to the Emergency Department. Now, I was not aware during the reasonably short period of time that that existed that there was an unfavourable outcome as a result of it, but it was clearly not an appropriate standard of care. The reason given for the base hospital not having a CAT scanner was it was too expensive. Now, CAT scanners at the time, I know, were - they were expensive. They were six to $700,000. But in my view, if you're going to be a trauma centre in a city of this size, I think it's of fundamental importance to have the equipment to be able to deliver appropriate service.

Was a CAT scanner eventually provided?-- A CAT scanner was eventually purchased as part of the rebuilding project of the base hospital and included in the Radiology Department.

Are there other examples of the budget driven administration of health services affecting-----?-- Oh, I think when I first arrived in 1994 the budget was based on historical budgets. That is, what had been allocated in preceding years. And if you were given a four per cent increase in your base budget, you know, well, that's terrific. During the early period of time that I was at the base hospital there was a fairly rapid expansion of service delivery, and there was this persistence in historical budget allocation without a recognition of the expansion of services being delivered. I did participate, during the period of time that the health services were regionalised in this State, in the budget process, and my impression was that Treasury exerted a very powerful degree of control over the Department of Health and they said, "Here's the amount of money. Do what you can with it", and I know Queensland Health felt somewhat intimidated, probably, by Treasury as a result of it. I think they made some poor choices about how that money should be spent, but there was not a sense of, "Well, let's see what our budget needs are, let's submit it, let's talk about what can or cannot be done." It was, "You might have your needs, but here's the amount of

money", and there was not a match, and so it became very, very difficult to be able to function realistically, or with any sense of long-term planning, because you didn't know what was going to happen two years down the track.

COMMISSIONER: Mr Morzone, I wonder if I might follow that up just a little bit. Doctor, I think we've all got to start from the understanding that health care budgets are always going to be finite?-- Absolutely.

It's often said that one could mount a persuasive case in almost every western country that the health care budget should exceed GDP, but that's just not a practical proposition?-- I agree.

Given that that's the situation, from our examination - I'm not expressing any concluded views, but we'll put out discussion papers on these matters - one thing that needs to be closely looked at is how more of the money can be spent on clinical services rather than administrational bureaucracy. The other thing, though, is that there is at least an argument in favour of having more budget control at regional levels so that clinicians at the regional level can say, "This is the priority. We can't afford to do coronary care here in Bundaberg and those people are going to have to go to Brisbane, but we do need more orthopaedic care", or, "we need another vascular surgeon", or, "we need this or that", so that the people on the ground in the town are making the decision rather than boffins in Brisbane?-- Oh, there's no question about that, and I think that would lead to a more effective utilisation of the budget dollar. I think it would enable individual areas to deal with what they consider to be important issues within their own geographic area without necessarily having every regional Queensland hospital being a duplicate of each other. I mean, one of the issues is, I think, there's little capacity to maximise opportunity which comes along in a particular area because it doesn't fit with what the view is from Brisbane. If Rockhampton hasn't got it, Bundaberg can't have it. That's the sort of mentality, and I don't believe it. I mean, I think there should be an opportunity to be opportunistic about delivery of services.

And, I mean, "opportunistic" can be a pejorative word. I think I know what you mean. If, for example, in Hervey Bay there is a larger than average geriatric population - I don't know if that's the case, but just as a hypothetical example - it may be that there would need to be a bigger focus on geriatric care in that place than there would be in another town, and if in Mt Isa there are more lung diseases because you're dealing with miners, then that's something you should focus on in that sort of thing?-- Yeah, absolutely. I agree with that, but I think - I mean, the sort of - you know, one can't divorce the delivery of health services from the political background, but in my view again, the politicisation has become so intense that it has a negative effect, and I'll give you an example. During my tenure as Director of Medical Services in the regional area, there was great discussion about the provision of renal dialysis services, and the view

was that that would be established at Hervey Bay. Now, we had a physician at the base hospital who had experience in dealing with renal dialysis patients, I had been experienced in access techniques for people going on dialysis, and it seemed to me a no-brainer that we had the fundamental requirements for a dialysis unit. I mean, it was commonly recognised that Maryborough and Hervey Bay were both marginal political seats, and one of the major difficulties that people working in the system down there was, you know, they were trying to please the political masters, but they could see that this really wasn't the smartest thing to do, and it took, actually, some patients in this town who became agitated about it, plus some of the staff, who raised a bit of a fuss in the media for the dialysis unit here to be finally established. But, you know, to me they're no-brainer things, and why you have to spend a year arguing, talking about that sort of issue, when there are real issues to be dealt with that are difficult - we spend an inordinate amount of time really on what I think are pretty straightforward issues.

Dealing then with this issue of regionalisation, one of the mysteries - at least so far as I'm concerned - from the evidence so far is what these District Health Councils do, what role they play. I can tell you that in 17 days of public hearings, the only mention we've heard of a District Health Council is that four days after Dr Patel left Australia, the Chairman of the District Health Council sent him a letter commending him on his services to the people of Bundaberg. What was your experience as Director of Medical Services and the import of the contribution made by the District Health Council?-- Well, I mean, that structure is a joke. That's an absolute toothless tiger. That's a stop to people in the district having some involvement with what goes on locally, and that organisation has no authority, it has no power to delve into issues within the hospital. A manager is really not responsible in any way to a District Health Council. I mean, in my view - I mean, that's part of the issue. There needs to be greater transparency in terms of what goes on in hospitals, and in my view one of the best ways in which that can be accomplished is you need to have an Executive which contains on it the local mayor or equivalent, the local Member of Parliament or equivalent, a patient care advocate - and I don't mean have these people involved in a separate committee where people from the hospital bring information to them as they see fit. This is what I think you need to know. I think these people need to be aware of the day-to-day activities of what goes on in provincial hospitals, and I think it is the sort of thing that would go a long way fairly quickly to restoring some public confidence in places like this in the health system, with the knowledge - people in the town knowing that there are respected individuals from the town who are involved on a day-to-day basis.

Now, I know from the standpoint of administration of the hospital it might make it a little bit more difficult, and I know that it would not really be too welcome by Queensland Health probably, but the biggest problem or one of the biggest problems of this Inquiry is how is this system going to be put back together, and I know that's your responsibility, but one of the issues is public and staff confidence. Morale in that place may have been low when I arrived in 1994 but I can tell you now it's gone below the floor, and I would think that many of the people in Bundaberg feel the same way about the sorts of services they are likely to get there. So, there has to be a big change, and to me part of that is allowing people within the community to see what goes on, and you can have Administrative Executive meetings where people who are full-time are involved in this area and can talk about things there, but I think the fundamental executive meetings, which are responsible for directing the hospital activities and what goes on and the big decisions, have got to involve local political people, locally active people, and it's got to have a patient care advocate on it. It's got to be something where patients are represented at that highest level, not at a level where they get filtered information from somebody else. I mean - and to me that's a democratic system.

MR MORZONE: You were asked about the District Health Council. Were you asked to serve on that relatively recently?-- Yes, actually. When I resigned Peter Leck asked me if I would be interested in serving on it and I told him it would be a waste of my time, for the reasons that I have outlined.

You have mentioned one example of there having been some political influence on the provision of services while you were the Director of Medical Services, and you made reference in your statement to another instance involving the establishment of the foundation of the hospital?-- Yes. Shortly after I arrived I discussed with the then manager the idea of establishing a foundation at the hospital to enable people to donate money which could be used in a discretionary manner by the hospital, separate from the budget which was provided by Queensland Health, and shortly after we actually had those discussions a very prominent family from one of the actual founding doctors in this town, back in the 1800s, came to us about a substantial allocation which they would be interested in making to the Base Hospital, but they did not want it to be part of the general revenue. I knew that a foundation existed at Nambour Hospital and I talked with the people at Nambour Hospital and there didn't seem to be any particular problems. But it took Queensland Health somewhere between 18 months and two years to finally sort of give us approval to establish the foundation. In that interim period, I had talked to a number of prominent businessmen in this town, prominent successful businessmen whom I thought would be most appropriate and had the skills to raise money and touch some people's pockets who had the capacity to donate large sums of money and who would be ideal participants as members of a foundation. When I finally received approval to establish the foundation, I was told who was going to serve on

the foundation and the names that were given to me had particularly primary political overtones to it, and if there was one thing that finally convinced me that I was sort of belting my head against a brick wall, I can tell you that was it.

Now, you mention these matters not necessarily for historians but do you believe the system that you have mentioned a moment ago can go part of the way or all of the way to overcome that sort of-----?-- Yes.

With the local community managing it, the specifics for themselves?-- I mean, I have a fundamental difference of opinion with Queensland Health and I do not believe this hospital belongs to Queensland Health. I believe this hospital belongs to the people of Bundaberg, and Queensland Health may have a certain responsibility about its running, but I do not believe that it should be controlled 100 per cent by Queensland Health. I mean, it just makes common sense to me that there should be an atmosphere and environment created where local people have a sense of pride in their local hospitals, and how do you do that? You do that by getting them involved in the running of the place, give them a say in the running of the place. You can't say, "Well, I'm very sorry, you might want strawberry ice-cream but the only thing we have is vanilla", and, I mean, it's that sort of above-down - probably with the best of intentions to some degree, but also with - I think a high degree of ignorance about how provincial towns function that that sort of attitude is adopted.

Until in or about 1992 administration of the Bundaberg Hospital service was largely in the hands of regional boards. Did you have experience of that or were you in the United States at the time?-- No, no, I did - I was here as Director of Medical Services in the latter part of the regionalisation experiment, yes.

Do you have some comments to make as to whether that worked and if it didn't why not?-- I think in some ways it worked. I think part of the reason it didn't work was the political overtones which operated within - within particular regions. But I think there was an attempt to optimise service delivery in the provincial and regional parts of Queensland. In fact, when I arrived there had been a very detailed study done of this particular region of its clinical services which, based on population expansion, these reviewers felt should be in place by a certain period of time, and I thought this was a very enlightened document and really provided a template for development and expansion of services in a place like Bundaberg. Now, that all went out, all of that concept of planning - not the concept of planning, but that particular plan where regionalisation was abolished, that just all went, and so there was not this sense of this is where we are going to be or this is where we would like to be in five years, let's plan along that line. The planning that was done in general terms was nonspecific about medical services. I'm not saying that there hasn't been expansion of delivery of medical

services in Bundaberg, there has been, but I don't believe to the extent there should have been.

COMMISSIONER: Doctor, one of the things that's been said to us by other witnesses in their evidence is that once the Hospital Board system went out the window and you had this two tier and ultimately three tier system of regions and zones and central administration, it has created the situation where there is no transparency and no feedback. When a person at the clinical coalface actually makes a request or suggestion up the line it can take, it's been said, six or seven layers of administration for a decision to go up the line and three or four or six months later you get a decision, but you don't know why, you don't know who made the decision. Was that your experience as Director of Medical Services?-- Yes. No question that happens, and that's where my view about having an individual such as a Chief of Staff at the top, at the executive level, would help bypass that sort of a problem. Now, it presupposes that you are not going to have subsequent layers of bureaucracy further down the line with that, or up the line, as you said. I mean, my primary interest, I can tell you, in being here is not necessarily looking to blame anybody about this. I mean, this is a fundamental system failure, and my interest is how the hell do we fix it.

Doctor, I should make it clear to you, it may seem to many people in your profession that height of arrogance for a lawyer with all the problems in our profession to be suggesting to doctors how to fix up the medical system, but what we want to hear more than anything else is input from people like yourself as to not what the problems are or who should be blamed, and that sort of blame-storming doesn't seem to do anyone any good, but what can be done to make the system better in future.

I wonder, Mr Morzone, whether that's a convenient time to take the morning break.

MR MORZONE: Certainly, Commissioner.

COMMISSIONER: While we do take the break, I wonder whether Dr Thiele's had an opportunity to see our discussion paper number 1 and whether it might be an opportunity for him to glance through that whilst we have the break.

MR MORZONE: He has had an opportunity to see it but we will talk about it with him.

COMMISSIONER: Thank you. Adjourn.

THE COURT ADJOURNED AT 10.43 A.M.

THE COMMISSION RESUMED AT 11.05 A.M.

BRIAN LESLIE THIELE, CONTINUING EXAMINATION-IN-CHIEF:

MR MORZONE: Dr Thiele, a couple of little matters that haven't been covered so far. When you were Director of Medical Services, did you establish an ethics committee?-- Yes, I did. The presence of an ethics committee is a feature which is considered important for joint hospital commission accreditation, but I also felt personally that it was an important part of the profile of a hospital, and, in fact, I had served on an ethics committee in the Pennsylvania State University - University Hospital, and that ethics committee that I established here included a local pastor, it included a member of the legal fraternity - with due regards to the importance of you gentlemen sitting here today - it also included a patient representative and a member of the clinical staff. I think people, particularly in provincial areas, are not too familiar with the concept of having an ethics forum, but it was promoted as being the type of committee where anybody could present a concern, whether it was - and it was actually primarily for staff where they might have a concern about a particular issue which they thought was an ethical issue. It was an independent forum which could be utilised to evaluate that sort of situation, and I don't know whether that committee still exists are not, but I think, in retrospect, that if there had been a viable recognisable ethics committee functioning within the hospital, that may have avoided some of the difficulties which subsequently occurred, and I do believe that, in the future, there has to be an appropriate ethics committee at the Base Hospital.

Another matter that you mentioned was the accreditation by the Royal Australasian College of Surgeons of Bundaberg as a training centre. Are there benefits as well as to training doctors? Are there benefits to patients of having such accreditation at the hospital?-- Absolutely. I may not have mentioned this before, but, I mean, trainee individuals function at a much higher level of competence than those who do not have a particular interest in a particular discipline, so the quality of care that patients receive goes up as well, and, I mean, this is where the whole business of health care that I'm talking about is integrated, and in the terminology of the day or this decade, it is - and administrative people will love this - it is seamless, so that's - that's just a natural by-product. The best quality medical care - and health care providers in the United States have discovered this - the best quality medical care is also the cheapest, because you have fewer problems, and it is not necessarily the primary delivery of health care that's so expensive, particularly surgically. It is the problems that cost so much money. So, if you minimise the problems, the cost of delivery of health care becomes optimised. So that rather than making your goal, "Let's shoot at the cost factor.", the goal should

be, "Let's shoot at the quality factor.", and much of the cost factor will be taken care of. I'm not saying that it wouldn't have to be tweaked a little bit, or in some cases it might have to be tweaked significantly, but I think if the emphasis is on quality and delivery of quality, the cost issue gets taken care of.

Now, before the break, the Commissioner asked you whether you had seen the discussion paper which is discussion paper number 1 which has been put out for discussion?-- Yes.

Have you read that-----?-- Yes, I have.

-----during the break?-- Yes.

What's your comments about that generally and specifically?-- Right. Well, Mr Commissioner, I think you are a very perceptive man. I think very quickly you have identified what are fundamental problems in the system. I think that the concept of having a trust that you have defined in that paper is one of the means of addressing the transparency issue; decentralising the administration. I will admit to you I am wary about any solution which imposes more administrative layers, and I think that's where, in the system, somebody has to go through it with a big knife and be absolutely ruthless and ask the tough questions, "Do we really need to have this administrative support function? What is its relationship to delivery of clinical services? Which clinical service does it help the most?", and if the answer is not readily apparent, it has to go, in my view.

COMMISSIONER: I suppose it comes down to a question - at the moment, there is fundamentally a four-tier system with hospital administration, regional administration, zonal administration and central administration, which I perhaps pejoratively refer to as Charlotte Street. Candidly, what I am thinking about - and this isn't a final view by any means - is that that should be replaced with, in effect, two layers of administration. There has to be a central administration, everyone accepts that, and there are some things that can only be done effectively at a state-wide level, whether it is the breast screening program or indigenous health or-----?-- Public health programs.

And so on, but in terms of hospital administration, it seems to me that it is simply a waste of resources to have both regions and zones when an area like Bundaberg can effectively look after itself. It has got the personnel, it is has got the quality of people here, both clinically and in the community, to run its own system?-- Yes, and I would agree with that. And, I mean, a very powerful plea that I would make is that it should be resisted that a solution is imposed from too far on high, because I think this has sort of been the traditional culture that all the problems which have existed can be solved by somebody in Charlotte Street, and this disenfranchises people who work in these institutions. It has not encouraged them to be problem solvers, and frequently the solution which comes down from a distance, as

you may well know, doesn't effectively deal with the problem. But, more importantly, the best way of quality management in this day and age, or the ethos, is quality management has got to come from the bottom up, not the top down, and we have been functioning in a system which, in my view, has been fundamentally, almost exclusively, top down, and I would just make a plea that in this reorganisation of whatever occurs, please involve people who work in the hospitals as well as the public, and don't have a group of people with suits on making decisions in isolation.

Yes.

MR MORZONE: Now, in your statement, you refer to the fact that by 1999, the attitude of Queensland Health had started to impact upon your desire to remain at the hospital and you left. Can you expand on that?-- I mean, that's correct. I felt that there was an inordinate amount of energy required to convince people of the necessity of this or the necessity of that, and I could also see that the goodwill, which was the oil in the cogs of the Queensland Health system, was drying up, and I was concerned that as that happened it would become increasingly difficult to be able to get people to work in the public system, and difficult to do things. I mean, I was interested at the Bundaberg Hospital in seeing this institution grow to its full potential, and my fundamental feeling was the atmosphere was not conducive to that, and as much as I or any other member of the Executive - and these are not dumb people, these are not stupid people, these are intelligent people, but they are restrained. They are restrained. And I value being able to do things. I don't want to sit somewhere and pass some pieces of paper and sign a few sheets of paper and leave 10 years later and not have a sense that there was something concrete or something important or something productive done, so the initiative gets taken away from people, and my own personal view is in my whole life I have prospered in an environment where one can use one's initiative, so it became a sort of a no-win situation as far as I was concerned, and I couldn't just go there and not be happy about getting up in the morning thinking, "Man, I'm going to work today. Isn't that great."

If the circumstances had been different, would you have liked to have stayed?-- They would have had to have been very different. Yeah, I mean - yeah, I had made a career decision to move from an academic teaching environment to my home town because I felt that I could make a contribution, and there's no question - I mean, there were a lot of things that have been done and a lot of things that have been done without my initiative either, but I'm sure if you ask the people who are there now what their frustration index runs at, I would almost put money on the fact that it is fairly high.

You say at paragraph 41 onwards that you visited the hospital for four years after 1999 as a VMO?-- That's correct.

You eventually even ceased doing that?-- Yes.

Why was that?-- Well, the environment was always increasingly less enjoyable to work in, and there are little issues that if there were cases scheduled to start at a certain time at the operating theatre at 8.30, they wouldn't start until, say, 9.15. Patients who were supposed to have an operation on occasions would be cancelled the morning of surgery, and I would not know about it, and the cancellation was potentially avoidable. I was concerned - with the sort of surgery I can do, people can get into big-time trouble, and you need to have individuals watching over those people who are qualified to do that, and the gradual erosion of the quality of the resident staff made me very uneasy about operating on individuals and then going home at night being comfortable that these people were being watched and cared for appropriately, and - so, I mean, it was just the general tenor of things that - it wasn't fun for me anymore. I mean, the issue of - and the opportunity for teaching disappeared with registrars and training no longer being there, so the help in the operating room was not as sophisticated, less of an opportunity to interact. I mean, I occasionally got calls from the Emergency Department about individuals who had arrived in that Emergency Department, and it was very difficult for me to ascertain over the telephone what was going on, because the quality of information delivered to me over the telephone was terrible, and you had no option but you had to get in the car and come in and have a look, and not infrequently you would come in and it was something relatively minor. So, I just felt increasingly uncomfortable about it.

COMMISSIONER: It was suggested to us by Dr Molloy from the AMA that the sort of circumstances you are talking about can be the result of a deliberate strategy on the part of Queensland Health to discourage VMOs - the scheduling problems, the cancellation of patient lists, the perhaps minor, in themselves, difficulties that add up to a major inconvenience to a person with a busy private medical practice as well as attending as a VMO. Do you have any sense as to whether these problems were deliberate or just a combination of coincidences?-- No, I mean, I had no sense that this was sort of a policy to sort of frustrate me at all. I mean - I think - I mean, it was just the gradual development of - you know, a general lack of morale in the place, a general erosion of the quality of the staff, and - no, in my view, it wasn't deliberate by the administration at all. I mean, they were actually - they were fairly positive about my involvement in the institution.

How did it come about that there were no longer registrants in training at the hospital? Was the accreditation cancelled after you left?-- Yeah, because of the fact that the surgeons who were Directors of surgery and subsequent surgeons were not graduates of the Royal Australasian College of Surgeons, and that's one of the prerequisites, and plus there wasn't an opportunity for people who were Fellows of the Royal Australasian College of Surgeons to be involved through appointments by the VMO system. So, ideally, the College requires that the full-time supervision of these people occur by highly qualified individuals, okay, and so as soon as you

get into the business of employing individuals from overseas from institutions which are not recognised by the College of Surgeons, you are going to lose your training status.

So, essentially, whilst you were there, Dr Nankivell was there, Dr Anderson was there, you met the requirements of the College, but when three of you left almost simultaneously, that was the end of that?-- That's correct, and I think, you know - I think that's an aspect of administration - that full-time administrators don't really comprehend, that - I mean, that's one of the - the importance of having a vigorous education process, because the spin-offs are it reduces the problems with recruiting and it increases the quality of medical services, and once you say, "Well, we are not going to be involved in the education process.", I mean, everything slips.

Yes?-- And it can look as if it is okay, because if you've got somebody's name in a box as a Director of Surgery, "Oh, well, that's okay, we have got our allocation filled.", but if you look at what that might mean - I mean, that's the reason we are here today.

What was your experience - after you left the hospital yourself and after the other two Australian-trained surgeons left, what has been your experience with other local specialists being prepared to take VMO positions at the hospital?-- Well, I can tell you when I was there - I will give you an example. There was a young guy trained in orthopaedics - like me, a home-grown product - wanted to come back to this town to practise - wanted to have some VMO sessions at the hospital and could not get a VMO position part-time, and that's when I was there. Now, I can tell you I made a lot of noise about that situation, but that's the sort of mindless thing which I just can't understand. Now, you are asking me what's the mindset of people in practice in this town today, I presume?

Mmm?-- I think they are generally in two frames of mind. I think there's a very strong sense of obligation about the desire to help fix this problem, because they recognise that you can't have a town of this size without a well-functioning base hospital. There are some essential services, as I mentioned before, such as trauma, that only the Base Hospital can provide.

Yes?-- So - and the other thing is that all of them are products of the old system where their consultants came into the hospital, taught them on rounds, taught them in the operating theatres, et cetera, et cetera, et cetera, and so there is a tradition which - of service in the public system which, I might add, is largely based on goodwill, as I mentioned before. There's another side of it that is very concerned that if they do get involved, what's to stop the old system or the old attitudes from coming back, and they don't want to have to deal with that. They just don't want to have to deal with that anymore. I mean, to put it bluntly, they have had a neckful of those sorts of difficulties. So, you

know, there's a general sense of obligation about helping to fix the problem, but under certain - with certain reservations.

Of course.

MR MORZONE: Do you have a view about the mode of remuneration for VMOs, leaving aside the quantity of-----?-- Yeah, I do, I have a very strong view. As I said earlier, the only way the public health system worked in the past was through this exchange of goodwill between Queensland Health and VMOs, and a big part of that was VMO involvement in teaching programs, training programs, et cetera, et cetera, as I mentioned before. People like to do that, they enjoyed doing it, and, you know, for that, they got a little bit of silver in their back pocket - nothing like they would normally make in their own private practice - but, I mean, it was a medical tradition for people to give of their time in this manner with the goal of training high quality people and, in so doing, optimising clinical service delivery. Unfortunately, with the erosion of the goodwill situation - over silly things, absolutely silly things - there's been a lack and a loss of respect, (1) by Queensland Health of VMOs, and (2) by VMOs of Queensland Health, and that's a difficult thing to retrieve. It is a very difficult thing to retrieve. I think one of the ways - and unfortunately we live in an age where goodwill is not all that common - and I think the only way you can deal with that situation and re-establish some respect is to pay the people in the public sector an appropriate remuneration for the work they do, not a pittance, and I'm talking about medical staff, nursing staff or whoever. But it is not really a money issue in a certain sense. It is a respect issue. Thirty, 40 years ago, you wouldn't have had to do that, but with the changing values of society, unfortunately I believe that the only way that VMOs, in particular, are going to get respect is if they get appropriate remuneration for what they do.

COMMISSIONER: We have talked a lot about the altruistic side of the profession making themselves available as VMOs, and when this Inquiry was sitting in Brisbane, I made the point that if senior barristers in Brisbane said to Legal Aid, "We are prepared to make ourselves available at negligible rates for a couple of sessions a week.", Legal Aid would be jumping at that, but it seems to me that there's another feature, too, with VMOs, and that is that there's an element of status, particularly for a new specialist coming to town, to be able to say, "Well, I have an appointment at the hospital as a VMO that has some cache or some credibility attached to it.", and that's why we have been looking at ways for Queensland Health to be more flexible and give new specialists coming to town the opportunity to have a live-in wage to be built into their part-time practice at the - do you want to check if it is an emergency-----?-- No. Hello? Sorry. Now, I can't turn it off.

So, really, again, it is a matter of giving flexibility to the system so that people can get - you know, not a King's ransom, but a live-in wage to act as VMOs whilst having the

opportunity to build a private practice?-- I mean, absolutely. I think - I mean, the only thing that can save this hospital in this town are the VMOs who are currently in this town. I'm not sure how you are going to recruit anybody from anywhere to work at Bundaberg Base Hospital given what's happened. I mean, somebody would probably have to have rocks in their head, given the notoriety that's been created. I mean, this is one of the great problems. It doesn't take too much to pull something down, but to build it back up is going to take a considerable period of time. It is not going to happen overnight. There is no quick fix. So, I feel very strongly that the VMOs in this town are the answer to, at least in the short to medium term, reestablishment of appropriate clinical services at the Base Hospital.

I have just been trying to do my sums. I know you have told us that you were a VMO for four years after you left in 1999. That would mean that - was there a cross-over between when you were still a VMO and when Dr Patel came to practise?-- Yes, there was, yes. You are asking me if I knew Dr Patel?

Yes?-- I met him in the corridors and I exchanged some words with him. I had some sort of mild concerns about him, but I should also tell you, you know, the practice of medicine, like the practice of law, has some unusual characters on the landscape. I was - I mean, I thought that he was a bit gung-ho for my liking in terms of just what he talked about, but, I mean, I suppose the longest conversation I had with Dr Patel was three or four minutes.

Yes. Dr Miach, I think, told us that when he first had dealings with Dr Patel he was concerned by the fact that Dr Patel claimed to be an expert in almost everything and that put him on his guard. Did you get a similar impression from your initial dealings with him?-- Well, I mean, that was the sort of impression that he promoted. But he knew, in fact, because I was familiar with the American training system that that wasn't the case. I knew very well the institution that he said he had done his Surgical Residency Program and I knew very well the Chairman of that program and I knew what their philosophy was. So that I knew that he was not trained to be all things to all people and so, I mean, he didn't - he didn't in those terms tell me about what he was doing.

Yes.

MR MORZONE: I think in paragraph 52 of your statement you make mention of that institution in Rochester, a New York State Institution, and you make mention to the fact that you knew that after a certain year there hadn't been thoracic work there; is that correct?-- Yes. I mean, there was a period of time in the United States when non-cardiac thoracic surgery was part of the General Surgery Residency Training Programs. But there also came a time when non-cardiac thoracic surgery was really dropped from General Surgery Residency Training Programs. So depending on which time you did your residency, and I have no idea what time he did a residency or how long he did his residency, or anything else, one would have been able to ascertain, you know, what he was capable of. But, I mean, one could also find out what sort of privileges a person could have by contacting a hospital in which somebody had worked, and what happens in the United States is a very strong credentialed and privileged set up, so that people don't apply just to be a surgeon, you apply to be a surgeon and you are approved to perform the following procedures, one, two, three, four, five, six, seven, eight, nine and ten, and you are not allowed to perform out of that list of procedures, and whether or not you can do those procedures is based on your demonstrated capability in those areas. So - and it's a fairly strict system.

COMMISSIONER: Indeed, from the sound of it more rigorous than our own?-- Oh, absolutely. Absolutely. But I think - but, I mean, it was during my tenure at the Base Hospital also that Credentials and Privileges Committees was established at the Base Hospital and I was aware of this requirement about involvement of a formal representative from the College of Surgeons. In my view, that really shouldn't stop a Credentials Committee from functioning. You don't have to have a formal representative from the College of Surgeons, in my view, in a practical sense, to be able to be review somebody's CV, call up their referees and find out what they're like. I mean, there are a number of people in this town who are Fellows of the Royal Australasian College of Surgeons who could be approached to review somebody's CV and, I think, you know, that's one - another one of the unfortunate things that sort of slipped through a little bit, that those things are designed to prevent people who are inappropriately

qualified from doing procedures they have no business doing, and there are some - there are some gung-ho mentalities out there that have this view that they can do anything and have to be restrained.

COMMISSIONER: Dr Thiele, I have the impression - and perhaps my own experience in the legal profession doesn't translate entirely into the medical profession - but given your background and where you've trained and where you've worked in the US, had you been consulted about Dr Patel's appointment, it probably would have taken you two or three phone calls to find out everything you needed to know about him?-- Yeah. I mean, I think, it's a terrible shame, you know, that a fundamental phone call was not made to either his referees or where he trained. I mean, I think - I think that's a shame.

MR MORZONE: You state in paragraph 52 of your statement that it would have been very easy for the hospital to have asked you to credential or assess Dr Patel's performance for the purposes of at least an interim credentialing and privileging of him. Can you extend upon that? What would you have been able to do?-- Well, I mean, I could determine, for example, how long he'd spent in a training program in the United States and exactly where that was. I mean, he told me that it was at the University of Rochester in New York. Now, I knew people at that institution in the surgical program very well. I knew most of the people in the academic environment fairly well. I could have ascertained from the duration of time he had spent in those programs really what his qualifications were likely to be. You know, part of the American scene, no matter what you want to look at, is you will look - you will find the very best and you will also find the very worst and I don't know what the aura about that situation was. I mean, we have had people come from - when I was at the hospital - from North America function as locum attendant specialist individuals. Anaesthetics, for example, was one area where that happened and those people's CVs were reviewed and we established that they had appropriate training that would fit with what we have - what the work requirements would be here. So, I suppose, because of the intimate knowledge - and, of course, this is all retrospect and, you know, hindsight is 20/20, no question about it, but I probably could have fairly quickly determined whether what was on the paper was real or whether there was some problem with it.

You've also made mention of VMOs and your experience when you were Director of Medical Services of the Orthopaedic Surgeon who offered himself as a VMO but was initially refused. In paragraph 44 you also mention the instance of an ENT surgeon who offered his services?-- Yes.

Can you explain that a little further?-- Well, the same situation applies there where there is a young ENT surgeon in this town currently who is also a home-grown product who has sort of made overtures of having a VMO appointment at the Base Hospital and he doesn't have a VMO appointment at the Base Hospital. So that - I mean, I just find that untenable and I think - I think these are the sorts of crazy decisions that

get made when there's a degree of authority exerted about you will or you won't do that. I mean, the decisions depart more and more from what I would consider to be commonsense decisions.

You refer also to a radiologist who wished to set his practice up in the hospital?-- Yes. When I was Director of Medical Services, the radiologist in town approached me about the concept of establishing their private radiology offices in the Base Hospital, which I thought would be a tremendous thing because radiology services are very difficult to recruit for. In fact, in the public system in provincial areas they're virtually impossible, in part because people in private practice make two or three times what the public hospital salary is, but it would have provided the best of equipment in the Base Hospital, that would have been the focus of radiology services in this town, and I was told at the time to - and it was not during the tenure of any of the individuals here - I was told to continue with the pursuit of employment of full-time Director of Radiology. Those individuals have subsequently expanded their services. I did negotiate a contract with them for provision of radiology services to the Base Hospital, but it's issues such as that where if you have a high quality Radiology Department with a sophisticated range of procedures being done, that helps attract people to the town and to the hospital. If it's just - if it just does the basic stuff, you know, that doesn't wear it these days.

You also in response to the Commissioner's questioning referred to remuneration of VMOs and talked about appropriate remuneration. Do you have any views about whether or not that should be on a hourly rate or some other basis?-- No, I think it should be fee for service.

Fee for service?-- Yep.

By that you mean fee for the individual services-----?-- That's correct.

-----varying cost services?-- Yes, and that's cyanide in the Queensland Health system, but other States do this and, in my view, I think, unfortunately, we've got to the point where that's the sort of thing that we have to look at.

COMMISSIONER: Why would the Queensland Health not like the concept of fee for service?-- Because it's much more expensive than an hourly rate. I mean, the type of hourly rate currently is about $140 an hour.

D COMMISSIONER EDWARDS: Are you aware that Medicare may have something to do with that rate?-- Yeah, I am aware of that particular problem, but I think, you know, to me that's a political problem. That's where the politicians need to exert their interest and ability, not telling clinicians what services or how they're going to provide medical services. I mean, you know, that's the political problem. I'm not going to tell them how to do that, I just tell them do it.

MR MORZONE: In paragraph 46 you refer to hardly having seen Mr Leck or Dr Keating during the time you worked as a VMO within the hospital. I think at one stage during your period Dr Wakefield was also Director of Medical Services?-- That's correct.

What about Dr Wakefield?-- No, I mean, once I became a VMO I really didn't have any significant contact with the administration.

In relation to those individuals, you mentioned before that you don't particularly blame those individuals or the system in which they work; is that correct?-- Yeah. I mean, I think to a degree these people are victims as well and I think, in my view, the system has let them down. Unfortunately, the view has been proposed, as I think I outlined earlier, that if you do A, B, C, D, one, two, three, four, everything will be okay. And, for example, you know, Queensland Health collects key performance indicators about surgical performance in its hospitals. Their review of the Bundaberg Base Hospital says Bundaberg Base Hospital did not stand out from other hospitals in the State. Now, the message from that to me is patently obvious; one, the people who are collecting the information aren't doing it; and, two, the information you're collecting is useless.

D COMMISSIONER EDWARDS: Or both?-- Or both, and most likely both, and it's this sort of blind acceptance of this imposition from above, "This is the way it will be done and everything will be okay," that permeates through Queensland Health and, you know, suddenly somebody in Bundaberg wakes up one morning and beware the Emperor hath no clothes. The information we've been getting I felt secure about will ensure that I'm doing my job correctly but I suddenly find out that the information I've been collecting doesn't help me ensure that my job is being done correctly. So the emphasis is making it look as if everything's okay without making sure that everything is okay and there is a subtle but profound difference.

COMMISSIONER: Just following on from that, Dr Thiele, we've heard and some of us at least have now seen the report from Dr Woodruff and others in relation to Dr Patel's patients. Dr Woodruff, I take it, is a colleague of yours in vascular surgery?-- That's correct.

That was based, as the report demonstrates, simply on a review of the clinical files. Would I be right in thinking that to arrive at a conclusion that, say, eight deaths are connected with negligence on the part of Dr Patel from a review of the clinical files would necessarily suggest that's a minimum rather than a maximum?-- I think that's a fair comment, yes.

That the confidence one can have on the figure of eight depends in the first place largely on whether the clinical files were accurate?-- Yes, absolutely.

And also that there are some forms of negligence that simply

will not be recorded in the very best clinical files?-- That's correct.

So if you're in Dr Woodruff's position reviewing those files and you could satisfy yourself that there were eight deaths resulting from poor surgical performance, then that would be the absolute minimum rather than the maximum?-- I mean, I think that's a reasonable premise, yes.

MR MORZONE: Are the clinical performance indicators and the information gathered by the hospital which is then used by the administrators to, as you say, believe the hospital is okay, what are - one of the reasons you were referring to earlier were having clinicians at the head of the office who get down and see what occurs within the wards?-- Yes, I mean, I just philosophically believe that if you want to know what a patient feels about what's happened to them in the hospital, you don't send them a questionnaire of 20 questions three weeks later, you walk around the hospital and you say, "Mrs Jones, how are things going?", and I firmly believe in a hands-on approach to the clinical situation. I mean, I - excuse me, but I almost became apoplectic when - and I think it was the start of the slide when Queensland Health decided to accept the corporate model and we were going to refer to patients as clients. Now, with all due respect to the people who are here, including yourself, clients to me were somebody who dealt with the legal profession.

COMMISSIONER: Or occasionally accountants?-- Beg your pardon?

Occasionally accountants?-- Occasionally accountants, and patients were something a little bit different. You know, one of the important things doctors do with patients is we lay our hands on people and there is something very realistic about that. It is very real, make no mistake about that, in terms of examining people. People give us their trust in that regard and I believe that you can't - you cannot accurately ascertain what's going on from afar and I think one of the beauties of these institutions, and one of the things that very much attracted me to coming back here, is you could get your arms around this whole facility, you can become familiar with the gardening staff, you can become familiar with the carpentry staff, you can become familiar with everybody who works there without any great degree of difficulty, and in contrast to somewhere like the Royal Brisbane where that's a total different ball of wax. But, yeah, I may - my view may be a little bit different, but as you can gather I hope I have a fundamental belief in the need to walk around and talk to people.

COMMISSIONER: I feel though, Dr Thiele, I have to warn you when you criticise the decision like the decision to use the word "clients" rather than patients, you are denigrating the work of many dozens of public servants who spent years coming up with that profound conclusion that patients should be called clients?-- Yeah, I'm aware of that, and, I mean, it's part of the adoption of the corporate model where, you know,

that was an American thing, and we have great capacity to take the worst things Americans do and make them even worse and that's just part of the corporate model. Well, you know, these are not patients, these are clients and everybody says, "Yes, sir, no, sir, three bags full," and, I mean, I know some people revolted against it, and I revolted against it and I will continue to revolt against it because we are not dealing with clients. These are not people who are separated from us by a display case with watches in it. These people are different and you have to have a different mind-set when you deal with them. If you consider them clients, that's part of the problem.

MR MORZONE: You refer to the low morale at the hospital at present. What are your views about the people though who work there, the nurses, the clinicians, and everyone else for that matter?-- I mean, there are people who work in the public health system who are among the very best in terms of what they do. The repository of talent which exists in the public health system is incredible. The potential for people in the public health system to display their talent, unfortunately, is not what it should be and I - I've been fortunate. I've had an opportunity in my lifetime to live in an environment where I could explore what I thought my talents were. I think everybody should have that opportunity and I don't think that's done by paying people or whatever, whatever. I think that's attitudinal and part of it is that people have to be encouraged to see how good they can be, and they are going to make mistakes, for sure, but that's how they learn and I just - I hope that somehow this huge repository of talent in Queensland Health can be really appropriately tapped, because I can tell you it won't be people like you or me or, with all due respect, Mr Morris, who are going to fix the problem. It's going to be those people who go to those hospitals every day who will eventually bear the brunt of fixing the problem.

COMMISSIONER: The most we can ever hope to do is give them the opportunity to do that?-- Absolutely.

Doctor, just following up one of the comments you were making. We've heard evidence already from Dr Miach about how the Tenckhoff catheter system was put in place at a private hospital in town. On one view, of course - and I don't want to be merely a mouth about this, I think it's to the great credit of not only Dr Miach as the doctor involved but also Dr Keating as the Director of Medical Services involved in having the foresight to get that roadblock out of the system so something could be done - but it just struck me when I was hearing about that from Dr Miach that wouldn't it have been wonderful if Dr Keating had the freedom within his administration to say, "It's silly carting a patient over to the Friendly Society Hospital, getting a private doctor to put in a catheter there, carting the patient back to the Base Hospital where the patient's treating physician and treating nursing staff are based."; is that an example of the sort of situation where more flexibility on the part of Queensland Health and allowing their local management specialists to use their initiative could achieve things?-- Yeah, well, with due

respect to Dr Keating, the fact of the matter was that I had left the hospital as a VMO, the Base Hospital, and during the period of time I was there I was, in fact, doing a fair amount of renal access surgery. I can tell you frankly, if he asked me to come back to the Base Hospital I would have said no. And it was - I mean, it's - I have some grey hairs. I've reached an age in my life where my time is very important to me. I am increasingly less tolerant of inefficiency and I didn't want to go back to, you know, having to deal with an inefficient environment where one may schedule a case for a certain period of time and then find something else comes up. I mean, I just didn't want to have to deal with that any more. So I don't think - I think Dr Keating in approaching - and it was largely Baxter's instigation actually, because they're the people who provide the dialysis fluid for these people, they were prepared to do this.

Thank you.

MR MORZONE: A couple of final things. First of all, the complaints system we haven't dealt with. In paragraph 53 and 54 you tentatively emphasise the complaint system, why is that?-- Well, I - probably 90 per cent of complaints, realistic complaints originate from poor communication and the other part of the equation is that complaints originate from poor quality service. I'm not saying there shouldn't be an appropriate complaint system, but I think there should be measures taken to, one, provide quality medical services, but, two, to ensure that the communication between doctors and patients is optimised. Now, I'm sure that some people have tried to get access to the doctors looking after their loved ones to find out what's going on and I would also no doubt state that that's probably just about impossible. So I think, for example, residents need to be trained and need to know that at 12 midday every day they have a session for meeting with patient relatives in the patient lounge and that's where the relatives come and that's where the residents go to talk to them about it. I mean, they have to get the message that's a priority of medical care and I think if those sorts of measures were taken, then the requirement for having a complaints system - I mean, it doesn't disappear - but I don't think that should be the focus, I think the focus should be how with we minimise the complaints.

You have expressed desperately in your evidence your views about how the Bundaberg Hospital tragedy came to happen; are you able to summarise?-- Yeah. If you wouldn't mind, is it okay to refer to some notes, and some of this, of course, may be repetitious, so please indulge me. My view, of course, this is and not necessarily totally the truth, whatever that is, but I think - I think this happened because there's been a gradual shift within the health care system from the primary goal of providing quality medical services to primarily being fiscally responsible. Now, those two are not mutually exclusive, and the comments made by the Commissioner earlier about there has to be fiscal restraint and responsibility I agree with 100 per cent. But I think that for whatever reason the system gradually became structured more to as a fiscal

organisation, corporation and not a healthcare delivery system. That's my view. I think that the service delivery issue became linked to unrealistic budget allocations and service delivery was made to fit fiscal boundaries, not the need that existed. Budgets became heavily linked to activity and activity measures and activity indicators without fundamentally ensuring there was not an erosion of quality.

Again I think that people were under the misconception that there were measures in place to keep a check on quality, and there were measures in place, but unfortunately they do not guarantee that there is quality. I think I mentioned that there is a very strong political/fiscal overtone to Department of Health, and I think when money issues become of primary importance, the desire to control becomes even greater. There is something quantitative that people can determine whether or not you're doing your job, and so if you're 20 cents over your budget, they know you're 20 cents over your budget and you might get a rap of the knuckles, and I accept that that is an exaggeration. But I think it contributes to this control freak mentality that permeates the system. There's a desire to control, which to me is almost pathological, and it discourages critical commentary, it discourages, thereby, progressive improvement from the bottom up, as I mentioned before, and it leads to a system which walks around with its head down, has not a great deal of self-respect because all the problems are identified from above and they're fixed from above, and so people ask themselves, "Well, what's my role here?" So it gradually erodes the importance of the individual contribution within the amorphous system. Finally, as I've said, goodwill has disappeared from the system, and I think, unfortunately, it has gone forever. I say that with great regret and sadness, but I think that's happened. I think doctors have attempted, and nurses - and this is an example of a nurse championing good - patient requirements and patient needs, and even to this current day there are health care issues in this State which doctors are complaining about which, for whatever reason, people who are in the more powerful positions choose to ignore, and they're serious issues. And if you keep complaining about something that you fundamentally feel is wrong, and those for whom you work ignore you and ignore you and ignore you, the natural consequence is you ask yourself, "What is my relevance here?"

How do we fix it?-- What do I think about how we fix it? Again, these are just some of my views about it, and I don't by any means presume to have all the answers, but I think the first thing is that there has to be a reaffirmation that the primary function of a hospital is delivery of quality health care, and all other activities need to be supportive of this goal. How do you do that? I think you've got to engage all the health care professionals - re-engage all health care professionals as the primemovers in the delivery of health care, and these people have got to have at least - at least - equal authority to administrative people. I mean, after all, these are hospitals dealing with treating patients, and I know there's a budget, and I know there are administrative requirements et cetera, et cetera, but the fundamental core business of these facilities is the delivery of quality medical care, and my view is administrators cannot do that. As much as they try, as much as they think they can do it, they can't do it. I think you have to utilise teaching and training as primary methods of quality control, multidisciplinary issues that I've talked about before. I think that you need to institute measures to prevent this excessive control environment from developing or recurring by

increasing the transparency of what goes on, and I think I've talked about this before. I think there has to be local representation and involvement in what goes on in hospitals. Not, I don't believe, in just a supervisory tone, but I think people need to know what's going on on a day-to-day basis, at least for a period of time, because public confidence has to be restored in this system, and I believe that's probably the best way to do it. The public has to have a representative on the Executive, or whatever major governing authority you decide oversees what's goes on in these hospitals. There has to be a marriage between public and private systems within provincial towns. I do not believe it is appropriate, nor is it effective, nor is it fiscally responsible to run these two systems in parallel, because I think the by-products are it's a much more expensive way of doing things, but it also restricts the availability of medical services in provincial towns and the reverse should really be the case. It is important, I think, in country towns that - or provincial towns that the basis for health care delivery at a medical level be VMOs. Period. There are certain circumstances where the employment of full-time staff, I think, are appropriate, but I think the axis upon which service delivery has to rotate is VMO services, and because of the erosion or the loss of goodwill in the system, I think the remuneration system has to be revisited by all staff in Queensland Health. And somehow or another, and perhaps it's by a change of philosophy or culture, I think it's important that the political process is sensitive to the health care needs, not that the health care needs are sensitive to the political process. Clearly I have not, by any means, probably more than put my big toe in the water, but I think - I hope that I've touched upon some issues which may be beneficial to you in your inquiry, and I trust that out of this mess will come a responsible Bundaberg Base Hospital and Bundaberg health system that the local community has a say in and is proud of. Thank you.

COMMISSIONER: Thank you, doctor. Would it follow from what you've just said that so far as Dr Jayant Patel is concerned, you see him very much as a symptom of a sick system rather than the disease itself?-- Yeah, I mean, I really do believe this was waiting to happen. I feel that very strongly.

MR MORZONE: That's the evidence-in-chief, if it please the Commission.

COMMISSIONER: Thank you, Mr Morzone. Ms Gallagher?

MS GALLAGHER: Thank you, Commissioner, I have nothing.

COMMISSIONER: Who is next? Mr Allen?

MR ALLEN: No, thank you, Commissioner.

MR HARPER: I have just one brief-----

COMMISSIONER: Yes, Mr Harper. Doctor, this is Mr Harper who represents the patients' group?-- Right.

CROSS-EXAMINATION:

MR HARPER: I just have one area of interest. I was very interested and, I think on behalf of my clients, gratified to hear earlier of your emphasis on communication as a priority in medical care, and you referred to the fact that you think a large number of complaints arise from this lack of communication. You also mentioned earlier that collecting the right information is important in any hospital and in the health system to ensure that it's doing its job properly in providing that quality health care. Do you think it's a fair reflection then that the number of complaints which a hospital receives is an important indicator of the quality of that health care?-- Yes, it is. It is. I mean, it is a factor which has to be considered.

So you would again then stress the importance of ensuring that all of the complaints are recorded appropriately?-- Yes.

And do you think that in those circumstances the failure to properly record those complaints in the case of Bundaberg would have been a contributing factor to the problems which you describe as being inevitable?-- Well, I mean, I think that would be one of the areas which are deficient in terms of delivery of quality to the system. It would have a negative impact on that, in my view.

I have nothing further, Commissioner.

COMMISSIONER: Mr Harper. Ms McMillan?

MS McMILLAN: No, thank you.

COMMISSIONER: Who does that leave? Mr Diehm?

MR DIEHM: Yes, I have some questions, Commissioner.

COMMISSIONER: Thank you. Mr Diehm of counsel represents Dr Darren Keating?-- Yes.

CROSS-EXAMINATION:

MR DIEHM: Doctor, I just want to ask you some questions on some peripheral issues that arise out of your evidence rather than the core matters. Firstly, in paragraph 42 you talk about your cessation of work as a VMO at the base hospital, and you've said that that, in the previous paragraph, was about four years after you left in 1999 as the Director of Medical Services. I just want to make sure that we're on common ground about the timing of things. When you speak of ceasing work as a VMO, are you speaking of a time around

January 2004?-- Yes, probably.

Thank you. Was it the case that the contract you had to work as a VMO at the hospital at that time actually had about another year to run?-- No, I don't think it had a year to run. I think it had a few months to run.

A few months?-- I was required by the contract to give, I think, two or three months' notice, and that's what I attempted to comply with.

Is it also the case, though, that whilst you did stop those two sessions a week that you've described in your statement, you did continue to do some work as VMO at the hospital?-- Yeah, and I probably should have elucidated that. I do supervise an amputation clinic once a month at the hospital, but I don't have any sort of formal clinical contact as the sort of a normal VMO, is really what I was talking about.

Yes, thank you. It's also the case, is it not, that when you made your decision to cut back on those sessions in early 2004, that Dr Keating organised a meeting with you to discuss your reasons for doing that?-- Correct.

And you explained to him that you had some concerns about a lack of support within the hospital-----?-- Yes.

-----for the services you were providing. You had some concerns about communication with anaesthetists and so on. Is that right?-- Yes.

Did Dr Keating try and talk you out of your decision?-- I don't know that he tried to talk me out of it.

It's the case that he couldn't have talked you out of it even if he tried?-- No, not with the circumstances as they existed.

Thank you. Is it also the case that since that time there has been another approach by Dr Keating to you, in the company of others, for you to provide some other vascular access services for renal patients at the hospital as a VMO?-- That's correct.

And that resulted in a meeting with Dr Keating and others in early February 2005?-- Correct.

In the period between, say, mid to late November 2004 through to early February 2005, did you have some leave that took you away from the Bundaberg area for a time?-- Yes, I was - my eldest daughter lost her husband in the United States suddenly and tragically, and I was in the United States from probably about 9 December through to about the beginning of January.

The meeting that you had with Dr Keating and others where the further services were discussed, did you ask at that meeting for some information about the likely demand for the service that was being proposed?-- Yes.

And you also wanted to know what arrangements might be proposed with respect to providing care for routine patients, pre-planned patients as it were, versus emergency patients?-- That is correct.

Because you, as you said before in your evidence, you were at the stage of your life and your career where your time was very important to you and you wanted to make sure that what was proposed was convenient for you in a professional and a personal sense?-- That's correct.

And Dr Keating came back to you with information about the historical patient demand for this particular service-----?-- That is correct.

-----in a letter?-- Yes.

And did he also in that letter propose that there could be an elective surgery operating session for the routine patients every three months?-- That is correct.

Now, was that proposal, in your view, sufficient to meet that historical level of routine demand?-- I don't quite understand the question. Can you - you mean was that an accurate representation of the workload that would be involved?

Yes. Was what was being proposed sufficient to meet that sort of routine patient demand?-- Probably, except for the emergencies that might occur.

With respect to the emergencies, what Dr Keating came back to you with was a proposition that was two-fold. One was that emergency procedures could be performed by you within certain hours of the day and certain days of the week?-- If possible.

If possible. So obviously if the patient presents during those times that were convenient to you, you could deal with the emergency patient?-- If nothing else was going on.

Yes. But if that was not possible, then Dr Keating's proposal was that the patient would be transferred to the Royal Brisbane Hospital?-- That's correct.

For completeness, doctor, can I ask you to look at this letter? I don't think it's gone into evidence, Commissioner, but I'll stand to be corrected.

COMMISSIONER: The letter of 22 February 2005 from Dr Keating to Dr Thiele, together with its attachments, will be Exhibit 119.

ADMITTED AND MARKED "EXHIBIT 119"

MR DIEHM: Doctor, if you could just confirm - it needn't go on the screen. Can you tell me whether or not that's the one you received?-- Yes, I'm aware of that.

I don't think we need to take that any further. In paragraph 48 of your statement you recall a conversation that you had with Dr Keating concerning Dr Patel's credentials, as you say, because you'd heard that Dr Patel was going to do some vascular access surgery. Now, I take it, firstly, that when you speak of vascular access surgery, are you talking about for the purposes of renal patients?-- Yes.

And given that you left as a VMO, as it were, in January 2004, I just wonder whether you may be mistaken as to the timing of these things in that what you learned, and the circumstances in which you then discussed it with Dr Keating, actually took place before you left the hospital as a VMO?-- Well, no, it was - it was around about the time that I decided to leave, and I think Darren and I had - it may have even been at the time where I told him that I was going to leave. So - but it was within that sort of general time.

It may have been late 2003 rather than early 2004?-- Might have been. Might have been.

Thank you, doctor. Now, if I suggest to you that what your inquiry to Dr Keating was about was the extent of vascular surgery that Dr Patel might perform, does that sound right as to the nature of the question that you asked him?-- No, I mean, from my point of view it was primarily directed to the issue of vascular access surgery and, I mean, it is a very demanding area of surgery and people need to have appropriate training in that area to be able to do it, and I had heard a rumour that Dr Patel had said that he was going to take it over. I mean, he had not said anything to me about it, but I'd heard a rumour, and that was the origin of my question.

Thank you. Did Dr Keating respond to you by saying that Dr Patel would not be doing major vascular cases of whatever particular type it was, and that otherwise the only other thing he would be doing would be emergency cases?-- Yes. I mean, I think Darren did say that he would not be doing any major vascular surgery.

And your response to that information was that that sounded reasonable?-- No, my response - I didn't have a response, actually. I mean, it still left the issue about vascular access, and I mean the general sense that I got from the discussion was that Dr Patel's credentials to do - particularly vascular access stuff, were okay. Now, I mean, that's the sense that I left that meeting with.

That was your impression?-- Yes, yes.

Doctor, you then mention at the end of the paragraph that you understood that the arrangement with respect to the Baxter Hospital was one that was reached because Dr Patel was not competent to do the work and that no other reason was ever

suggested. Perhaps if I can suggest to you that in a broader sense the reason for the Baxter program being implemented was that there was no surgeon at the Bundaberg Base Hospital who could or would do those vascular access cases, is that the context in which the program was set up?-- No, I mean, the context in which the program was set up was that Dr Miach first approached me and said that he was uncomfortable about Dr Patel putting in peritoneal dialysis catheters.

Thank you?-- Putting in peritoneal dialysis catheters is a much simpler procedure than doing vascular access where - in vascular access you're required to sew blood vessels together or put in artificial grafts and things like that. But he said he was uncomfortable with Dr Patel doing it and Baxter had a program in Western Australia, and I think South Australia, where they financed patients having catheters put in, and he asked me if I would be interested in participating in the program.

Yes?-- So, I mean, I was aware of the fact that there was other vascular access which needed to be done and there really wasn't anybody at the base hospital who was capable of doing it.

Doctor, the next matter I wanted to ask you about concerns paragraph 51 of your statement where you talk about the credentialling and privileging system and its application to Dr Patel, and you say it affords another example of the Queensland Health mindset, and you've mentioned in your oral evidence that there was, it sounds, as I understand your evidence, a Queensland Health policy that was in place even in your time as a Director of Medical Services concerning credentialling and privileging, and I gather from your evidence that that imposed some requirement to liaise with the respective college for that process. Are you aware as to what the policy with respect to credentialling and privileging was at around the time of 2003/2004 in Queensland Health, or is that something that you don't have any particular knowledge about?-- The only knowledge that I have is a comment made by the Acting Director of Medical Services at a recent meeting where I, for example, asked the question why hadn't my credentials been reviewed in the last three or four years, and he made the statement that he did not think that the format of the credentialling and privileging process was really appropriate, and he had decided to extend it out, and I can't remember how many years. So that's my knowledge of the credential and privileging process at about that time.

The policy as it existed, at least at the time that you were Director of Medical Services, did it require that the person who was to do the privileging be a person specifically approved of by the college?-- Yes, yes.

And so assuming that system continued to exist at the time of Dr Patel's presence at the hospital, you could nominate yourself - or you could be contacted and asked whether you would do the privileging of Dr Patel, or indeed any other surgeon, and you could express your willingness to, but it was

then required for the management at the hospital to go back to the college and say, "We've got Dr Thiele here. He's prepared to do it", and get the college's approval to do so?-- Yes, absolutely right. But to me, you see, that's sort of symptomatic of the circumstances where you're sort of made to appear as if things are being done. I mean, the purpose of credentialling and privileging, with all due respect, is not to satisfy the needs of the Royal Australasian College of Surgeons. It is to satisfy the needs of the hospital where the individual is applying to work. Because if there's a problem with the College of Surgeons, in my view, I don't think that should paralyse the system, because it leaves that system vulnerable, and to me again - I understand why it's not done. They say, "Well, all right, the College of Surgeons won't be prepared to participate", but again to me that's a common sense issue. If we really want to make sure about the people who are working here for us, we need to have a credentials and privileging process regardless of what the College of Surgeons wants to do.

Doctor, I'm not challenging what you say about these things?-- Right.

But you've adverted to something I did want to ask you about. Are you aware - or were you aware that there was then in fact a problem with respect to getting the College to respond to any nominations?-- Yeah, I am aware of that. I am aware of that.

So, the system as it was that was imposed by the policy couldn't work?-- Yes.

Thank you.

COMMISSIONER: But was there anything to prevent a Director of Medical Services or a District Manager, or anyone else even, if it wasn't approved by the College of Surgeons approaching people like yourself and saying, "We have got a nomination or an application from Jayant Patel. You tell us what you can about him."?-- In my view, there's not, and - but again it's sort of part of the mentality where - you know, there are certain dictums which come down which people believe are fundamental laws or rules, and they are not, they are guidelines, and they misunderstand that there is an opportunity for a little bit of wiggle room in there. But more importantly people become preoccupied with the process and not what it's really there for. I mean, I think it should be patently clear to everybody if you want to know about the quality of an individual who is going to work in the hospital for you, then it is in your own interests to have a mechanism for establishing that. Now, if there are individuals who don't want to cooperate, fine. But, you know, to me - and maybe credentialling privileging in this country hasn't reached the stage that perhaps it should in terms of acting as a filter and scrutiny, but to me it is a fundamental process for reviewing the quality of individuals working in an institution.

MR DIEHM: I have-----?-- It happens in the private sector. If you wish to function at either of their two private hospitals in town you will have to submit to have your credentials reviewed and to receive privileges. So, it doesn't impede them from having an active process.

Thank you. I have nothing further.

COMMISSIONER: Thank you, Mr Diehm. Who's next? Mr MacSporran?

MR MacSPORRAN: I have nothing, thank you.

COMMISSIONER: Ms Feeney?

MS FEENEY: No, thank you, Commissioner.

COMMISSIONER: Mr Farr?

CROSS-EXAMINATION:

MR FARR: Thank you, Commissioner. Dr Thiele, my name is Brad Farr. I am appearing for Queensland Health and there's just a couple of issues that I wanted to clarify with you, if I could?-- Certainly.

And the first that I can turn to is in relation to the issue of VMOs and permanent staff that regional hospitals employ. I understand the evidence that you have given. Can I just ask you to turn your mind to one other aspect that you have not commented upon to date, permanent medical staff, doctors, specialists, that type of thing, employed at regional hospitals. My understanding is that they often are the source of supply for the ultimate specialist service, the private specialists of that town in that a doctor might, for instance, come to a town, work in a public hospital, decide that they like this place and ultimately set up a practice, private practice in that particular town or region. Is that your understanding of how it frequently does occur?-- I think it does occur but I don't think that's by design.

I'm not suggesting that it's by design?-- Right. Sure.

But it is a flow-on effect?-- Absolutely, yeah.

And my understanding again is that for some regional towns that is the method via which a lot of the private professionals enter into that town or that region?-- Yeah. That was the only method.

That's right?-- Mmm.

Because it would be, I think you have suggested, a courageous step to set up private practice, for instance, in a region with which you are not familiar, particularly if your speciality is already represented in that area. You agree with that?-- Correct.

And the way the system functions, when it should be functioning well, is that a medical practitioner comes to a region, is employed, for instance, in a public hospital, can make a name for himself or herself, can get to know the local profession, the local GPs, so on and so forth, and ultimately then have the confidence to go out to the private profession?-- Certainly.

And I understand your point of view is that that person then is in the ideal position to put something back into the system, if you like, by use of the VMO system that you would hope is working appropriately?-- Yeah. But I think if I - if I may make a comment?

Certainly?-- And that's the mechanism that's worked in this - in this State for many, many, many years. But it does not take cognisance of those individuals who wish to go to

practice in a town and you do not want to spend the obligatory two, three, four or five years full-time in the public health system as a prerequisite to going into private practice, and of necessity that, therefore, serves as a delay in providing the breadth of medical services which could be provided if the maximum recruiting capacity of the town was utilised, public and private. But historically that's what has happened.

So, what you're speaking of is a greater flexibility of process, if you like?-- Absolutely.

To give people options?-- Yes.

All right. Can I move on to something else that you have spoken of in your evidence. You have mentioned the complaints process in the regional hospital, Adverse Event Reporting process, and you have spoken of the importance of a Director of Medical Services, for instance, getting down on to the wards and speaking to patients and/or staff himself or herself. I don't understand you to be saying that that would be the only process that such a director might take to inform himself of problems that might be arising or have arisen, that that is an option that should be undertaken in conjunction with other features?-- Oh, absolutely. Yeah. I mean, people have different styles of management, and I would admit that, but - and I have made it clear that it's my view that I believe in health care a hands-on approach is of fundamental importance.

Certainly. I think we will hear some evidence in the future, that in February of 2004 the Bundaberg Hospital introduced an Adverse Event Reporting system or a new Adverse Event Reporting system. Are you familiar with that system when it was introduced?-- No.

Okay. We also understand that in November 2004 it was modified, I think, to some relative and minor degree to coincide with the new Queensland Health policy on that topic. Again are you familiar with-----?-- No.

-----that system. All right. I do understand, however, from your evidence and your statement that your view is that whatever the system might be for such complaints or adverse reporting, it should be adopting a no blame approach, one that's looking for what was the cause and how can we ensure it doesn't happen in the future?-- Absolutely.

That would be, in your view I take it, the ideal goal of any such reporting or complaint system?-- Absolutely.

And if people can be - if staff can be encouraged to accept that that is in fact the goal, that would be a most worthwhile enterprise?-- Certainly - I mean, against the background of the reason for it being ensuring that the quality of care delivered to patients is optimum. I mean, it's not just this for the issue of - you know, the piece of mind of the staff. I mean, everybody in hospitals has to understand that the primary individual is the person in the bed.

I think we can take it as read that everything you have said is in the context of the first and foremost paramount is quality of patient care?-- Absolutely.

You have also spoken of and acknowledged that the complexity of the provision of health care, public health care of particular relevance here, of course, has increased dramatically over the recent years?-- Yes.

Can I ask you this, and if you don't know the answer, please say so, but you have indicated or you have told us that when you started as the Director of Medical Services you were able to devote, I think you said, 20 or 30 per cent of your time to clinical-----?-- Yeah, that's correct, that's correct.

-----services?-- Mmm-hmm.

That was now - that was in '94. That's 11 years ago. My understanding is that the complexity of that job has increased tremendously over that 11 year period of time. Do you agree with that?-- I would suspect it has.

I also understand - again if you don't know please say so - but even things such as the e-mail communication system has eaten into time that might otherwise have been available for people in that position?-- But, you see, that's the disease. I'm not suggesting the e-mail system isn't good a system by any stretch of the imagination, but people have got to have enough gumption to say, "I am going to switch this thing off"-----

Yes?-- -----"I am not strapped to it. This is not my primary job. My primary job is to be out there, look at those people in the beds", and the culture that keeps promoting more and more - and, you know, computers were designed to relieve us of a lot of mundane issues. I mean, I have some very strong views about that. I mean, for me in terms of what I do, I think it's an absolute waste of time for me to sit down in front of a keyboard or a keypad and type a memo. All right, I'm a surgeon. I'm not been trained as a typist. I don't type 140 words a minute. But I will guarantee you that within Queensland Health a primary mode of communication and a primary mode of time-wasting is people doing that sort of activity. That's not what they are really supposed to do.

Yes?-- I mean, if you are going to communicate with people, do it face to face, and this is what I said about this hospital. It's small enough, you can get your arms around it. It's much simpler and much, much more effective to walk up to somebody and say, "How are you doing? How's your day going?", you know, "What are your problems?"

Certainly?-- Well, you know, we are going to introduce this new, whatever, whatever, and I mean, as you may well gather, I feel somewhat strong about this proliferation of electronic equipment, that instead of liberating people, it makes them slaves.

I think you have identified that not all time-saving devices save time?-- Absolutely.

And unless one is careful, they can take up a lot of one's time?-- Absolutely.

Putting that to one side, if you like, the complexity of the position of Director of Medical Services has increased. There's no question about that. I take it that increase in complexity would have a commensurate effect of decreasing the amount of time that a person holding such a position would have to devote to clinical duties?-- Absolutely, and that is what I talk about in terms of it being a system failure.

Right?-- I think it's - the system has put people in untenable positions-----

All right?-- -----with the view that they are to perform certain tasks, but it won't allow them to.

Can I also ask you your opinion on this topic? You have spoken of the importance of having a clinician, either as Director of Medical Services or-----?-- No, it's not as Director of Medical Services, per se.

Well-----?-- Yeah.

If that position is the head position, you like, of the Chief of Staff as the equivalent-----?-- Right.

-----position on the clinical side?-- Right.

Do you have any views as to the type of speciality that would be most appropriate for a person holding such a position? For instance, do you see any advantage or disadvantage if the Chief of Staff, for instance, was a psychiatrist?-- No, no.

It is just the fact that there is a clinician who has the clinical background, if you like, and has the advantage-----?-- A clinician who would be elected by - elected by - the clinical staff, and, therefore, have the confidence of the clinical staff, and I think that to make that appointment and to give it some teeth you are going to have to pay that person a certain amount of money to fulfil that job because they may well have a private practice and they may have to devote, you know, maybe a day or two days a week to their roles as Chief of Staff. Now, I believe there needs to be a Director of Medical Administration, which - the title now being is the Director of Medical Services, but I think that's asking too much of that individual, given the complexity that you have talked about.

Certainly?-- There needs to be somebody who oversees those fundamental issues, you know, credentialling and privileging , the ethics committee, et cetera, et cetera, to organise the structure of the hospital whose expertise is administration, but for heaven's sake, don't make that guy responsible for

making sure that there's quality health care. That's not - he's not trained to do that and health care's getting more and more and more sophisticated. 30 years ago a doctor was a doctor was doctor door was a doctor, you know, they were jack-of-all-trades, master of none. That's not the case any more. And so - I mean, I have said it.

The rate of change seems to have been significant in recent years, in medical services, medical practices, that type of thing?-- Absolutely.

You agree with that?-- Yes.

So it's not a stagnant beast, if you like, it's this evolving creature that one needs to keep in a close eye on in total?-- That is correct.

And if one takes one eye off for even a moment things can lag behind-----?-- Absolutely.

-----I take it?-- And even if you have your eye on the ball bad things can happen.

And I take it that the views that you expressed here today are the views that you hold in an attempt to return the situation to an appropriate position?-- Absolutely. I mean, I think I mentioned initially - I mean, my interest in being here is - you know, how do we fix this.

Thank you. That's all I have.

D COMMISSIONER VIDER: Could I ask you a question, Dr Thiele?-- Certainly you mention privileging and credentialling. I am familiar with has process in private sectors. That is the same body that assesses and has reported to it significant clinical problems, usually those of competence, perhaps of behaviour, of a person who has been credentialled by that institution to work within that institution, and on that basis of peer review, that problem is then assessed at local level. Would you envisage that role being carried through into the public sector at local level?-- Absolutely. I mean, that's - you know, that's one of the buffers, and - you know, it diffuses the responsibility of away from one individual all the time.

Yes?-- And so it - it involves those people who best know what's going on.

It can provide an opportunity also for an assessment and corrective-----?-- Yes.

-----action that can take place at the local level?-- Yep.

And we have certainly heard evidence from the Medical Board that that's the system they are working towards?-- Yeah, I mean, I don't know what's taking them so long. I mean, you know, you could say this is the way it's going to be done, and - I mean, what do you have to discuss?

COMMISSIONER: Doctor, I just wanted to follow up one of Mr Farr's questions. You were talking about the concept of having a director of Medical Administration and with equivalent or superior authority a Chief of Medical Staff?-- Not superior.

Not superior, but at least equivalent?-- Maybe.

Yes. I'm concerned - or interested, I should say, about the idea of the Director of Medical Administration. Are you envisaging that that person would be a medical practitioner?-- Yes.

And why is that?-- Well, I think - I think they would still deal with the issues which have a very strong medical base, and the medical knowledge base would facilitate their making appropriate decisions. Why do I say there should be a director of Medical Administration? Because I - I view the Chief of Staff role as not full-time.

Yes?-- Okay. So, that person is clearly not going to have time to deal with a whole bunch of other issues which naturally fall under the purview of the current Director of Medical Services. So, there are - administrative issues are still going to remain and they have to be appropriately handled. I mean, you know, there's an exception to every rule and I am sure there would be some people who are nonmedicos per se who may be able to fill that role, but my preference would be that that individual be a medical administrator.

I guess, Dr Thiele, that one of the concepts that passes through my mind from time to time is that really you should have administrators reporting to clinicians rather than clinicians reporting to administrators, and that's why I have - I just want to explore why you would have a Director of Administrative Services who is - has either the same or a higher authority-----?-- No, I don't.

-----than a Chief Clinician?-- No. With all due respect, I'd like to correct you.

Yes?-- I would never say higher authority than the Chief of Staff.

Yes?-- Okay. Maybe equal.

Maybe equal, yes?-- But maybe not. Maybe not. And the reason - I mean, it is essential to have appropriate administrative services which support the delivery of clinical care, but the issue is making sure the clinical care is in front of everybody at that decision-making level and the best people to do that are clinicians.

Yes?-- And that's what I see the function of the Chief of Staff, and I - you know, I would not have a problem with the Chief of Staff having greater authority and the Director of Medical Administration answering to the Chief of Staff.

The only difficulty with that is that if the Chief of Staff is not full-time in the institution-----?-- Yes.

-----It's a little bit of a problem?-- Yes. It doesn't mean to say he's not contactable at his private rooms or something like that, but - you know, if he in a sort of de facto sense assumes responsibility for all the activities of the Director of Medical Administration, that could be a problem and would dilute his effectiveness, and I think and I foresee that role - its function has to be clinical services number 1, clinical services number 2, clinical services number 3.

Yes. See, the other concern I have with any of these remodeling concepts is that there is a shortage of medical practitioners. There's a worldwide shortage. There's certainly a shortage in Queensland, and the same in nursing?-- Yes.

There are well documented shortages. The last thing we want to do is to take another medical practitioner out of clinical work and put that person behind a desk. Frankly, I'd prefer to see an outcome that frees up medical practitioners to deal with patients, rather than lock some more of them in desk jobs?-- Yeah. I think, though, that there has to be a leader.

Yes?-- Okay. And I don't think it can just be the VMO thing which can be an amorphous mass, that, you know, if there are medical issues which need to be addressed, how do you do that? Do you allow all of these people to go along to an Executive meeting or to whoever is head honcho, or whatever, whatever. I mean, there has to be some organisation to it, and my view and my intention is not to take that person out of providing clinical services.

Yes?-- But have them recognised that if you want to optimise the delivery of clinical services, which doctors have got to accept for responsibility for-----

Yes?-- -----and they have not been really good at that in the past, if they want to have a better environment in which to work, then they have got to be prepared to take responsibility for it, and by - I mean, I think one day a week would be a Chief of Staff's - I mean, you know, he would supervise training programs, he would supervise and ensure there are appropriate clinical conferences occurring, he would be involved in credentialing privileging, you know, he might meet with the Director of Nursing, whatever, whatever. I don't see that taking up a large amount of time.

Yes?-- It would have to be - I mean, preferably somebody senior-----

Yes?-- -----who's been around, and who maybe has a bit of time to do that. I mean, I think even in Brisbane you would find that - I don't think the Chief of Staff concept is nonviable in Brisbane, and I think it could be eminently

adopted in Brisbane to propel and elevate the role of doctors in what goes on.

I don't think we're at cross-purposes, doctor?-- No, no.

I see all of the merits of having a practising clinician as Chief of Staff. I guess my concerns are a slightly different one. We have heard that the training positions in Australian universities and through the colleges have essentially been frozen for something over 20 years now. I suspect that when that figure was fixed, whatever it was 20 or 25 years ago, there may not even have been such a thing as a College of Medical Administrators, let alone a sort of standard career path that people would study medicine-----?-- Right.

-----for six years, or whatever, do their training work and so on, but end up being full-time administrators?-- Right.

And that seems to have taken a significant number of medical practitioners out of clinical work and behind desks, and my concern is that if you have both a Chief of Staff for medical services and a Director of Medical Administration who is a medical practitioner, you have got one person out of clinical services for maybe one day a week, you have got another one out of there for five days a week. Again, the patients are losing the benefit of having medical practitioners?-- I think, though, that - I mean, generally speaking, as you are aware, people follow career paths which most suit them, and people go into Medical Administration because that's what they like to do.

Yes?-- So, I mean, they are not - they don't make an option - you know, "Well, I have to go into Medical Administration rather than a clinical function", and so I mean the number of - I mean, there is a shortage of medical administrators as well-----

Yes?-- -----I mean, appropriately trained medical administrators, and the situation, no question, is aggravated and exacerbated by the lack of specialists being trained in this country, and it is going to get worse, because within a period of five to 10 years something like 30 to 40 per cent of specialists in this country are going to retire, and there is no way that that manpower shortage is going to be replaced in time, at a time when the need for specialist staff is blossoming, because - you know, 10 years ago in this town GPs did obstetrics.

Yes?-- 20 years ago GPs did general surgery.

Yes?-- So, in this day and age to even provide the same sorts of services which were done in the past you need an increasing base of specialists, and that's why the imperative of providing clinical services to a community has to be a public private concern, in my view if you want to optimise it.

You raised the issue earlier about cardiology. I mean, we have a major crisis probably in this country with regard to

appropriate care of people with severe coronary artery disease. I mean, you can't take everybody to the Prince Charles Hospital. Part of the answer's got to be you have got to get these services out into provincial areas and it's not that difficult.

Yes?-- I mean, I can tell you if you lived in a town of 75,000 people in most areas of the United States you would have a cardiac catheter lab and two or three cardiologists where you could go within 24 hours of getting your severe chest pain and have an angioplasty done.

Yes?-- I see no reason whatsoever that similar sorts of approaches can't occur in this country.

Ms Gallagher?

MS GALLAGHER: Nothing.

COMMISSIONER: Mr Morzone?

MR MORZONE: No, thank you, Commissioner.

COMMISSIONER: Dr Thiele, thank you so much for your time today. I don't think there's anything I can say that would be as eloquent as the round of applause you received from the audience here?-- Thank you very much.

Your contribution is hugely valuable and enormously appreciated on our part and we are particularly thankful of the fact that you are able to make your morning available from what is, I am sure, a very busy private practice?-- Well, I'd just like to say thanks very much for the opportunity of being here and being able to express my views, and my hope is that this will be fixed. All the best.

WITNESS EXCUSED

COMMISSIONER: It's ours as well. Ladies and gentlemen, we will now take the lunch break until 2.15. Just for future planning, I will mention two things. One is that a number of people here, not only lawyers, but journalists as well, I understand, are on the 5.15 flight back to Brisbane, so we will rise at 4.15 sharp to make sure everybody can get that flight.

On a similar sort of footing, I note that some people returning for next Tuesday are booked on the Tuesday morning flight rather than Monday evening. I don't want to keep people away from their homes and families longer than is necessary or put anyone to greater expense than necessary, so

I thought we might start on Tuesday at 10 o'clock rather than 9.30 to allow people to catch that early flight if they wish to do so. Anyone have any difficulty with that?

The other thing the Secretary's asked me to look into is future planning, because we have got two more weeks after this in Bundaberg. The plan was then to have a nonsitting week before resuming the sittings in Brisbane. But particularly I will ask members of the Bar and solicitors to consult their diary to see if that is convenient to have, as I say, two weeks in Bundaberg, then a nonsitting week, and then resume the sittings in Brisbane after that. Okay. 2.15.

THE COMMISSION ADJOURNED AT 1.02 P.M. TO 2.15 P.M.

THE COMMISSION RESUMED AT 2.28 P.M.

COMMISSIONER: Mr Fleming, if you would be kind enough to return to the witness-box. Make yourself comfortable, or as comfortable as you can?

MR FLEMING: Thank you, Commissioner.

COMMISSIONER: I will just remind you that you are still under oath.

IAN GRANT FLEMING, RECALLED AND CONTINUING
EXAMINATION-IN-CHIEF:

MR ATKINSON: Mr Fleming, you have a photograph that you would like to show the Commission?-- Two photographs, yes.

And those photographs are of the current state of your wound; is that correct?-- That's correct. This is after having had three corrective procedures performed already.

Now, can you see those photographs on your screen, Mr Fleming?-- Yes, I can.

That's the current state of your belly?-- Yes, it is.

Commissioner, that's the evidence-in-chief.

COMMISSIONER: All right. Those two additional photographs of Mr Fleming, current condition, will be marked as Exhibit 120.

ADMITTED AND MARKED "EXHIBIT 120"

MR HARPER: No further questions, Commissioner.

COMMISSIONER: Mr Allen?

MR ALLEN: No, thank you.

COMMISSIONER: No questions. Now, Ms McMillan is not with us.

MR DIEHM: I think she has left, as has her solicitor.

COMMISSIONER: Okay. We will proceed on the assumption that there are no questions.

MR DIEHM: Yes. I do.

MR MACSPORRAN: I have none, thank you.

MS FEENEY: None, thank you, Commissioner.

COMMISSIONER: Mr Diehm?

CROSS-EXAMINATION:

MR DIEHM: Mr Fleming, you know that I am Geoff Diehm, counsel for Dr Keating?-- Yes.

Mr Fleming, you told us that the - in the conversation that you had with Dr Keating on the 30th of October that you told him that you didn't want Dr Patel to - and I'm supposing that it was something like this - but you didn't want to see Dr Patel again; is that the case?-- Absolutely.

No, when did you form the view that you didn't want to have Dr Patel treating you again?-- The day that I was discharged on the 4th of June.

All right. And you were very clear in your mind, I take it, that he had done you serious wrong, and that therefore you didn't want him to have anything more to do with your medical care ever again?-- That's correct.

Now, before you phoned Dr Keating, had you been in consultation with your general practitioner about your problems?-- I did not phone Dr Keating.

I'm sorry. Before your discussion with Dr Keating, had you been in contact with your general practitioner about the problem with your post-operative complications?-- Yes.

And did you tell your general practitioner about your concerns regarding Dr Patel?-- Yes.

Did you tell your general practitioner that you didn't want Dr Patel to treat you again?-- Yes.

Now, as you adverted to in your evidence yesterday, the medical notes show - and I think it is in your statement as well - the medical notes show that Dr Patel did consult with you on the 10th of November in the out-patients' clinic?-- He did not.

No, I'm sorry-----?-- The medical notes state that, but he did not.

They would suggest that it was he who saw you on 10 November?-- That's what they say.

You accept you went to the out-patients' on 10 November but you say it wasn't Dr Patel that you saw?-- Absolutely not.

I'm sorry, that's my fault for putting two questions to you in one. Firstly, you accept you went to the out-patients' clinic on 10 November?-- Was it the 10th or the 11th?

Sorry, I could be-----?-- I believe it may have been the 11th.

Bear with me, Mr Fleming. I'll make sure I'm not misleading you. Sorry, I stand corrected, 11 November?-- Yes.

So, you went there, but the doctor you saw was some other doctor, not Dr Patel?-- Correct.

Now, you also mentioned that there was a consent form that was completed for the proposed colonoscopy-----?-- Was that the colonoscopy form or the endoscopy form?

The document I'm looking at seems to be for a colonoscopy, so I will have it put up on the screen, if I may?-- Or I can refer to my notes.

By all means, but I'll show you the document as well. It is two pages. We will start with the first page?-- Yes.

You see it is headed "Colonoscopy"?-- Yes.

And it is for a PO bleed?-- Yes.

Perhaps we can scan down to the bottom of the document, the bottom of that page, so we can see what's there entirely. I think - bottom of the page. If we can then go to the second page, please? Then the standard document, if we can scroll down, please? This is the document that's signed by you on 11 November?-- That is my signature, yes.

And signed by Dr Patel on that date as well?-- I don't know if he signed it that day.

It purports to be Dr Patel's signature and purports to have been done on that day?-- All the rest of the information written there, apart from my signature, is not my handwriting.

I accept that, Mr Fleming. And what you have told us in your evidence yesterday is that, in referring to this document, you said you signed a blank form and anything else that was on it you say was put in afterwards?-- Correct.

Commissioner, I propose to tender that document. I'll confess to having lost myself now as to what was happening with Mr Fleming's records as exhibits.

COMMISSIONER: I think we ended up just putting them in piecemeal, so we will give that a separate exhibit number and that will probably make the transcript easier to follow in any event.

MR DIEHM: Thank you.

COMMISSIONER: Exhibit 121 will be the colonoscopy consent form signed by Mr Fleming and bearing a signature purporting to be that of Dr Patel.

ADMITTED AND MARKED "EXHIBIT 121"

MR DIEHM: Thank you, Commissioner. Can I also say that document I have taken out of what I understand to be the Commission's copy of Mr Fleming's medical records.

COMMISSIONER: Sure.

MR DIEHM: So when it is returned, it will be complete for any of those documents, I will take it.

COMMISSIONER: I'm sure that's not a problem.

MR DIEHM: Thank you. Now, Mr Fleming, do you recall when you had your discussion with Dr Keating on the 30th of October him mentioning something to you about how it was necessary, if you were to have a colonoscopy at the hospital, for you to come to the out-patients' department to be reviewed by a specialist because you could only get on to the list for a colonoscopy if you were referred to the list by a specialist?-- I don't recall him saying that at all. I do recall him saying that an appointment would be made for me at the out-patients' and I attended at the out-patients' and saw a junior doctor. I signed that form. Later that day, I attended at - I believe it was Friendlies Hospital, and had a Barium swallow X-ray.

Okay. If I can ask you to look at this document, please? Now, Dr Pagel, is it? He is your general practitioner?-- She.

She, sorry?-- She was.

She was?-- She no longer is.

And she wrote a letter of referral-----?-- Yes.

-----for a colonoscopy-----?-- Yes.

-----for you to the Bundaberg Hospital?-- Yes.

And you have seen that on your patient file at the Bundaberg Hospital since?-- I only came to learn of its existence when I got a copy of my patient file.

Can we just scroll back up to the top of the document, please? Do you see who the referral is addressed to?-- Absolutely. Mr Patel. And I was most distressed when I found that out.

You see, what you are telling us, Mr Fleming, is that you told

Dr Keating on the 30th of October 2003 that you did not want to have Dr Patel treat you ever again?-- Correct.

You say that the reason why the clinical notes record that Dr Patel did, in fact, see you on the 11th of November is because they are a forgery, and the reason why the consent form would suggest that Dr Patel saw you on the 11th of November was because you filled in a blank and somebody else came in and filled in the details later?-- Yes.

And that you had also told your GP that you didn't want to be consulted - didn't want to have Dr Patel as your doctor ever again, yet the GP wrote a letter of referral to Dr Patel?-- Yes.

I suggest to you that you did not tell Dr Keating in the conversation on the 30th of October 2003 that you did not want to see Dr Patel?-- I most certainly did, emphatically.

Mr Fleming, you say in your evidence and in your statement that the wound that you were left with did not heal until late August 2003?-- Correct.

Now, in the complaint that you made that led to your conversation with Dr Keating, which is attached to your statement as - I think it is IGF - part of IGF3, the notification of complaint?-- Yes.

You see in the first line there, where it says at the conclusion of that first sentence that the wound infection healed in July 2003?-- That is not what I said. That is, I assume, taken from my hospital records, which apparently Dr Patel took it upon himself to supposedly have seen me and fully - which he did not do - and showed incorrectly that the wound had fully healed, which was not the truth.

Right. That's a reference, is it, to a consultation on the 16th of July 2003?-- A supposed consultation with Dr Patel which did not take place.

Thank you. If I can ask you to look at this document, please? I'm sorry, did I tender the letter from the general practitioner?

COMMISSIONER: You didn't.

MR DIEHM: If that may be received into evidence?

MR HARPER: There is one matter on this, Commissioner. Mr Fleming did indicate his preference that his personal address not be included.

COMMISSIONER: That's so. The letter that's been tendered and the exhibit attachment to one of Mr Fleming's statements also contain his private address and I will ask the Commission staff to make sure that that doesn't appear. During that interruption, I thought of something else I had to deal with and I apologise for interrupting Mr Fleming's evidence with

this, but I expressed the situation with P26, the young man that lost his leg - I'm told that his mother is still concerned to the extent, perhaps, of even being distressed
that despite the urgings from the Bench and from - or the responsible attitude from the media to date, that his name may come out in the media. Given his age and tragic circumstances he has been through, I'm inclined to accede to the suggestion that that name should continue to be suppressed. That creates a rather irregular situation of his mother giving evidence but her surname being the subject of a suppression order, and so I would invite anyone at the Bar table to - who feels that there would be an inappropriate outcome, to let me know now.

MR ANDREWS: Commissioner, P26's mother uses a different surname.

COMMISSIONER: Ah, I didn't know that. All right. Unless anyone objects, I will reinstate the suppression order regarding P26, but I won't regarding anyone making use of the mother's surname when she comes to give evidence.

MR ANDREWS: I'm instructed that P26's mother would prefer that her surname not be used because of the risk that that will lead to an identification of her son.

COMMISSIONER: Yes. I take the force of that. Well, I will go back to the original proposition. Does anyone have any difficulty with the name of either P26 or his mother being suppressed?

MR DIEHM: No.

MR BODDICE: No.

COMMISSIONER: I will then order under the Commission of Inquiry Act that the name of P26 and his mother, when she comes to give evidence, not be broadcast or published outside these proceedings. Thank you.

MR DIEHM: If we can scroll down to the next entry, there's one for the 16th of July. That entry there, which purports to be signed by Dr Patel, says, "Wound healed completely. Discharged from clinic, 16 July 2003." That's the one that you say is a forgery as well?-- Correct.

And-----

MR ATKINSON: To be fair, I don't think the witness says the signature is a forgery.

MR DIEHM: I will correct that.

COMMISSIONER: I'm sure Mr Diehm is being very technical in a legal sense that it is a forgery because the signature has been applied to the document in a way that misrepresents the circumstances, but perhaps so there's no confusion, Mr Diehm, you might be a little bit more non-technical in your use of

language.

MR DIEHM: Thank you, Commissioner. I'm sorry for that, Mr Fleming. What you say is that what is represented by the information in that note is misleading -----?-- It is totally false.

Yes, and is it totally false in the sense that you did not even see Dr Patel on that day?-- I did not see him.

Or anybody else at the hospital?-- I'm not sure if I saw anybody else or not, but on that date, the wound had not healed completely. By that time, I may have discharged - I can't recall exactly when I chose to stop attending the clinic - it is in my sworn statement - but I chose to continue to dress and treat the wound at home. I felt competent enough to do that.

If we can just go up to the note that's above it, please? Now, this is - purportedly a consultation with a different doctor on the 2nd of July 2003?-- Is it a doctor or a nurse?

I think it is Dr Igras, I-G-R-A-S, if I have interpreted it correctly, a name we have seen referred to in other places, and that seems to be the printed name underneath the signature there?-- Mmm.

Let's leave aside for the moment who it is, whether it be a doctor or a nurse, but what that is purporting to show, by both the diagram and the words, I suggest to you, is that the wound was very close to healing as at 2 July?-- Can you read that handwriting to me?

I'm not so sure I can off the screen, Mr Fleming. I think I can do better when I had the document?-- Personally, I can't understand that form of handwriting.

First line is, "Abdominal wound much improved. Small area granulation of tissue", and I can't make out the next word, but then "remaining", it seems to be after that, "much improved from two weeks ago. Continue dressing clinic 3T/week", presumably meaning three times a week, "and review again in out-patient department"?-- So, what is the question?

Well - I'm sorry, the other thing I should have pointed out about the document, the top left-hand corner of that note appears the letters "PHO", so that would suggest the doctor concerned was a Principal House Officer?-- Mmm.

Now, what I'm asking you about that is, firstly, did you have that consultation?-- Most probably, yes.

And is that a fair representation about the state of your wound as at that day?-- Well, I'm unclear as to what it's representing.

Well, the words I've just read out to you and the drawing appears to suggest, I suggest to you, that the wound was quite narrow?-- That's not my recollection of the state of the wound at that time. The wound, if you recall, was approximately 18 centimetres long, five centimetres wide and probably about five centimetres deep, and the scarring since closely illustrates that fact, and I had been told that it was a type of wound that would take two to three months to heal and, in fact, took three months.

I tender that document, Commissioner.

COMMISSIONER: Yes. Exhibit 122 will be the document you tendered earlier, the letter of the 22nd of September 2003, from the Barolin Family Medical Centre addressed to Mr Patel, and then Exhibit 123 will be the Outpatient Notes relating to Mr Fleming for the period 2nd of July 2003 to 11th of November 2003.

ADMITTED AND MARKED "EXHIBITS 122 AND 123"

COMMISSIONER: Mr Diehm, I wonder if you could help me with a thought that's gone through my mind that might explain some of the inconsistencies here. It's my recollection from a previous medicolegal case I was involved in concerning the P A Hospital in Brisbane, that it was the practice at that hospital where a patient attended at a particular surgeon's Outpatients clinic where the Outpatients Notes would appear very much like this, "Surgeon Dr Brown", we will say, but that didn't necessarily mean that the patient had been seen by Dr Brown, it merely meant the patient had been to Dr Brown's clinic and might have seen one of Dr Brown's Registrars or junior doctors. I'm just wondering whether you can get instructions and tell us whether there was a similar system at Bundaberg that might explain the apparent discrepancy between Dr Patel's name appearing in the Outpatients Notes and Mr Fleming saying he didn't see him.

MR DIEHM: I think there is some evidence about that, Commissioner, but I will obtain some instructions.

WITNESS: I don't know whether it's appropriate to mention this, but I'm just referring to my medical file and-----

COMMISSIONER: Just wait a moment, let Mr Diehm get his instructions?-- Sorry.

MR DIEHM: Commissioner, in that short time, albeit it a relatively straightforward matter, Dr Keating instructs me that whilst on some rare occasions the duty doctor who consulted with the senior doctor might write the note up, generally speaking if the senior doctor had seen the patient he should be the one to write up the note.

COMMISSIONER: Yes.

MR DIEHM: That, of course, doesn't exclude the possibility that a doctor who didn't see the patient wrote the note.

COMMISSIONER: As I've said on a number of occasions, I don't want to go off after red herrings if there's an innocent explanation, as there may well be. It will save us a lot of time and heartache.

MR DIEHM: Commissioner-----

COMMISSIONER: Mr Fleming did have some comment to make about that though?-- Yes, just in relation to the wound care chart. I don't know where it is in relation to the total file, but it records all my attendances for dressing reviews.

Yes?-- And the last attendance was 7th July 2003, "Dressing Review, wound cleaned", and, "DIG", I think it says, "patient discharged from Day Clinic" and it's signed.

MR DIEHM: I was about to come to that.

COMMISSIONER: Yes.

MR DIEHM: And that, I suppose, Mr Fleming - and it is hard to read some of the writing, I accept - but maybe, I suggest to you, "wound clean and dry", but you would be speculating about that though?-- Well, it may be. It looks to me like "DIG".

I understand what you say?-- But it clearly refers to a wound and it describes the wound as being clean and something.

Yes?-- But it doesn't say-----

And you were discharged from the Outpatient Clinic on that day. That was your last dressing review, wasn't it?-- That's correct.

Thank you. I won't in the circumstances put that document in. It's been accepted what Dr Boyd says. Now, the other document I wanted you to get out of your record, Mr Fleming, is a page for the entry on the 28th of May 2004, which is the date that you came back for review before your wound ruptured?-- Sorry, 2004? You mean 2003?

You're perfectly right though, but as you'll accept, as you will see in a minute, the document is wrong in that it purports to be 28 May 2004 where it is quite apparent it should be 28 May 2003?-- Yes, I have that here somewhere in my records.

In that consultation you will see there it says 28 May 2004 but the next entry is 10th of June 2003?-- Correct.

And the consultation on the 28th of May, you told us before you went there, and we've seen photographs, as I recall it, that show that there was some redness around the area of the wound and you said that Dr Patel told you that there was nothing wrong with you and sent you home. If we can just go back to that entry for 28th of May. Now, the first reference would seem to be - this was the date you had the staples removed, wasn't it?-- Correct.

So that may be what is represented in that first note. Then it says, "No infection."?-- Yes, that's what it says.

It then says, I suggest to you, "some area of erythraemia" - E-R-Y-T-H-R-A-E-M-I-A?-- I don't know what that is.

I suggest to you that's on my understanding a redness, some inflammation in the area of the skin?-- If that's the correct definition I'll accept that.

And then says, "Started on Augmentin."?-- Sorry?

"Started on Augmentin", an antibiotic, Mr Fleming. Did Dr Patel start you on Augmentin on that date? Did he give you a prescription for medication?-- I don't recall that, no.

I tender that document, Commissioner.

COMMISSIONER: The clinical notes, Progress Notes they're entitled, of Mr Fleming from the 28th of May 2003, in fact, to the 18th of June 2003, will be Exhibit 124.

ADMITTED AND MARKED "EXHIBIT 124"

COMMISSIONER: What I am probably now going to do is demonstrate my complete ignorance, but my impression would have been that Augmentin, as I understand it, is an antibiotic. It seems strange to me that there would be a prescription of an antibiotic if there was, in fact, no infection. Perhaps that "no infection" is no infection evident or no puss obviously, something like that.

D COMMISSIONER VIDER: The indication there of the redness around the wound would indicate to me that would be a hint that an infection might be brewing, and so that prescribed antibiotic would be to prevent the infection any further.

COMMISSIONER: Anyway, that will be Exhibit 124.

MR DIEHM: Thank you. Now, Mr Fleming, if I can come to the circumstances of your complaint. When you made your

complaint, you told us about what the various things were, the four items in particular that you were concerned about?-- Yes.

It would be fair to say, would it not, that the thing that was concerning you the most was that you were still bleeding internally?-- There were a number of things that were concerning me. The most concerning at that time was that I'd four admissions to Emergency over the previous period of two months and for severe right abdominal pain and for post-rectal bleeding, and certainly the internal bleeding was - you know, both myself and my GP were very concerned. But the other items were still very fresh in my memory and in my mind and I was sort of caught in a situation where I needed treatment but I did not want to be treated by Dr Patel ever again.

Out of the four items that you detail in your statement, three of them were events or concerned events that had happened by this stage almost four months before?-- That's correct.

And you had not made a complaint to the hospital about those things before this time?-- A formal complaint?

Yes?-- No. Verbal complaints to staff but not a formal complaint.

Yes, all right. The reason for you primarily proceeding to make a formal complaint at this point in time was because of this, I suggest to you, a major concern that you had that you had these ongoing symptoms and they weren't being dealt with?-- That's correct.

And so that when you had your discussion with Dr Keating, I suggest to you, that was the thing that was foremost on your mind?-- It was a primary concern, but I - and I understand why you are asking me this. The fact is that each and every area that I've identified I went through with great care and articulated specifically what had happened and what I needed to happen and why I did not want Dr Patel to ever see me again.

Mr Fleming, you made the observation yourself yesterday that the explanations that Dr Keating gave you with respect to a number of these concerns that you had were identical to the explanations that Dr Patel had given you?-- Specifically with reference to receiving no anaesthetic or morphine, it was remarkable to me and it really stuck in my mind. They were virtually the same words being said by two different individuals.

I suggest to you that what's happened is that you have over time become somewhat confused about the events and have attributed to Dr Keating the statement that Dr Patel, in fact, made to you on that issue?-- That is totally incorrect.

I put it to you that Dr Keating did not say to you that you would not be given morphine because it was expensive or because there was a danger that you could become addicted to

it?-- He most certainly did say that.

COMMISSIONER: Mr Fleming, I know you told us yesterday that you spent a number of years in the Victorian Police Force?-- Correct.

In that career, did you receive training in taking statements?-- Absolutely.

Recording events?-- And if I might address that issue specifically? During the course of my service in the police force, I took literally hundreds of witness statements and literally thousands of what you would call prima facie or allegation-type statements of persons that had committed offences. For example, I was in the Traffic Department for three years and you were pulling up people every day and you would make a presumptive statement or a prima facie allegation as to what you had seen or witnessed, and immediately the first statement made by Dr Keating to me just started alarm bells ringing in my head, because I felt that I wasn't being asked to give a witness statement, I was being asked or interviewed on the basis of being a suspect, if you understand my distinction.

Yes?-- It was a presumptive statement made at the beginning and which caused me great concern, and this is very traumatic for me to have to relive, but it caused me great concern and it is why I took particular lengths to articulate fully the four main points of my concerns, and at every single one of them I was rebuffed or given some ridiculous reply and at the end of it I was just so disgusted because I felt again I'm being victimised.

MR DIEHM: Mr Fleming, I put it to you that Dr Keating did not introduce this conversation to you by saying the words that you have attributed to him in paragraph 23 of your statement?-- He did say those words. He began the conversation with those words or words to that effect having that meaning.

I suggest to you that Dr Keating, when he contacted you, merely commenced it by making an inquiry of you about what your concern was?-- He did not.

COMMISSIONER: Just so I understand, Mr Diehm, what you are putting to Mr Fleming is to the effect that the words about Dr Patel being a fine surgeon and impeccable credentials weren't said in the beginning of the conversation or weren't put at all in the conversation?

MR DIEHM: I will be clear about that, and can I say, Commissioner, lest there is any doubt, this is relying on usual practice, there is some imprecision in the sense of it.

COMMISSIONER: Of course.

MR DIEHM: Mr Fleming, I suggest to you that Dr Keating did not say those words in his conversation with you at all?--

Which words are you referring to?

The words that you attribute to him in paragraph 23 of your statement?-- Could you read them, please, for the record?

"I hear you have lodged a complaint against Dr Patel. I must tell you that he is a fine surgeon with impeccable credentials and we are lucky to have him here in Bundaberg. I understand you are bleeding internally since the operation but this can be caused by many factors."?-- He most certainly did say those words or words with similar meaning.

And I put it to you that Dr Keating was not intimidating, belittling or condescending in his conversation with you?-- I felt like I was being lectured by a headmaster to a naughty student.

Would you say Dr Keating was completely unhelpful in this conversation?-- No, because he arranged for an appointment for ongoing procedures. So to say that he was totally unhelpful is inaccurate, he did arrange follow-up procedures.

In fact, when he phoned you he already had the details of an appointment for you on the 11th of November, didn't he?-- Yes, and he informed me of that.

I would suggest to you that in the conversation that he had with you, he explained to you that the colonoscopy list at the hospital was not a list that a general practitioner could simply refer a patient onto but rather it is necessary to have an appointment in the Outpatients Department so that you could be reviewed by a specialist to be placed on the list?-- My understanding was that I would be seeing Dr Faint who had done the colonoscopy in March.

All right. I'm not talking to you at the moment, and I'm not suggesting to you in these questions that I ask you, Mr Fleming, that he told you that you would be seeing Dr Patel, but did he explain to you that it would be necessary for you to come into the Outpatients Department to see a specialist before you could be placed on the colonoscopy list?-- No, I was told to come into Outpatients to be reviewed and I attended at Outpatients and I saw a junior doctor.

Did he explain to you that a colonoscopy, as it was in your mind to have, was one investigation that was able to be done for peri-rectal bleeding?-- Yes.

But he shall-----?-- Well, I don't recall if he actually said that.

Sorry?-- But I certainly knew that I needed a colonoscopy to try and identify the reason for the post-rectal bleeding. I don't recall him actually stating those words but I certainly knew that's what I needed.

He explained to you, I suggest, that a colonoscopy though

wasn't the only investigation that could be had?-- No, in fact, I was to have endoscopy and colonoscopy and a Barium swallow.

Now, I also suggest to you that he told you that he had looked at your records and saw from your blood tests that the HB - just excuse me, Commissioner - the haemoglobin levels from your blood tests had remained constant and so that therefore there wasn't any urgency in you having the procedure?-- No, he never said that.

That you told him that you needed medical attention and that you thought that it was something that needed to be done soon but you accepted that you would have to wait until the procedure was organised?-- No, I told him that I needed urgent attention and that I had been admitted to Emergency four times and I was still bleeding and was basically begging for the first available opportunity to have the follow-up procedures performed.

See, just to put it completely, what I'm suggesting to you is that he said your haemoglobin levels as shown from your blood tests suggested that there wasn't an urgent need and it would be sufficient for you to wait until the appointment on the 11th of November for you to have a review by a specialist?-- No, he did not say that. I do not believe Dr Keating even looked at my charts before he rang me. Maybe he did. If he did then he would have clearly seen I would have had a wound reopened with no anaesthetic given and he should have been very concerned about that.

I suggest to you that after he explained those matters to you, you acknowledged to him that you understood what was being arranged for you and why?-- I acknowledged that I had to attend Outpatients Department on the 11th of November, yes, clearly stated that.

And he said that there would be no further action in the sense that the primary concern that you had in contacting him or in making your complaint was by the arrangements he put to you dealt with?-- He told-----

COMMISSIONER: Mr Fleming, there's no need to get caught up in all of this. If your evidence is that that's not correct, that's all we need to hear?-- Could you please repeat the question?

MR DIEHM: Yes. He told you in effect that there would be no further action in response to a complaint on the basis that what had been discussed and the arrangements that had been put in place dealt with the primary concern that you had?-- No, he told me that there would be no further action taken other than my booking with the Outpatients Department.

Now, just one final thing for completeness. In terms of the communications for your complaint, I suggest to you what occurred is that when you first phoned you spoke to a lady named Joan, which is, as I understand it - and please check

your statement or your notes as you need - your first contact was with a lady named Joan?-- Yes.

And that you were subsequently phoned by a lady named Judith, who asked you for some further details which are what appear in a handwritten note that's annexed to your statement?-- No.

No, all right?-- Once - when I received the copy of this file, I was surprised to find that the person I identified as Joan was not the person that drafted the Notification of Complaint and I see that the Notification of Complaint has been drafted by another individual, not the Joan that took the complaint.

So you're talking about the Notification of Complaint?-- That form there, it's got a signature that says "J Dooley".

Yes?-- Well, that I've been advised is not the same as the Joan that I spoke to. This is a different lady who's actually typed up this Notification of Complaint.

J Dooley, I can put to you, is a woman by the name of Joan Dooley?-- My understanding is that the person that took the initial complaint was Joan Collins.

Excuse me, Commissioners. I have nothing further, thank you.

COMMISSIONER: Mr Diehm, I appreciate that you don't want to put Mr Fleming through more than is absolutely necessary-----

MR DIEHM: Yes.

COMMISSIONER: ----- but if it were to be suggested that the contents of paragraphs 25, 26, 27 and 28 are inaccurate, I think it's appropriate that he be given the opportunity to respond to that.

MR DIEHM: Thank you, Commissioner. Reflecting on my instructions, for the reason I mentioned to you before about Dr Keating having to rely upon the usual practice rather than actual recollections, that, of course, makes it difficult to put anything too highly to the witness.

COMMISSIONER: Of course, yes.

MR DIEHM: If I can ask you these things, Mr Fleming: with respect to paragraph 26 where you say in the final sentence, "Dr Keating said that it was up to the doctor and not the nurses to decide the best course of treatment", is that meant to be a quote of his actual words or is that the effect of what he said?-- That's a quote of what he actually said, or words to that effect.

COMMISSIONER: You don't pretend to have a verbatim recollection of it?-- No, Commissioner, but-----

But that's the substance of it?-- Exactly, and it was very clear to me in my mind. That was the substance of the words that he conveyed to me.

MR DIEHM: If I were to suggest to you, Mr Fleming, that what Dr Keating would have said to you would have been words to the effect that it was up to the doctors and the nurses together to work out the management of that for you, would that be consistent with what you understood him to say?-- No, that is totally inconsistent, and if you read my medical records you will see that there is several references to discord between the nurses and the doctors in relation to my treatment.

Yes. There's how many references, do you say, to the nurses suggesting something about the suction pump?-- How many times did that occur?

Yes. How many times in the notes do you say there are references to that?-- Well, that's a very interesting point, if I can just have a moment to find the relevant sections. And I say this with the greatest respect to the nurses, and I'll place on record the fact that my wife is a second year nursing student. The nurses did not write any of these issues

into my official notes until after the wound had been re-opened, and they were greatly aggrieved at what had been done to me, and from that point on they started to make notes from the 2nd of June relating to the disagreements over the dressings.

COMMISSIONER: Mr Fleming, I know it's very difficult, but if you can avoid the editorial comment and just tell us what your answer is to Mr Diehm's question, it will be all over for all of us a lot quicker?-- Can I just read directly from the notes?

Yes, please do?-- Second of June, "Nursing care as per care path. DX" - I think that means doctor - "attended at 1000 hours. Dr Patel wants Sorbasan dressing. TDS - discussed same. I/C A/NPC" and then "TILSED - request BD dressings only", then it looks like "I/L" or something, "talk to doctor"-----

If you just identify the date that will be sufficient?-- Okay. Second of June '03 1530 hours, then a following entry by another nurse on 2 June '03-----

MR ATKINSON: Perhaps I can provide the page-----

WITNESS: "Inpatient Progress Notes", and I'd just like to read one sentence where the nurses were trying to address the issue as delicately as they could. It's part of this - part of the notes dated 02/06/03 and it's towards the end and it says, "Patient states that he feels as if the doctors don't treat him adequately and that his wound infection is not getting better and will not. I have suggested to him that he should have a good talk to his doctor in the morning regarding his present care and what he expects in the future."

COMMISSIONER: Mr Atkinson, there's the following page after the one you just handed.

MR ATKINSON: There's another page. That's what the witness is reading from right now, actually.

COMMISSIONER: Yes. I think we should make those two pages together an exhibit. So we've got the entry at 1532 hours and the later entry on the 2nd of June 2003 which commences, "Current dressing unsuitable. Doctor contacted for discussion. I suggested suction dressing, but Dr Patel does not want this", and so on, and then the passage on the next page that Mr Fleming has referred to. Those two pages together, Inpatient Progress Notes, will be Exhibit 125.

ADMITTED AND MARKED "EXHIBIT 125"

COMMISSIONER: Yes, Mr Diehm?

MR DIEHM: Thank you. Commissioner, I'll do this rather broadly for the sake of Mr Fleming, and within the confines of the instructions I have on the matter, I think I'll put it this way: Mr Fleming, I suggest to you that the only subject matter of your conversation with Dr Keating in terms of your complaint was about your problems with respect to continued internal bleeding and symptoms of that nature?-- That is totally and completely untrue.

I have nothing further, Commissioner.

COMMISSIONER: Thank you, Mr Diehm. Just on that last point, Mr Fleming, what seems to be suggested is that having been through the situation you described on the 2nd of June, having your wound opened for several centimetres on the 2nd of June 2003, you then chose not even to mention that to Dr Keating, or possibly that Dr Keating has forgotten being told about it?-- That proposition is totally absurd, I would submit. It was an extremely traumatic event to me personally and it had a great impact on my life for the next six months.

Mr Fitzpatrick?

MR FITZPATRICK: No questions for Mr Fleming, thank you, Commissioner.

COMMISSIONER: Any re-examination, Mr Atkinson?

MR ATKINSON: Just a couple of questions, Commissioner.

COMMISSIONER: Thank you.

RE-EXAMINATION:

MR ATKINSON: Mr Fleming, included in your statement are some typed notes. You've seen them? They're the transcribed notes that we spoke about earlier?-- Yes, correct.

The penultimate page in your statement?-- Yes.

And just to address something that the Commissioner asked of you, you mention in those typed notes - and I appreciate they're someone else's notes, but you've already agreed they accurately record part of the conversation?-- Yes.

You mention the word "dehiscence", or at least the open wound and the discharge, and you mention the excruciating agony?-- Correct.

They were things that you mentioned during a telephone conversation with Joan on the 28th of October 2003?-- Yes.

And is it your evidence that you also mentioned them with the doctor two days later?-- Sorry?

When you spoke to the doctor two days later, Dr Keating, again you mentioned the open wound and the excruciating agony?-- Yes, I can clearly identify in this typewritten transcript all four of the individual items of my complaint.

Just to be very clear, that's a transcript that you obtained from Queensland Health's own records?-- That's right, and I would like to add that I also was of sufficient soundness of mind that - there's a line there that says "was later told problems - Dr Patel scheduled for colonoscopy", which I take it to mean they're referring to Dr Faint's colonoscopy, but anyway-----

And certainly there's a line there, Mr Fleming, that talks about "no anaesthetic open incision up"?-- Absolutely.

You think that still might have been clear in your mind two days later?-- Absolutely, and-----

That's okay, Mr Fleming?-- Thank you.

May this witness be excused?

COMMISSIONER: Yes, thank you, Mr Atkinson. Mr Fleming, you are excused from further attendance. You leave with our very sincere thanks for coming to give your evidence, and also for the support that you've provided for fellow patients through the organisation of which you're cofounder?-- Thank you, Commissioner. I'd like to say on behalf of myself, personally, that it has been a tremendous privilege and honour for me to have played some small part in helping so many people, and I've seen people change from being victims to once again feeling like they're human beings again, and I've been able to share in their grief, and some of our members are still dying, and we share with them in their grief, and I thank the Commission from the bottom of my heart. Thank you.

Thank you, Mr Fleming.

WITNESS EXCUSED

COMMISSIONER: Who do we have next, Mr Atkinson?

MR ATKINSON: Mrs Kemps.

COMMISSIONER: I don't think we've got copies of her statement. Ah, they've just been handed to me. We might take a five minute break. It will give us a chance to read these.

THE COMMISSION ADJOURNED AT 3.25 P.M.

THE COMMISSION RESUMED AT 3.37 P.M.

MR ATKINSON: Commissioners, the next witness to be called will be Aleida Judith Kemps, Mrs Kemps, and the matter is all about the patient Mr Gerry Kemps who, Commissioners, you will recall, was the subject of an oesophagectomy. Perhaps because I'm calling the witnesses somewhat out of sequence, I might just give a very short overview of what happened in the matter.

COMMISSIONER: Yes.

MR ATKINSON: Mr Kemps was born on 14 August 1927. He immigrated from Holland to Australia. He was married with three children and he moved into the Bundaberg district in 1965. Mrs Kemps will say that he was generally in very good health until about 2002.

In 2004 he was looking anaemic and he was admitted to the general ward of the Bundaberg Base Hospital. When he went there he met with an internal medicine specialist, a physician called Dr Dawid Smalberger who was, of course, under the line management of Dr Miach. Dr Smalberger did a number of tests. He arranged for a CT scan, a biopsy and also an endoscopy, and he worked out as a result of those tests - and this is about the 8th or the 9th of December 2004 - that Mr Kemps was suffering from a very large cancerous mass at the bottom of his oesophagus. He also worked out from the pathology that the mass protruded beyond the sphincter, below the sphincter, and that there were other indications of masses in the stomach or the lungs.

That evidence that Dr Smalberger will give is corroborated by two other doctors, first of all by Dr Fitzgerald who will give evidence on this issue having reviewed the notes - that's the Chief Health Officer from Queensland Health - and second of all by Dr Woodruff. Dr Smalberger will say that at this stage it was very clear to him that there was a strong likelihood that the cancer in the oesophagus had become metastatic, and for that reason it seemed very clear to him that the proper procedure was that the patient be transferred to Brisbane and he then have conservative care in the nature of radiotherapy or chemotherapy and a stent.

I should say that the initial complaint was that when Mr Kemps went to swallow the lump was stopping him from digesting his food.

In any case, Dr Smalberger will say he was firmly of the view that there was probably a metastatic cancer, as I say, and moreover, that given that Mr Kemps was not a young man any more, it made some sense in all the circumstances that there be conservative - or effectively palliative care.

The problem was this: when you're a physician or an internal medicine person and you speak to people in Brisbane in surgical wards and say, "I'd like to transfer this patient", Dr Smalberger's experience was that the surgeons in Brisbane would say, "We need to know that this has the support of your local surgeons, that it's not a problem that can be handled locally."

Dr Smalberger says that faced with that likely consequence if he was to call Brisbane, he sent the patient, Mr Kemps, and his records, to the Surgical Ward at Bundaberg Base Hospital and, effectively, expecting that they would support the view he had taken. He will also say that at that stage he explained to the Kemps family that that was what he proposed to do, there would be a transfer to Brisbane. Mrs Kemps will say that she was told that. She expected the transfer to happen.

But then Dr Patel got involved. He said that the operation in Brisbane was really just patch-up work and he could do something much more thorough, an oesophagectomy, and in the event, that operation was carried out on the 20th of December 2004.

Commissioners, you'll hear from a number of medical practitioners who were present during the operation, suffice to say that it went very badly and there was massive - there was considerable bleeding on the first operation. Notwithstanding that Dr Patel closed up the patient and sent him to the ICU and did a different operation on a different person, he returned later on and took Mr Kemps back to the operating theatre. When he did that, he wasn't able to stop the bleeding and eventually, although Mr Kemps was again closed up and returned to the wards, he died of bleeding on the 21st of December 2004.

Commissioners, you'll hear from Dr Berens in particular, who was the anaesthetist in the operation, that he then approached Dr Keating with Dr Carter to voice concerns about the operation and to voice concerns that the matter should be perhaps referred to the coroner, and Dr Berens' evidence will be that there was not much interest in the idea of investigating the matter further.

This is a matter also where there's a Death Certificate, and the Death Certificate was not signed by Dr Patel. I should say that the witnesses will say it's usual for the Death Certificate to be signed by a junior doctor rather than the operating doctor. The Death Certificate suggests that Mr Kemps died from something called refractory shock rather than what Dr Patel suggested, which was bleeding to the aorta.

Commissioners, you'll hear from Dr Kariyawasam who was present in the operation, and he will say that Dr Patel told him that there was no need to refer the matter to the coroner because the parties were all aware of the cause of death, and in those circumstances one doesn't need to refer the matter to the coroner.

I might then at this point, unless there are particular questions, call Mrs Kemps.

COMMISSIONER: I do have two questions. One is the signatory for the Death Certificate, Dr Athanasiov, is it intended to call that doctor?

MR ATKINSON: It is. We have a statement that Queensland Health provided yesterday from Dr Athanasiov, and he's in Bundaberg and it is intended to call him next week.

COMMISSIONER: And my second question is whether this is one of the eight cases identified by Dr Woodruff.

MR ATKINSON: It is. It is, Commissioner.

COMMISSIONER: Thank you.

MR ATKINSON: I call to the stand, then - oh, there she is - Aleida Judith Kemps.

ALEIDA JUDITH KEMPS, SWORN AND EXAMINED:

COMMISSIONER: Mrs Kemps, please make yourself comfortable. Do you have any objection to your evidence being photographed or filmed?-- No, okay.

MR HARPER: Commissioner, I might indicate one matter of instructions which Mrs Kemps gave me, which is on page 6 of one of the statements tendered, the police statements. There is reference to the place where her husband is buried. She has indicated that she would ask that there be a suppression order over that. It would be a matter of some distress to her if that were to become public.

COMMISSIONER: It also appears in the death certificate itself, and I will direct that evidence relating to the location of the grave of the late Mr Kemps not be published outside these proceedings.

MR HARPER: Thank you, Commissioner.

CLERK: Excuse me, Commissioner, Mrs Kemps was unable to hear that particular point.

COMMISSIONER: Mrs Kemps, at the request of counsel, I have made a direction that essentially the press and media aren't to disclose where your late husband is buried?-- Okay.

So that your family's privacy is protected as regards his burial site?-- Thank you. After I read my statement the other day and I came to the end and I saw it was mentioned where he was buried, all of a sudden I thought, "I don't want them to take photos or", you know, "televise it" - where he is buried.

That's understood. Thank you?-- Thank you.

MR HARPER: Keeping in mind that direction, I wonder if you would also give the media here the direction - I'm not sure if the non-publication order extends to them only getting that information in the course of these proceedings. It may be what's necessary is some sort of caution for them not to go out to the site and photograph it.

COMMISSIONER: I'm sure that - put it this way: the press and media have been extremely responsible in reporting these proceedings to date and Mrs Kemps has made her position very clear and I would simply urge everyone, out of ordinary human compassion, to take into account her preference that there be no publicity as to her late husband's grave site.

MR HARPER: Thank you, Commissioner.

MR ATKINSON: Witness, would you tell the Commissioners your full name?-- Aleida Judith Kemps.

Mrs Kemps, you have given a statement to the Commission?-- Yes, I have.

Do you have a copy of the statement with you?-- Yes, I have it here.

Would you look at this signed original version?-- Yes.

Mrs Kemps, is that your name and your handwriting?-- That's right.

Is that a statement that you prepared for the Commission?-- Yes.

Are the contents of the statement true and correct to the best of your knowledge?-- To my knowledge, yes.

I tender that statement, Commissioner.

COMMISSIONER: Yes, the statement of Aleida Judith Kemps will be Exhibit 126.

ADMITTED AND MARKED "EXHIBIT 126"

MR ATKINSON: Mrs Kemps, can I ask you to turn to the police statement which is at about the fourth page of your statement? Do you see that statement?-- I turned it over. Sorry, my apologies. Yes.

Now, you should find in the top right-hand corner the date 6 May 2005?-- That's right.

Is this the statement that you gave to the police on 6 May 2005?-- I gave it to the police on that day; is that what you are asking?

Yes?-- Yes.

Now, if I can just take you through the statement slowly, if you don't mind, Mrs Kemps?-- Okay.

You met your husband in 1953?-- Yes, I did.

And you were married in the following year in St Patrick's Cathedral in Melbourne?-- That's right.

You have three children with your husband?-- Yes, three.

One of them, Bernie, is in Court today?-- Bernie, yes. The youngest.

I'll just take you straight to the following page, if you don't mind. You moved to Bundaberg in 1965?-- '65, that's right.

Can you tell me generally about your husband's health over the last 20 years?-- Well, besides his blood pressure, he was always very healthy. He used to go - we used to go bush walking, tennis, golf, everything.

Now, you mentioned on page 2 of your statement at the third paragraph that he started showing some signs of sickness in 2002?-- Yes. Well, he had terrible pains in his neck - or in his - the upper part of his body and he didn't know what it was from, and he couldn't stand it any longer. It was the weekend, so I took him to the Bundaberg Base Hospital, and they found it was just a pinched nerve in his neck, but because of all of - because they thought it might have been a heart attack, because being in his left arm - but they went right through him and the hospital - they found an aneurysm.

In his stomach?-- In his stomach, yes.

Now, in consequence, he was operated upon by Dr Thiele?-- By Dr Thiele, that's right.

And he developed pneumonia and he was flown to Brisbane?-- Flown to Brisbane, yes.

But he recovered well?-- Yes, yes, definitely.

Now, can I take you to the next page of your statement?-- Yes.

You mention - I might just take you straight to the second paragraph. You talk there about a date 3 December 2004-----?-- Yes.

-----when you noticed that your husband, Mr Kemps, was looking anaemic?-- Yes, but I have to go back a little bit because we received - why it all happened, we received a letter - it was a government letter - that he was entitled to a free medical, and I rang the clinic and they made - they had one doctor put aside - not our normal doctor - but another doctor put aside, Dr Prerera, to check him out, and he had to bring a urine sample, and a few days later, Dr Prerera - he rang us and he was not happy about the urine sample. He wanted Gerard to come back in again, and he gave him more tests to do over a full week. The following day I said to - we were having lunch. We were sitting there and I looked at him and I said, "You look yellow. You look anaemic to me." I said, "I'm not happy about this four weeks of waiting.", because he was sort of slowing down and he was getting tired very quick, and I said to him on Monday - this was on the Friday - on the Monday morning, "I'll ring our own doctor, Dr Crane.", which I did, and I took him for an appointment in the morning, and as soon

as she saw the urine sample or the test of it, she rang straightaway - she rang the hospital, and Dr Miach was on that day-----

Can I slow you down there. Dr Crane, I understand, Mrs Kemps, told you that your husband was suffering from internal bleeding?-- Internal bleeding, that's right.

And then she-----?-- Then she rang the hospital, and Gerry wanted to go home first. She said, "No, you go straight to the hospital." So, we did not see Dr Miach, but - well, the ones in out-patients, they knew that he was coming, and they put him in and they put him in medical ward, and they gave him a blood transfusion straight off, and they started doing other tests.

Now, do you recall who the doctor was who was in charge within the medical ward?-- No, I didn't know at all.

So, you had a number of tests, and you mention in your statement that there was a CAT-scan for Mr Kemps?-- Yes.

And there was also an endoscope procedure?-- Well, he was there for a few days. They had done tests and - Gerry, being a very social man, he was always talking to everybody - you know, loved people - so he was - would just talk to everybody in the ward, and laughing, and then a little nurse came in and she said to us - she said, "Gerry, you two are happy under the circumstances." He said, "What circumstances?" We didn't know what she was talking about, and she said, "Oh, don't you know?" We said, "We don't know anything.", and then she raced out and then Dr Smalberger came in and he told us that he had done the endoscopy and that's when the camera - whatever they used - touched a cancer, it started bleeding straightaway, so it was - yeah - but he didn't tell us at that time, he just said that, but he didn't tell us what I learnt later on when I went to Dr Fitzgerald through Gerry's records that it had already started to spread and he found some spots on his lungs as well.

We will come back to that - what you learnt from Dr Fitzgerald. But when you are speaking to Dr Smalberger at this time, he has explained to you that in the course of the endoscopy, they found a mass, and when the endoscope touched the mass, it started to bleed?-- It started bleeding already, so it was very delicate, apparently, and he said he wanted to send Gerard to Brisbane for a keyhole surgery.

Now, in your statement, Mrs Kemps, at the last paragraph on page 3, it says, "Once the cancer was found, the doctor who did the endoscope told me that Gerry was to be flown to Brisbane for keyhole surgery to remove the cancer."?-- Yes, but we wiped it later on. We did wipe it. It was wiped.

I understand your position. The words, "to remove the cancer"?-- He did not say that, no.

So, Dr Smalberger spoke about a transfer and keyhole

surgery?-- Yes.

But he didn't suggest that it would fix the cancer altogether?-- He said - so, he didn't explain any further, so we just presumed that was for that, yes.

So, at that point you were expecting a transfer to happen?-- Yes, we were waiting another few days, and - because we thought we were just waiting, you know, for him to be removed to Brisbane, and then, all of a sudden, Patel came in and he said he was Chief Surgeon at the hospital and-----

I will ask you to slow down there. Before you saw Dr Patel, did you change wards from the medical ward to the surgical ward?-- No, not until after. He was still in medical when Patel came in, and he said to us - he said - he said, "Keyhole is only patchwork", and if he was to do it - he drew out for us exactly what's - you know, what he was going to do - take part of the stomach away, part of the oesophagus, and then put it all back together again, and the way he talked he was very sort of convincing. I mean, I had no qualms at all about his - you know, his capabilities, because, you know, I thought - well, they all have to have tests done or tests to, you know, to show that they are capable of working here, all the overseas trained doctors.

Just to go over what Dr Patel told you?-- Yes.

He told you, is this right, that they were going to resect the oesophagus and rejoin the stomach?-- And rejoin it all, yes.

And that's an operation that you now understand is called an oesophagectomy?-- Mmm. I heard it now.

That word wasn't mentioned to you at the earlier time?-- No, it wasn't. But he said - oh, he said - he said, you know, "It's a big operation", he said, "But they have done hundreds of them." I should have woken up then.

Did he say "they" or "he" had done hundreds of them?-- He had done hundreds of them.

Right. Did you have any discussion at that time about the transfer that had been on the cards?-- No, because Gerry was sent straight from the doctor's appointment to the hospital. He kept on saying, "But I haven't been home. I haven't been home. I want to be home. I want to play the piano. I want to" - you know, just - Patel said to him - he said, "Well, you can" - he said, "Well, you can go home on Friday and Saturday, but be here on Sunday early, at half past 8", or something, "because we have to do some more tests." And so Gerry came home - you know, Friday, Saturday he was home, and he had a lovely time.

Right?-- And he - he was back in on Sunday but he was then in the Surgical Ward.

Right?-- He was admitted to the Surgical Ward there.

My question was really this. You had already been told by Dr Smalberger that Mr Kemps was to be transferred to Brisbane?-- Yes, but he said, "Well, we have decided to do it here because Brisbane's coming" - and he said, "I'm going on holidays soon and I have got to be at least nine days after the operation to keep a check on him". So, I mean, he didn't, you know - so, we just thought, well, it was the same or the doctors - you know, who am I?

Can you tell us, was Dr Patel an impressive sounding person?-- I beg your pardon, sorry?

COMMISSIONER: Did he come across to you as being impressive?-- Yes. He sounded really - you know, fairly confident of himself.

MR ATKINSON: Dr Smalberger, you mentioned earlier, did you witness any discussions between Dr Smalberger and Dr Patel?-- That's the only time I have seen Dr Smalberger, when he came in to tell us that Gerry had the cancer.

Right. So, you were saying that you took Mr Kemps home for a couple of days, for the weekend?-- Yes. He was home for a few days. All the kids came. He had a lot of visitors, played the piano. He had a lovely time.

Now, you brought him back to the hospital on the Sunday?-- On the Sunday morning, yes. I stayed with him all day, and Dr Patel told me because we didn't see Patel on the Sunday, but he told me when he was - he - that time when he saw Gerry, he told me - he said, "Well, the operation will be early in the morning.", and he said "It's no good coming in because you will only be waiting." He said, "As soon as the operation is over I will give you a ring."

Now, Mr Kemps was 77?-- Yes.

Did Dr Patel discuss the risks associated with the operation?-- No. No, not really. He - well, he did - no, not really. He was just confident. He said, oh, you know, "We are going to do this and that and one thing and another", but later on that same day another doctor came in, and we both had a big laugh about it really because he was talking to us and - oh, well, all right, yeah, and then he left. Well, I looked at Gerry, Gerry looked at me, and I said to him, "What was he talking about?", and he said I thought - I was hoping - he was Indian or whatever he was, I don't know - and we couldn't understand him and I thought Gerry could understand him and he thought I could understand him, so we don't know what - he was in for us or what his name or what he was in - function, we don't know.

Do you think that was Dr Athanasiov?-- I couldn't tell you. We never understood a word of what he said.

All right. When you had discussions about the operation with Dr Patel, was there any discussion about the internal bleeding that your general practitioner had picked up?-- No, no. No, he didn't, because we thought it came from the - from the cancer.

Now, you bring Mr Kemps back to the hospital on Sunday?-- On Sunday, yes.

Right?-- He was just there all day. I don't think they did much. They were worried about his kidneys. They sort of - he had to take something to isolate the kidneys, as they called it but-----

All right. So, the operation happened on Monday morning?-- Yes, that's right. I was home and about 2 o'clock in the afternoon but Patel rang me and he said - oh, he said he was - you know, real cheerful. He said, "It was a great success. We have got it all", and - oh, he said, "There's a little bit of bleeding there but that's nothing."

COMMISSIONER: Mr Atkinson, sorry to interrupt you, is anyone expecting they will wish to cross-examination Mrs Kemps?

MR DIEHM: No, Commissioner.

MR FITZPATRICK: No, Commissioner.

MR MacSPORRAN: No.

COMMISSIONER: Because I think it would be very unfortunate to keep Mrs Kemps over the weekend. Her statement is very comprehensive.

MR ATKINSON: It is.

COMMISSIONER: Mrs Kemps, I wonder, you have provided us with a statement, initially to the police and now to this Inquiry, which is very detailed and comprehensive. Do you feel that this tells us your entire story?-- Oh, yes.

I don't want to put you to the distress of having to go through it all again in front of all these people when your story is fully covered in the statement. Is there anything that you feel you need to add or-----?-- I don't think so.

Well-----?-- Do you think so?

MR ATKINSON: See, I guess what the Commissioner is asking is is there anything you would like to say while you have the floor?-- I think - I think it's all right. Unless you want to hear more about what happened in the ICU when I came there?

COMMISSIONER: Well-----?-- You have to go.

No, no, no, it's not that. Is there really anything that isn't in your statement, because we promise you, we've-----?-- No, because it says in this statement - you know, that the nurse took me aside and told me that he was in - you know, on life support as soon as I arrived, and - well, really - and later on he took him back in theatre again, operated on him again, and he said, oh - you know, I had my two sons with me and he said, "Oh, you can go because it's past 6 o'clock", and he said, "You can go out and get a bite to eat.", so we went to Subway, Sugarland. We weren't there five minutes and he rang us and we had to come straight back and but - I mean, the only thing when I came in ICU, most important thing, that when - he goes - when I went in there was this nurse. She ws standing there pumping the blood into him. She was really pumping it into him because it wasn't going fast enough. He was bleeding profusely.

MR ATKINSON: One of things, I imagine, Mrs Kemps, you find distressing is that when you spoke to Dr Fitzgerald subsequently he explained to you that there didn't seem to be a good clinical reason for the operation?-- No. Even our own GP said - she said an operation like that should never have happened in Bundaberg, and Dr Fitzgerald said there's - if he'd been sent to Brisbane he would never have been operated on. They would have put him straight on radiation or the chemo or whatever.

D COMMISSIONER VIDER: Mrs Kemps, can I just ask you a little bit about the Intensive Care Unit?-- Yeah.

And you just made a statement that you went into the Intensive

Care Unit and a nurse was squeezing blood out of a bag?-- That's right, into him.

And blood was coming out of Mr Kemps?-- They pumped 27 bags of blood into him.

What did Dr Patel tell you about that bleeding? You said initially the phone call said there was a little bit of bleeding but nothing to worry about?-- There was nothing to worry about. That's all he said.

Now, we have Mr Kemps going back to the operating theatre?-- But when I - no, and then when I came in the nurse told me he was on life support and that's when I came in, they were pushing it into him. So he was already bleeding, he - profusely when he told he it was just a little bit of blood.

COMMISSIONER: Did Dr Patel speak to you again after that?-- Well, he called us because we had to take him back in again and - well, when - we came back from - because he'd rang us up to come back, he said to us - he said - "Well, I take the spleen out", and - because at that time he said, "Oh, take him back in. I will take the spleen out. That's got to be the only reason why he's bleeding", and he said he took it out but there was no - that was all right, and he had a look at his lungs and they were all right. He said, "Oh, it comes from the heart.", he said, "And he won't last the night."

D COMMISSIONER VIDER: Did Dr Patel mention at any stage to you that he had nicked the aorta?-- He said, "Oh, might have nicked something." That was never mentioned, the aorta or anything, no.

So the aorta is mentioned on the Death Certificate?-- Yeah, but he didn't mention the aorta in name to us.

No. You didn't understand that a major blood vessel-----?-- Yeah.

-----had been damaged?-- No. No, I didn't know. I couldn't believe it.

MR ATKINSON: Just a couple of extra questions, Mrs Kemps. When you were speaking to Dr Patel prior to the operation, was it ever suggested to you that bleeding to the aorta was one possible or likely consequence of the operation?-- I didn't quite get it, the question.

Did Dr Patel ever tell you prior to the operation that something like this could happen?-- No, no.

All right?-- No, he didn't. No, he could do it, he had done it all, he knew how to do it.

And after the operation did anybody ever suggest to you that there should be a Coronial Inquest?-- I had never been in a situation like that. We never - ourselves, we never thought of it because we didn't know how procedures like that go. We don't know.

COMMISSIONER: Did Dr Patel or anyone ask you for your opinion as to whether or not there should be an inquest?-- No.

MR ATKINSON: Now, you learnt subsequently from the nursing staff that things had been a little irregular in the operation?-- Well, it was just - I don't know, the Intensive Care Ward already there was sort of a - looking back there was a sort of body language. They were sort of - as if they didn't want to look at us or they were just trying to avoid us or - especially the night nurse, he was a male nurse, I don't think I exchanged 10 words with him.

In other words, you are saying there was a certain sense of embarrassment or shyness?-- Yeah, I don't know. It was funny because, well, as I say, two years before he had been in ICU and they were all the time to me, "Oh, would you like a cup of coffee? Would you like a cold drink? Or would you" - you know, they were very concerned, but this time they sort of just ignored us.

Now, after this was all over, did you ever think about making a complaint?-- No, no, no.

No. Thank you, Mrs Kemps, that's the evidence.

COMMISSIONER: Mrs Kemps, you, of course, have our very deepest sympathy for your loss?-- Thank you.

But also our thanks for coming in to give evidence, and speaking only for myself, my complete admiration for the courage that you've shown us all in coming here?-- We were

married for 50 years in October, two months later he was dead. I mean, I can't just sit back and let it go, can I?

No?-- You have to do something. I owed it to him.

Thank you so much for your time?-- And, please, can I ask you, Commissioner, please-----

Yes?-- -----get Patel here and do your utmost to get him here because something has to be - well, he needs what he deserves, but also he will do it somewhere else again and all of these other people, they will go through the same pain we are going through. So, please, he has to be stopped, he has to be stopped.

I understand. Thank you. Ladies and gentlemen, we will adjourn now and resume at 10 o'clock on Tuesday morning.

THE COMMISSION ADJOURNED AT 4.13 P.M. TILL 10.00. A.M., TUESDAY, 5 JULY 2005