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SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, 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

BRISBANE

..DATE 25/07/200

..DAY 26

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THE COMMISSION RESUMED AT 10.02 A.M.

MR M C CHOWDHURY (instructed by Hunt & Hunt) for Mr Peter Leck

COMMISSIONER: Mr Andrews.

MR ANDREWS: Good morning, Commissioner. Before calling Dr Anderson to the stand, I should announce that it is proposed that next week on Tuesday, Wednesday and Thursday, the 2nd, 3rd and 4th of August, that you should hear evidence in Townsville. Those dates have been selected to meet the convenience of counsel for Mr Leck and Dr Keating who, on those days, will be appearing in Brisbane in another matter.

COMMISSIONER: A related matter?

MR ANDREWS: A related matter.

MR DIEHM: I am indebted to Mr Andrews and the others responsible for making those arrangements, Commissioner.

COMMISSIONER: Thank you.

MR ANDREWS: I might say that one of the witnesses whose name has been notified to some of the parties as a witness likely to be called in Townsville was a Dr Sam Baker, but it appears that Dr Baker could potentially have evidence to supply that may relate to Mr Leck, and for that reason it's proposed not to call Dr Baker unless Mr Leck's counsel is available to listen to that evidence and to cross-examine.

COMMISSIONER: Well, you might liaise with Mr Leck's counsel about that. Obviously we want to make sure that there's every opportunity to undertake appropriate cross-examination, but it may be possible, for example, for Dr Baker to give most of his evidence in Townsville, and then if he has to come to Brisbane for cross-examination, to do that as expeditiously as possible. I'll let you-----

MR ANDREWS: That's certainly worth pursuing.

COMMISSIONER: Yes.

MR ANDREWS: Commissioner-----

MR CHOWDHURY: I'm sorry to perhaps interrupt. I should announce my appearance. I'm appearing for Mr Leck in the absence of Mr Ashton this week, so as a matter of courtesy I'm advising the Commission of my appearance today and for the rest of the week.

COMMISSIONER: Yes, thank you, Mr Chowdhury.

MR CHOWDHURY: Thank you. Just on the point that's just been raised, if there is a need, I might be available to go to Townsville next week. That's something I'll have to discuss with my instructing solicitors and Mr Ashton.

COMMISSIONER: I wouldn't want to put Mr Leck to the potential disadvantage of not having his, as it were, lead counsel available, if that's his preference.

MR CHOWDHURY: Yes. Thank you.

MR ANDREWS: The parties were notified that this afternoon it was likely that a Dr Ray would be called. Dr Ray is indisposed today and Queensland Health are making efforts to supply one or two other witnesses so as not to waste time this afternoon.

COMMISSIONER: Splendid.

MR ANDREWS: For the interests of the parties, those witnesses, if they can be supplied, would be Glen Tathem and Adam Tozer, and perhaps Janette Young.

COMMISSIONER: Thank you.

MR ANDREWS: I call Dr Peter Anderson.

MS GALLAGHER: If the Commission pleases-----

PITRE EDWARD ANDERSON, SWORN AND EXAMINED:

COMMISSIONER: Please be seated, Dr Anderson. May I inquire whether you have any objection to your evidence being filmed or photographed?-- No, no objection.

COMMISSIONER: Thank you, doctor.

MS GALLAGHER: If the Commission pleases, I seek leave to appear for Dr Anderson, a member of the AMAQ.

COMMISSIONER: Such leave is granted.

MS GALLAGHER: Thank you, Commissioner.

MR ANDREWS: Commissioners, if you do not have copies of Dr Anderson's statement, they are being obtained now.

COMMISSIONER: Thank you.

MR ANDREWS: Dr Anderson, what's your full name?-- Pitre Edward Anderson, P-I-T-R-E Edward Anderson with an O.

Dr Anderson, you have prepared, haven't you, a statement which is dated the 31st of May 2005 with 14 exhibits?-- I have.

The facts recited in that statement, are they true to the best of your knowledge?-- They are true to the best of my knowledge.

And the opinions you express in that statement, are they honestly held by you?-- They are honestly held.

Doctor, you are a Fellow of the Royal Australasian College of Surgeons and a Fellow of the Royal College of Surgeons in Edinburgh?-- I am.

And you were so before you moved to Bundaberg in 1994?-- That's correct.

You commenced work in 1994 as the Director of Surgery at the Bundaberg Base Hospital?-- I did.

And in June of that year Dr Brian Thiel was appointed Director of Medical Services?-- Correct.

And in February of 1995 Dr Nankivell commenced work at that hospital also?-- Correct.

And Dr Nankivell was, like you, a Fellow of the Royal Australasian College of Surgeons?-- Correct.

Now, a Dr Strahan also worked from 1994 to about 1999 at that hospital?-- That's correct.

Dr Strahan was himself a Fellow of the Royal Australasian College of Physicians. Do you recall that?-- That's correct, mmm hmm.

Do you remember those years before you initially left work at that hospital - now, you did leave New Zealand about 2000, did you not?-- That's correct.

Can you say whether the hospital's surgical department was operating efficiently?-- Yes, it was a very efficient department. It built up over those first five years with the help of Dr Thiele and Dr Nankivell into a department which performed a lot of surgery. It also reached standards acceptable to the Royal Australian College of Surgeons to allow their both junior and senior trainees to rotate through the hospital for part of their formal training. That required a number of criteria which I have listed in the statement.

Among the criteria that enabled accreditation by the College for persons to train there, would the primary criterion have been the availability of persons suitable and willing to supervise the trainees?-- Absolutely.

And at the time there would have been three Fellows of the College, Dr Thiele, yourself and Dr Nankivell-----?-- That's correct.

-----able to provide supervision?-- Yes, we were the supervisors.

Within your statement at paragraph 5 you express your own opinion that there were some periods of administrative incompetence at the hospital. You don't, however, identify the period of administration about which you hold that opinion, and one notes from your statement that you were there for many years. When do you regard the administration as being incompetent?-- I think that period started with the coming of Mr Leck to the hospital, and Dr John Wakefield who was the Director of Medical Services. Prior to that we had Bruce Marshall and Barry Doolan who were in administration, and they seemed to run a much fairer organisation.

Now, you refer in paragraph 7 of your statement to numerous suspensions and inquiries, but you name - or identified four persons. Are they the numerous persons?-- Yes, they are.

One of those, of course, was yourself?-- That's correct. There are a good deal of other inquisitions that went on which I haven't numbered, and I can't give you details of those.

COMMISSIONER: Can you tell us the types of inquisitions that you're referring to?-- The ones that I've listed relate to Dr Marsh May who was the psychiatrist, and he wanted to make some simple structural changes to the Department of Psychiatry. He couldn't get the support of administration and a dispute arose, and finally a grievance was brought against him by one of the staff in the department which led to a complete breakdown of the department and his resignation.

MR ANDREWS: He'd been a hospital psychiatrist for 20 years. Is that correct?-- That's correct.

Another was a Dr Malcolm Stumer?-- That's right.

A staff obstetrician and gynaecologist. Are you able to recall what led to his departure?-- There were some complaints made by other staff against Dr Stumer and he was subsequently put - he was subsequently suspended. The problem of his suspension was that Queensland Health put a lot of pressure on him to resign and disappear, and for a good number of months he was never actually provided with the details of the complaints. That's not natural justice as I understand it.

When did Dr Marsh depart?-- That was very early in the time I was there. I would say '95.

So his departure was at a time when you regarded the administrators as competent.

COMMISSIONER: Is that right, doctor?-- Who was the administrator at that time?

MR ANDREWS: I'm not sure. It's - Dr Thiele, for argument sake, began in 1994?-- Yes, I think it must have been

subsequent. I think Mr Leck was the Chief Executive Officer by the time Dr Marsh resigned.

I see. Dr Stumer's departure, do you recall who the administrator was?-- Mr Leck and John Wakefield, Dr John Wakefield.

And you've mentioned Chris Royan as an administrative officer who was suspended. Do you recall when that was?-- I think that was subsequent to Dr Stumer's resignation.

And is there something about his suspension that causes you to regard it as inappropriate?-- I think the fact that the charges weren't provided to him for months and months is a miscarriage of justice, and he was left in a position of limbo, trying to get information from Queensland Health.

Is it the case that Dr Stumer was suspended on full pay for two years?-- It is.

Now, during the time when you, Dr Thiele and Dr Nankivell built up, as you say in paragraph 9, a strong surgery department, among the people you trained, do you recall a Dr Sam Baker?-- I do.

And Dr Baker, do you recall, has subsequently obtained a Fellowship of the Royal Australasian College of Surgeons?-- He has, yes.

And for a short time Dr Baker returned to the Bundaberg Base Hospital?-- That's correct.

With his specialist qualifications?-- Yes.

Now, it seems that the hospital lost its accreditation to train persons for the Royal Australian College of Surgeons?-- It has.

Did that come about because it lost sufficient persons to give training?-- That's right. I think two full-time specialists - Australian trained surgeons are required to have trainees rotating through the hospital.

COMMISSIONER: Doctor, am I right in understanding that there are advantages to being a training hospital beyond the prestige, if you like, or the glory of having that status, in that it gives research opportunities, opportunities to share ideas with other people involved in training? There are all sorts of flow-on benefits, as it were, to the hospital?-- There are indeed, yes, particularly in education programs. The trainees do prepare and present a lot of - at a lot of the meetings, and this is usually at a very high quality. They also are involved in the audit process which, according to their experience, becomes of high quality. The other advantage is that they also can share in the afterhours call, and they have responsibility for managing cases, to some degree at least.

COMMISSIONER: I guess like a lot of vocational training the trainers actually learn as much or more than the trainees?-- Absolutely correct.

MR ANDREWS: Is it an advantage for the staff specialists or VMOs to have competent trainees at the hospital?-- It's a major advantage.

Do the trainees have the opportunity to assess emergency patients?-- They do, and that's one of the very major benefits, to have someone who has experience and knowledge to assess and sort out the patients in casualty and initiate early and appropriate treatment, and then call the specialist on call to come and confer and proceed to surgery as necessary.

And the trainees, would they also, if they are more competent, be in a position to relieve some of the workload for the specialists?-- They are, yes. The senior trainees are within a year or two of becoming specialists, and they're certainly competent to perform a number of surgical procedures unassisted.

And there are different levels of supervision that are provided to trainees in accordance with the level of their experience and competence. Is that correct?-- That's correct, yes.

And one level of supervision permits trainees to perform surgical work without the accompaniment of a specialist. Is that the case?-- That's correct, but there's also a specialist in my time who is on call to come and assist the trainee if there are any difficulties.

Is one level of supervision a level whereby the specialist isn't necessarily within the hospital precincts, but available to attend at short notice?-- Yes, indeed.

You've spoken at paragraph 11 of your statement of the need when maintaining the status as a surgical training hospital-----?-- Yes.

-----to have appropriate education programs?-- Yes.

Can you give examples of such programs?-- Yes, we had a weekly clinical meeting, and these meetings consisted of an audit program, a case presentation on a subsequent week, we had a pathological - a pathologist presentation on the third week and discussed the clinicopathological implications of cases, and we had a - what was called a journal club in which journal articles were reviewed and presented to the meeting.

I notice at paragraph 11 you speak of a peer review process?-- Yes.

Who was reviewed and who were the peers?-- The audit program depended on a computerised program. So all cases were entered into - all cases that were operated went into the audit

program. We had to complete the forms and then they were processed and presented to the meeting. At that meeting the specialists within the hospital were there and the trainees, but also there were a number of private surgeons who used to attend those meetings and provide the peer review.

Do you mean to say that during the time that you were there with, for instance, Dr Thiele and Dr Nankivell-----?-- Yes.

-----that there would be persons employed outside the hospital who would come to assist in reviewing the hospital employees such as yourself?-- That's correct. They did it on their own free will and for their own education and benefit, and they often contributed to the audit program in presenting some of their own complications and mortalities.

You have spoken of inputting information to a computer. Is that the Otago audit system which you refer to in paragraph 12?-- It is, that's right.

There is evidence that Dr Patel discontinued the Otago system and said to his team that instead they should keep their own written records of any complications, and he instituted regular Morbidity and Mortality meetings to supplement that. Can you tell us whether that system which was introduced instead of the Otago system is another satisfactory alternative?-- I think both computerised and notebook audit systems all depend on the input and the honesty of people, and also the keenness of people to record complications and mortality. Certainly with a computerised one you have a piece of paper for every patient and at the end of the month you can see which papers haven't been completed. So you have a system which should cover all patients. I think with a notebook it's not difficult to forget this case of problem or - that's right.

D COMMISSIONER VIDER: Dr Anderson, could I ask you, when you were part of this audit team that reviewed records and cases, who did you report the outcomes of some of those things to?-- The conclusions of those meetings didn't go beyond the meeting itself.

So if you had identified problems-----?-- Yes.

-----or issues-----?-- Yes.

-----that you had considered needed further investigation or action, was there someone else that - would you take those, for example, either to a Medical Advisory Committee or a Council or whatever, or to the hospital executive?-- No, I don't think we would take it to those bodies. I mean, if there were a major problem, we would seek senior peer advice from a surgeon from the Royal Brisbane Hospital or from the College of Surgeons.

Did your review at any stage have any role in satisfying yourselves with the competence of a practitioner?-- Yes.

And was there a credentialling committee, by whatever name, that you then could have referred those matters to?-- Yes, there's a credentialling committee.

Would that have been an avenue that you could have explored?-- I think if we'd found that a surgeon was having an unsuitably high rate of complications, which we didn't at that time, then the avenue to go to the credentialing committee would have been there.

So in your experience in dealing with this committee, you were able to use the review - the audit and the review for your own assessment, if you like?-- Yes.

And you would then have a discussion that might come about saying in the future you would do A, B and not C?-- That's actually correct.

Or whatever?-- I think our management strategies changed in some circumstances as a result of the audit meetings and the discussion that went on.

Yes, thank you.

D COMMISSIONER EDWARDS: Could I ask: would it be more difficult, when Dr Patel was occupying the position that he occupied, to have found the deficiencies that were later discovered?-- Sorry, could you just repeat the question?

Could I ask you was it because Dr Patel was in the position he was in within the hospital system that there was perhaps not the notice taken early to the complication rate that he was having?-- Yes, I think that could relate to his position. I think he was also dealing with much more junior surgical staff who may not have had the knowledge to say, "Well, this is an unacceptable complication."

And from your experience with other hospitals and other surgeons, do you think, therefore, there may be a deficiency in the way in which surgeons are rated within hospitals or their complication rates are rated that led to this incident - these incidents with Patel?-- Auditors are - audit is a very difficult process because it really comes down to the honesty of surgeons and surgical staff to declare the complications and deaths.

Some would say, if I could ask one other question, the Otago process may have eliminated some of those potential possibilities?-- I think it would have, yes.

So therefore you feel as a general - as a surgeon within the system and now out of the system, whatever it may be, that the Otago system could once again be perhaps explored as a basis for accountability and surgical prowess?-- Yes, I think a computerised audit program is acceptable. It is something which the college of surgeons have their own version of and I think the college of surgeons would advocate the use of a computerised system for comprehensive audit.

COMMISSIONER: Just following up from Sir Llew's questions, whilst that sort of technological aid is undoubtedly helpful,

I get the impression, from what you said earlier, that any audit depends on the integrity and the competence of the surgeons who are feeding in the information?-- Yes, indeed.

And it is quite possible that the most sophisticated auditing software and system would not have picked up the Patel incident unless he or the junior staff working with him had the capacity to input the right information?-- Yes, I think that's correct. It is hard to sweep under the carpet deaths in any program and they - you can fudge a little bit on complications, it wasn't a serious complication, but all the deaths should have come out or would come out in an audited - in a computerised audit program.

MR ANDREWS: Now, Dr Nankivell retired somewhere towards the end of - in about December 2001 or January 2002. Do you recall that to be the case?-- I do.

Would I be correct in deducing that it was at about the time of his retirement that the hospital lost its accreditation as a training facility from the Royal Australasian College of Surgeons?-- I think that's correct.

That would mean, would it not, that from about 2002 the standard of JHOs and PHOs at the hospital might have been different from the standard that you'd have found if it had continued as a training hospital?-- That's correct.

Is it correct to assume that a training Registrar would be in a better position to pick up incompetencies in a Director of Surgery than a PHO or JHO in a facility which was not a training facility?-- I think that's generally correct.

While you were a surgeon at the hospital, the persons who would review you would include persons junior to you, would they not?-- Yes.

But also persons with qualifications equivalent to your own?-- Yes.

When Dr Patel in 2003 became Director of Surgery, are you in a position to advise whether there were persons of specialist qualification who were reviewing him in peer reviews?-- I think - I am afraid I didn't have time to attend those meetings, but Dr Howard Kingston, a surgeon in Bundaberg, I think attended a number of the audit meetings.

Doctor, I will ask you to outline the number of requests that you recall made by either yourself or other surgeons for VMOs to be appointed to the hospital. As I look at your statement, I see at paragraph 14 you mention Dr Thiele as resigning as a result of frustration, in your opinion caused by the failure to fund VMO sessions for a Dr Michael Delaney?-- That's correct, yes.

Was Dr Delaney a surgeon within Bundaberg at the time?-- He was a native of Bundaberg and a fully qualified orthopaedic surgeon who wanted to return to Bundaberg to set up public and

private practice.

So he wasn't residing there at the time that you understand Dr Thiele to have been applying for his appointment?-- That's correct, he was applying from outside with a view to coming back home, so to speak.

And what's the advantage of appointing Dr Delaney as a VMO at a time when obviously Dr Thiele was available, you were presumably available, and Dr Nankivell was available?-- Dr Delaney was an orthopaedic surgeon, a bone surgeon, and there was shortage of orthopaedic surgeons in Bundaberg-----

Thank you?-- -----at the time.

COMMISSIONER: Is Dr Delaney still practising in Bundaberg?-- He is, yes.

Do you know whether he now has VMO accreditation?-- I think he does, yes.

Do you know how long that took?-- No.

MR ANDREWS: Now, you recall asking yourself that an additional surgeon be appointed - and this was at a time after Dr Wakefield and Mr Leck were working at the hospital?-- That's correct.

You say that the workload had become enormous, but surely you had Dr Nankivell to share that load with you?-- Yes, that was correct. But let me explain, I have a subspecialist interest in urology which drew in a lot of extra cases. I think the two full-time general surgeons may well have been adequate at the time, plus a urologist, but half my time was taken doing urology, and you will appreciate that urologists are extremely scarce outside the capital cities in Queensland. So I think the GPs started to learn if you want to get something done in the public sector, send them to Anderson and Nankivell at Bundaberg, you can get them into the clinics, they will facilitate major urgent surgery and, you know, the system was building up popularity in the region. Consequently the workload increased.

COMMISSIONER: In addition, we've heard already from Dr Thiele that in his position as Director of Medical Services he was giving over something like 60 per cent of his time to administrative work, so he was less than a half time surgeon?-- Yes, Dr Thiele is a vascular surgeon and dealt with vascular surgery almost completely. I mean, he didn't do general surgery to any degree, as Dr Nankivell and I did.

MR ANDREWS: So at paragraph 15 where you mention requesting an additional surgeon to be appointed, because you don't have dates, you have only as an aid the fact that Dr Wakefield and Mr Leck were there, I would like you to confirm the time of this request. It was just you and Dr Nankivell who were the general surgeons employed at the hospital?-- That's correct, yes.

Dr Thiele, had he resigned by this stage?-- No. But this is I think in sort of 1999. I went on sabbatical, I think, from May to July '99.

You do mention that at paragraphs 17 and the unnumbered paragraph below. Am I right to deduce that in '99 you requested an additional surgeon and VMO sessions for yourself?-- I did.

So you were asking, were you, to - for the hospital to consider your resignation as a staff surgeon so that you might perform services as a visiting medical officer?-- That's what I requested.

And exhibit PEA1 is the letter that you wrote to Dr Collie agreeing to relinquish even your Director of Surgery position so that a new staff surgeon might be appointed?-- That's correct.

To permit you to do some VMO sessions?-- That's right.

Was it your opinion at the time that there was a need at the hospital for two full-time general surgeons and a VMO to provide general surgical services?-- Yes, my view was exactly that. Bearing in mind that the after-hours call, when Dr Nankivell and I were the only two staff surgeons, was every second night. That's a frequency that is unsafe and untenable.

COMMISSIONER: You do mention that a Dr Howard Kingston-----?-- Yes.

-----could stand in for you at times?-- Yes.

Was he a surgeon in private practice?-- He was a private practice surgeon, that's correct.

How many VMO sessions did he have?-- He did one session of operating per week. That was one step that was taken to improve the situation somewhat.

But that was obviously no replacement for having an additional surgeon on the staff to cover for you when you are ill or Dr Nankivell-----?-- That's right, when someone was ill, I would ring around to Dr Kingston or perhaps get Dr Thiele to do a general surgical call.

Yes.

MR ANDREWS: There are some advantages, are there, to having a number of VMOs as opposed to staff specialists?-- I think there are advantages, and my opinion is that every surgeon in a rural town should be involved in the public hospital providing VMO services. The advantages is in the scope of the surgery which they can provide and also they can cover the after-hours call.

So it is not an opinion based upon a difference between the competencies of the staff specialists and the VMOs; it is more to do with flexibility and the provision of a wider range of services?-- I agree.

COMMISSIONER: Also it has been suggested to us by Dr Molloy, the out-going President of the AMA, that one of the difficulties with having a staff surgeon - particularly an overseas-trained staff surgeon - is that if that person leaves the hospital, you have got to replace 100 per cent of that surgeon's practice. Whereas if you - if the same number of sessions are done by three, or four, or half a dozen VMOs and one of them leaves town, you are only replacing one or two sessions a week instead of replacing a 100 per cent equivalent surgeon?-- That's correct. And one of my recommendations is that staff surgeons do have the facility to go on to become VMOs so that their services are not totally lost to the public sector.

And particularly not lost to the town?-- That's right.

Yes.

MR ANDREWS: Is it attractive for staff surgeons to be given the opportunity themselves to take private work and to become VMOs rather than staff members?-- Staff surgeons, yes, it is attractive, I think. It is financially more rewarding to work in private practice.

The financial rewards, are they because one earns more in private practice, or because one is paid more by the hospital proportionately per hour if one is doing VMO sessions as opposed to staff sessions?-- At this stage VMO - VMOs are paid rather more an hourly rate than a staff surgeon. In private practice one is paid fee for service, and that would be two or three times the rate of VMO pay rates in the public sector.

So it does become more expensive, am I right, for a hospital to engage you as a VMO to do nine sessions a week rather than to engage you as a staff specialist to do nine sessions a week?-- Yes, I was asking for five sessions a week. I think that that would have - a half time VMO would be somewhat more expensive than a full-time staff surgeon. By becoming a VMO, one, however, had to relinquish some other benefits like the motor vehicle benefit, which is provided by Queensland Health, the communications device, that sort of thing.

COMMISSIONER: Superannuation, long service leave, holidays?-- Yes, I think so.

All those sorts of things?-- Yes, that's right.

I guess you are not in a position to tell us the - any comparison between the total cost to the hospital of hiring a staff surgeon or staff specialist as compared with the cost of hiring VMOs for an equivalent number of sessions?-- No, I can't give you an accurate figure on that.

Yes.

D COMMISSIONER EDWARDS: But it is important in the system - it is important in the system to have a blend of part-time and full-time specialist services?-- I think so. It seems to be a tenet of Queensland Health that up until now they have been very strong on employing full-time staff surgeons. Across the border in New South Wales staff surgeons - sorry, VMOs are the norm, all hospitals run with the majority of surgeons on a VMO contract.

And in historical terms that was - the New South Wales system was preferred in Queensland until, say, the last five years?-- It certainly hasn't been the Queensland Health policy in my time here of 11 years. They were always intent on having full-time staff surgeons. I think the reasons are they are cheaper. I think Queensland Health also has a better hold and control of staff surgeons. They are totally dependent on the public side.

And would it also be fair to say, from some of the figures that I've seen, that the majority of these positions in full-time places are by overseas-trained specialist - I am not decrying the value of those people in any way whatsoever, I am just suggesting it appears to me, from some of the information that we've been provided, that the number of people who are employed in full-time specialist position, particularly in surgery, have been overseas-trained?-- I think the advent of overseas-trained surgeons is attractive to Queensland Health for two reasons: (1) is that they are often employed as SHOs, Senior Medical Officer, rather than full-time specialists. So there is a significant saving. They also are very compliant because they don't have the option of going private. If they don't like the job, then they generally have to leave the country.

COMMISSIONER: Doctor, if we focus for a moment not on what's good for Queensland Health in a corporate sense but what's good for the patients, particularly the patients in a city like Bundaberg, it strikes me, from the evidence you have given this morning, that the citizens of Bundaberg are actually extremely fortunate to have people like a specialist vascular surgeon, a specialist urologist, an orthopaedic surgeon. We have already heard from Dr Miach who is a renal specialist and so on. You have got this quite extraordinary array of talent there in Bundaberg, but from what emerges from your statement, the management at the Base Hospital wasn't prepared to support that talent by providing you with VMO positions?-- I totally agree.

D COMMISSIONER VIDER: Was there any avenue or any consultation sought with the medical staff when these various resignations were coming through? Was there ever a staff meeting - medical staff meeting where you were asked what was your thoughts, considerations for the future?-- Yes, I think there were a number of meetings to try and resuscitate the medical staff in the hospital. I mean, we used to have a

monthly medical specialist meeting at which the management would attend, and on a number of occasions staff issues were raised at that meeting but to no avail. Perhaps the most notable meeting was at the time that Dr Nankivell left and Dr Baker was resigning, I think the Cabinet and Premier Beattie came to Bundaberg and there was a meeting at that stage, and that crisis - I was then allowed to have VMO sessions.

Was there ever any discussion regarding the apparent change in direction from employing VMOs to preferring staff specialist which seems to have become a preferred option? Is that correct? Is this a preferred option now, in your opinion?-- I think in a town like Bundaberg you need a combination of staff surgeons and VMOs.

Yes?-- VMO discussion - requests for VMO positions was raised repeatedly. I mean, Dr Nankivell would probably still be in Bundaberg if he had been given a VMO session and another staff surgeon.

When you had raised those issues, when you didn't get any positive outcomes to that, were you told the reasons why?-- I think it is shortage of money.

Was that assumed or were you actually told that that was the direction that Queensland Health-----?-- I think the management would say there is no funds to appoint someone. That's right, it was straight out.

COMMISSIONER: When I referred earlier to the array of talent, we have also heard extremely favourable comments about Dr Nankivell's surgical skills. Are you able to confirm that Dr Nankivell was a very good surgeon?-- A very good surgeon.

And he is just another one who has been lost through the refusal to provide him with a VMO opportunity?-- He is lost to Bundaberg. He is now working at Logan Hospital as a staff surgeon there.

D COMMISSIONER VIDER: What was the reaction of the hospital to the situation whereby with these resignations you end up with no registrar positions, so no-one in training you could share the call load with, and then you have got someone either doing a one-in-two call or worse, the only person available for call?-- Then the hospital has to go and get locum surgeons. And fortunately there have been a number of good locum surgeons who have been able to come to Bundaberg and help for periods of time over the years. These surgeons are often senior surgeons in the retiring age range who elect to do locums and see Australia and vacate their full-time jobs in other places.

We have had some evidence of that given to us as well, but, you know, they come at a decent expense. So if the attitude is you can't have VMOs because they are too expensive, I would have imagined that locum surgeons were even more expensive?-- Yes, I think they are.

COMMISSIONER: The other problem with locums - I am sure you are right in saying that they're a good temporary solution but they don't put down roots in the local community, they don't get to know and get known by the local GPs and they are not building up the ongoing strength of the medical community in a place like Bundaberg?-- That's correct.

Mr Andrews, I suspect you are about to get to paragraph 19. I see that paragraphs 19 to 26 of Dr Anderson's statement deal generally with the circumstances of his resignation from the hospital. That's not a matter of any interest to this Commission of Inquiry unless someone else wants to challenge Dr Anderson's credit, for example, on the basis that the version given there isn't the entire truth. So I am inclined, subject to your views, of course, to let paragraphs 19 to 26 stand, they speak for themselves and we needn't trouble Dr Anderson to discuss what was obviously a rather unpleasant phase of his professional career.

MR ANDREWS: Yes, with respect, Commissioner, I had no intention of going into the accuracy or otherwise of the allegations and responses.

COMMISSIONER: Yes.

MR ANDREWS: For it does seem to me that it will be of no benefit to the Commission at all.

COMMISSIONER: No. Of course, if Mr Chowdhury or someone wants to challenge Dr Anderson's evidence, then that's a matter for that counsel, but, as it stands, I am happy for you to pass over those paragraphs, subject to anything that you feel is important to bring out, and move on from about paragraph 27.

MR FARR: Can I just raise one issue on that?

COMMISSIONER: Yes, Mr Farr?

MR FARR: I am more than happy to not cross-examine on those paragraphs.

COMMISSIONER: Yes.

MR FARR: I do have some information that would tend to suggest that it doesn't reveal the entire picture, if I can word it that way, but I wonder, given that these statements are published, effectively, if the senior counsel assisting might give thought or the Commission might give thought to those particular paragraphs not being published.

COMMISSIONER: I don't think we can do that, Mr Farr. I think you have to come to your own judgment, obviously take instructions as to whether you wish to challenge the evidence given by Dr Anderson. My point is simply I don't think we need to waste time going through it. The paragraphs speak for themselves and Dr Anderson has set out his version of events.

If someone has instructions to and feels the need to challenge that, that's a matter for that party and the party's representatives.

MR FARR: Certainly.

COMMISSIONER: Thank you, Mr Farr, for raising that.

MR ANDREWS: Dr Nankivell, after your departure, was the only general surgeon working at the hospital?-- No, I think locum general surgeons were provided to fill in the second position and I think Dr Baker then came on the scene.

The locums, were they supplied continuously so that Dr Nankivell had a situation which was the equivalent of having another staff surgeon, or were they supplied sporadically so that there were times when Dr Nankivell alone was the general surgeon?-- Look, I am sorry, I can't answer that.

Dr Baker seems to have come to the hospital some time during 2001 as a staff specialist. Do you recall that to be the case?-- I think, yes, yes. Mmm-hmm.

And some time towards the end of 2001 we will hear evidence that Dr Nankivell announced that he was intending to leave within a short time. Do you recall that to be the case?-- Yes.

And there was, as I understand it, some press coverage of this situation and you yourself wrote a letter; am I correct?-- You are, mmm-hmm. I wrote it to the News Mail - sorry, to the local paper.

And we see that at PEA7. Are the opinions you expressed in that letter PEA7 opinions you still honestly hold?-- They are opinions I honestly hold.

Dr Baker announced his retirement some short time after Dr Nankivell's; is that correct?-- Yes.

Can you say whether the workload for Dr Baker would have been likely to increase as a result of the departure of Dr Nankivell?-- Yes, I think that Dr Nankivell had a very large clientele and a lot of this would have come to - to Dr Baker's care.

There is a news article which you've annexed to your statement as Exhibit PEA8 which seems to have been published in the News Mail on 30 November 2001. It observes that, "Staff Surgeon Sam Baker tendered his resignation on Tuesday just three weeks after Director of Surgery Charles Nankivell announced he was leaving because he was physically worn out." Now, did you speak with Dr Nankivell to determine whether that was his reason for leaving?-- Yes, I did.

The article goes on to observe that, "Dr Baker, who has only worked at the hospital for 11 months, said yesterday the main reason he was resigning was the demand placed on general surgeons to work 12 days before getting two days off." That opinion, is it a reasonable one?-- Yes, it is. He would work five week days and then a weekend and then another five week days before he would get his weekend off, so those figures are correct.

The article suggests that Dr Nankivell said that staffing shortages created serious safety issues and that one wouldn't want to be operated on by a doctor who was dog-tired. Now, the rosters that existed, were they such as to make the doctors dog-tired?-- They were, working - being on-call every second night at the call to come into the hospital to attend patients was too much and if one - it was very tiring. I mean, you didn't have to get out of bed every night but if you had a couple of nights when you were called up through car accidents or major illnesses through the night, by the end of the week you were dog-tired.

Even with competent surgeons, are you suggesting that's an

unsafe system whereby they are on-call every second night?-- That is an unsafe situation and the College of Surgeons have made recommendations regarding rural surgery and surgery in general that a roster of one night in four is the harshest roster that should be applied to a surgeon.

In your opinion, is that like an ambit claim asking for something that's verging on the luxurious or do you regard that as a reasonable estimate of the harshest rostering system for rural hospitals?-- I think one night in four is the minimal or is the maximum responsibility a surgeon should have to shoulder.

D COMMISSIONER EDWARDS: One night in four in a public hospital you're meaning?-- Yes.

Yes.

MR ANDREWS: And one sees from that article that there were observations made about you and your honesty in the news article?-- That's correct.

COMMISSIONER: Well, to be more accurate, there were reports of observations made in parliament about you?-- That's correct. Under parliamentary - under parliamentary privilege.

Yes?-- A politician slandering a doctor under parliamentary privilege gets no respect from me.

MR ANDREWS: Now, the crisis created at about the time of these news articles led to a visit from the Premier to the hospital; is that the position?-- That's correct, yes.

And immediately after the Premier's visit, were you re-engaged - well, offered the VMO position that you'd been seeking since 1999?-- That's correct. Perhaps one correction in my statement is while Peter Beattie and the Cabinet were in Bundaberg, it was Dr Rob Stable, I think, who authorised - he was the Director of General Health at the time - for my appointment as a VMO.

Are you in a position to know who it was who authorised these things or are you deducing that it was Dr Stable?-- I think Dr Sam Baker can give you accurate information on that which is imparted to me. I think he was in the room when Dr Stable, with a meeting of specialists and high - and hospital staff, authorised that appointment.

It was at paragraph 21 that you expressed the opinion that Dr Wakefield initiated disciplinary action against you. One sees from the correspondence that Dr Wakefield is not the author of the letter PEA2. What makes you express the opinion that it was Dr Wakefield?-- I think Dr Wakefield was in a position to have all the details to fill in that letter. Kate Young was a locum Director of Medical Services and, to the best of my knowledge, signed the letter.

COMMISSIONER: And, in fact, the final paragraph identifies

Dr Wakefield as the point of contact in relation to the matters covered in the letter?-- That is correct, mmm.

MR ANDREWS: So you accepted the VMO's position that was offered?-- I did.

And you, accordingly, have worked at the hospital during Dr Patel's tenure?-- That's correct. I still have a VMO position at Base Hospital.

Now, you recall a Dr Lakshman Jayasekera?-- I do.

L-A-K-S-H-M-A-N J-A-Y-A-S-E-K-E-R-A, who was a Fellow of the Royal Australian College of Surgeons?-- Yes, like Sam Baker, he was a more senior trainee who came and spent six months training in Bundaberg when I was the Director and he subsequently passed his Australian Fellowship exam, liked Bundaberg, was interested in settling there so he came back as the Staff Surgeon.

Now, the position of the Director of Surgery seems to have been vacant for some time during 2002; is that correct?-- I think so, yes.

It was advertised during 2002 and among the applicants was the Staff Surgeon Dr Jayasekera?-- I think so.

You recall that he was initially an unsuccessful applicant because a Yugoslavian doctor was awarded the position?-- That's right. I was only the selection committee for that appointment.

But the Yugoslavian doctor declined the position?-- That's correct.

You suggested Dr Jayasekera should be given the position of Director of Surgery?-- I brought the issue up at the next staff advisory committee and asked why he hadn't been offered the position and I was met with looks of surprise.

The dates of this are of interest to me. Do you mean at paragraph 38 that it is inaccurate where you say, "I suggest" - "I then suggested to the hospital that they should have given the position of Director of Surgery to Dr Jayasekera." I'd inferred from that that the position hadn't been awarded to anyone else when you made the suggestion?-- That's correct.

D COMMISSIONER VIDER: And Dr Jayasekera met the eligibility criteria for the position?-- He did, yes.

For Director of Surgery?-- Yes.

COMMISSIONER: I think you mentioned you were on the selection committee when the Yugoslav doctor was offered the position?-- Yes, correct.

Was Dr Jayasekera a candidate at that same time?-- He was a candidate for the Director of Surgery at that interview, yes.

There were two interviewees.

Was it at least your view as a member of the selection committee that either of the two candidates was adequately qualified or appropriately qualified?-- Yes, all people on that committee agreed that either of them could have become the Director of Surgery.

Thank you.

MR ANDREWS: The suggestion you make at paragraph 38, would you remind me, what was the group to whom you made it?-- It was the Medical Staff Advisory Committee.

What was the response of the group when you suggested it should have been given to Dr Jayasekera?-- There was no response from the administrators that were in that meeting. There was no word of explanation. The topic was dropped.

And at this stage was Dr Jayasekera, do you know, still a member of staff?-- He was, yes. He was the Staff Surgeon.

Who were the members of the committee, apart from yourself?-- Mr Leck. I don't think Mr Keating was there at that time. I think there was - Kees Nydam was the acting Director of Medical Services and then there were a number of staff specialists at that meeting.

Well, to have been met by silence doesn't necessarily indicate whether the offer to Dr Jayasekera was rejected or accepted; that is, whether the group decided that Dr Jayasekera should or should not be offered the appointment?-- Yes, no, the meeting was told that he wasn't going to be appointed the Director of Surgery.

Ah?-- But they would offer no reason for that.

Do you recall who told the meeting?-- I think Dr Nydam.

And is it at that stage that you suggested that he should have been given the position?-- It was.

Was the meeting told whether there was anyone else in prospect for the position?-- No.

And do you recall whether Dr Jayasekera was present?-- I can't recall.

Would a Medical Staff Advisory Committee meeting be the sort of meeting that would be attended by the staff surgeon?-- They were open to all staff surgeons. Unfortunately, most of them were a waste of time. Nothing was achieved, so the attendance at that meeting was poor.

At paragraph 41 you do speak of a Medical Staff Advisory Committee meeting held on the 13th of February 2003?-- Yes.

Is that the same or a different committee meeting from the one

you refer to at paragraph 38?-- I think the meeting of the 13th of February was the subsequent meeting to the one we've been talking about.

And were they held periodically?-- Monthly.

Would you look, please, at PEA13, an exhibit to your statement, which is a motion for Medical Staff Advisory Committee meeting of the 13th of February 2003?-- Yes.

Did you propose the motion or was it proposed by all the named persons on that page?-- I organised the motion, wrote the motion, and I asked all the specialists at the hospital whether they were in favour and those who signed were in favour. So the statement was simply tabled at that meeting.

The exhibit, of course, is unsigned. Was there a signed version?-- I can't recall.

Were all those named present when it was tabled?-- No.

Dr Jayasekera, for instance, had he absented himself, having resigned by that date?-- I can't recall.

Do you know what the response was to that motion?-- It brought about some discussion in the meeting among those who were present, but the effect on the management, in particular Mr Leck, was like water on a duck's back, it just ran straight off. It made no effect on him at all.

What, do you mean he didn't speak?-- He didn't speak, as I recall, but it obviously didn't affect him, in my opinion. He was indifferent to it.

What indications do you have that he had an - that he was indifferent to it?-- His lack of expression.

D COMMISSIONER VIDER: At that stage though in February 2003, Dr Patel's appointment had been announced, had it not?-- I think it was subsequent to that but I would stand correcting.

Yes.

MR ANDREWS: Deputy Commissioner, as I recall the evidence, Dr Patel's appointment as a staff medical officer - senior medical officer resulted in his arriving at the hospital some time in early April of 2003 and his appointment as Director of Surgery followed a day or two later.

Yes. My point was though, probably, Mr Leck may have known that another process was in place?-- I think he would have.

Mmm. I see from your return to the hospital that there will have been occasions where you may have encountered Dr Patel?-- That's correct.

Was there - were you aware that there had been no credentialing and privileging process carried out in respect

of Dr Patel?-- I didn't know about that.

COMMISSIONER: Did you have anything to do with Dr Patel? You didn't-----?-- I had a little to do with Dr Patel. I - my appointment at the hospital is in urology, separate to general surgery. I used to do the call on weekends every month or so and Dr Patel would pick up the patients on a Monday morning, those who required surgery or further management. So we discussed those patients on a Monday morning before I went to my private clinic. I have some patients that Dr Patel referred to me and - but I don't know of his - of his practice to any degree, I'm afraid.

No. Thank you.

MR ANDREWS: Would you have been a person in 2003, who would have been appropriate to perform or assist in performing credentialing and privileging for Dr Patel?-- I'm not sure who was on the credentialing committee. I am not",

Which credentialing committee do you speak of, one at the Bundaberg Hospital or a committee of the College?-- The credentialing process at the Bundaberg Base Hospital, I'm not - I am not sure of the structure, I'm afraid.

It's suggested to me that there may be a Fraser Coast Committee. Are you able to confirm or deny that?-- I think that's correct. Certainly credentialing is very big in its encompassing of what's allowed. I mean, we've just been through a further credentialing committee for the Base Hospital as is appropriate, and one asks for credentialing to perform general surgery, urology, endoscopy. There is not a lot of - you know, it's a massive field and I presume Dr Patel applied for credentials in general surgery.

COMMISSIONER: I think Mr Andrews' question, though, was had the hospital administration sought your assistance, would you have been in a position to assist them in examining Dr Patel's credentials and giving them advice regarding his suitability?-- Yes, I would have given my time to do that.

It's already, of course, now public knowledge, but Dr Patel had a chequered history in the United States. In your experience, would a proper credentialing process normally pick up that sort of chequered history?-- Yes, I am not sure who would be responsible for doing that, whether it would be the Medical Board or the staff surgeons of the hospital, or the College of Surgeons, I'm afraid. Certainly the credentialing committee, as I understand it, involves other surgeons, you know, in credentialing for surgery, but I'm not sure that they delve into the details of what procedures can be done and what can't. Though, I think - I think Queensland Health has some guidelines according to the grade of the hospital, in that - I don't have the details of that, but major surgery like oesophagectomies and Whipples operation may not be appropriately done at Bundaberg, but that was all news to me, I must say, at the time that Dr Patel was there.

It was news to you that he was doing that sort of major surgery?-- It was news to me that there were actual levels of hospital gradation which would say that sort of surgery was appropriate or not.

Yes?-- I mean, I have done those surgeries at Bundaberg Base Hospital myself.

MR ANDREWS: Which surgeries have you done?-- In my early years as a Staff Surgeon we performed a number of oesophagectomies.

And Whipples procedures?-- I think I did two at Bundaberg.

In performing those surgeries, would you have felt - do you know whether there was a practice at the time that you performed them of ringing some of the tertiary hospitals if you encountered difficulties; that is, to ring them and seek advice?-- Yes, there was always the option, if problems arose, to seek advice from the tertiary hospitals and to refer patients on. I think the surgeries of those major conditions have become, you know, over 10 years, much more a subspecialist sphere of surgery and teams of surgeons rather than individuals. It's more appropriate that teams of surgeons tackle those major surgeries than a single surgeon working in a rural setting. So my practice in private these days is to refer all those cases off.

That multidisciplinary approach, can you say for how long that's been the accepted wisdom in Bundaberg?-- No, I can't. I think those sort of surgeries depend on the people's previous training and also the structure of the intensive care, the backup facilities that are present in the hospital.

I have no further questions, Commissioner.

COMMISSIONER: Yes. The statement of Pitre Edward Anderson will be Exhibit 199.

ADMITTED AND MARKED "EXHIBIT 199"

MR ANDREWS: Thank you.

COMMISSIONER: Dr Anderson, before I invite questions from other counsel, there were a couple of things I want to ask you. You've provided us with some very useful evidence about the problems, as you identify them and as you have experienced them at Bundaberg hospital. I guess our primary concern at this stage is what can or should be done to resolve those problems. Let me begin by saying that from a lot of evidence we've heard so far, I am more and more inclined to the view that there is a difficulty in having people who are not practising clinicians in charge of a hospital. We all accept that there has to be management. We all accept that you need

people to manage a whole range of functions at the hospital, from paying the staff, to organising the admissions, to providing the hotel services, refreshments and beverages, and food, and gardening, and all the other things. But what's your view about the necessity or desirability of having someone who is not a practising clinician being the person in charge of a hospital?-- I think it's been proven a disaster. I agree with you totally that it is important to have a practising clinician high in the management of rural hospitals, and I think it's also very important to have the specialist staff and other doctors having a very good voice in the management of the hospital. At this stage they are totally alienated from any of the decision making, at least in Bundaberg.

We've heard that there is something called - it's a District Health Council. In your time at Bundaberg, have you had any dealings at all with the District Health Council?-- I have not.

Have you seen any sign that they do anything useful?-- I don't think they do. Michael Delaney, one of the other surgeons in private, was on that committee and soon found that it was a toothless tiger and he resigned.

D COMMISSIONER VIDER: Just one comment. You intimated that you would not have expected that the levels of clinical services may have been - I don't know, ascribed - prescribed for a hospital like the Bundaberg Hospital. I'm just wondering whether you still hold that view, having made the observation that specialties have moved on now and very often teams of practitioners are utilised for the treatment of patients. For clarification, would it be helpful, do you think, if there was a thing that delineated the roles of particular hospitals in line with the clinical expertise that's available to them?-- Yes, I think one has to be flexible in this issue. I mean, hospitals - rural hospitals have a grading on the complexity of their structure and the surgery they can provide, but it does also depend on the expertise of the surgeon involved. One practical example is Dr Thiele, who is a world class vascular surgeon who was performing aortic aneurysm surgery in Bundaberg extremely well, requiring the ICU, the cases did extremely well, and aortic aneurysm surgery would generally be beyond the class of the Bundaberg Base Hospital. So it does depend on the expertise, and to some degree on the will of the surgeons involved with a particular complex procedure.

Yes. It does also have the dimension though it's got to have the support and back-up services available to undertake those procedures too?-- That's right. So I think credentialling committees need to say, you know, "We're not generally in a position to do aortic aneurysm, Whipple operations and oesophagectomies unless you can prove to the committee your ability and your audit of cases that you've done."

Because we have evidence before us where certainly the level of intensive care services that was available was prescribed as in Level 1, but the difficulty arises then when that's not adhered to and you then get into difficulties?-- That's correct.

COMMISSIONER: Sir Llew? Ms Gallagher, do you have any further evidence-in-chief you wish to lead from the doctor?

MS GALLAGHER: No, thank you, Commissioner.

COMMISSIONER: Thank you. We might then take the morning break and resume in 15 minutes or so.

THE COMMISSION ADJOURNED AT 11.31 A.M.

THE COMMISSION RESUMED AT 11.54 A.M.

PITRE EDWARD ANDERSON, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Mullins has disappeared for the moment. Mr Allen, do you have any questions?

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: Mr Devlin?

MR DEVLIN: Yes, just one topic, Mr Commissioner.

CROSS-EXAMINATION:

MR DEVLIN: Doctor, you've had the opportunity of looking at a patient chart in the name of Warren Stanaway-----?-- I have through the break.

-----through the break. In particular there's an entry by you on 4 March 2004 relating to that patient. Do you want to see that again?-- No.

Thank you. Do you have some independent recollection of the patient?-- Yes, I do.

I should say I represent the Medical Board?-- Good.

What was the role that you played then in relation to the matter on 4 March 2004?-- I was asked by Dr Patel and Dr Berens, the anaesthetist in intensive care to see the patient to give a second opinion about the patient's state and whether they required a further surgery - a further laparotomy. I saw the patient on 4th of the 3rd and, by assessing the patient and his condition, thought that there was intra-abdominal sepsis and that a further laparotomy needed to be done. I note the patient, on 23 February, had rejoining of a colostomy. He went back to theatre for evacuation of peritoneal fluid, a further laparotomy on the 28th of the 2nd, and then I saw him on the 4th of the 3rd. I understand on the 28th of the 2nd there was no obvious leak from where the bowel had been joined, but my feeling is if I'd been in that situation, that I would have done the loop ileostomy on that occasion - though there are pros and cons for doing that - rather than what Dr Patel did, bring him back a further time and do that procedure on the 4th of February - 4th of March.

Do you have any recollection of making any observations at the time of your second opinion that led you to the belief that, from what you saw - I can only ask you about what you saw - that there was mismanagement of the patient up to that point?-- The only query I would have is whether the second

laparotomy of the 28th of the 2nd was an adequate procedure.

Right. Is that, in your opinion, a matter for judgment or-----?-- I think it's a matter of judgment. The patient's trying to get rid of the colostomy, bringing the bowel out on to - the large bowel out on to the surface of the abdomen has complications possibly from the leak from the join. I think on the 28th I would have washed out the abdomen, brought out an ileostomy, a small bowel out, as a stoma to defunction where the join had been.

Yes?-- But Dr Patel intimated that he didn't - he couldn't see an obvious leak, but I think that's what must have been there to cause further problems to occur, so that on the 4th of the 3rd he found an abscess, had to evacuate that and do the defunctioning ileostomy.

Thank you. Thanks very much. Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Devlin. Mr Mullins?

MR MULLINS: Thank you. I apologise, Commissioner.

COMMISSIONER: Not at all.

MR MULLINS: I was watching on the television outside and I hadn't seen you come in.

CROSS-EXAMINATION:

MR MULLINS: My name is Mullins. I appear on behalf of the patients. I just have some questions about the Otago audit system that you mentioned?-- Yes.

Can you give the inquiry a thumbnail sketch of exactly how that works?-- Well, each patient who had surgery is given an information sheet, a data sheet which has entered the operation, the dates, different other information and then complications or death, and these are then put on a computer program.

You say the patient is given the sheet-----?-- No, no, sorry. Each patient is allotted - it remains in charge of the surgeon. I mean, we used to put them in files in the surgeon's room in theatre so when you've done one you'd put it in the file. The important thing is you had to come back the next week - it requires discipline to come back the next week and say, "Oh, yeah, did have a complication. He's gone", and put in the date of discharge, and it's an ongoing discipline to record the information on the sheet. Once again, it does depend on discipline, the honesty of the person doing it, and the honest of the person putting in the information.

COMMISSIONER: When I asked you earlier about that system you

said it's hard for a death to escape the net of that system?-- Yes.

But it would still depend on the accuracy and honesty of the information entered to draw attention to the fact that the death was unexpected or unnecessary or resulted from incompetence or from complications. That would still - the mere fact there was a death wouldn't tell you anything unless the surgeon recorded other information that perhaps alerted to the possibility that the death was, shall we say, a suspicious one?-- Yes, that's correct. I mean, unless you take the piece of paper out and throw it in the bin and then it's not recorded at all - I mean, there are other hospital records that record deaths. At the time of the audit meeting, having compiled the data on the computer - at the time of the audit meeting it's presented in a form on overheads, and the notes are brought into the meeting and the case is presented by the junior staff, the junior staff in training, and then the consultants comment and may make recommendations about the management of the patient.

D COMMISSIONER VIDER: Further to that, Dr Anderson, does the audit tool collect information regarding the comorbidities?-- Yes.

That's initially recorded?-- Yes, yes. Deaths and comorbidities are recorded, that's correct.

My reason for asking that was because otherwise the complications could all be coming out of the comorbidities, which would be not very visible unless you had recorded the comorbidities?-- That's true.

MR MULLINS: Taking you back to the commencement of the process for the database, each patient, as you say, is allotted a sheet - or given a sheet for a particular surgery?-- That's correct - yes.

Who prepares the initial data that's inserted for the purposes of the sheet itself that forms part of the file?-- We would always say the person who did the operation had to complete the sheet, the initial entry of the sheet.

But the initial entry of the sheet - for example, the name-----?-- Yes.

-----date of the surgery-----?-- Yes.

-----patient number?-- That's right.

Would that be generated by the computer within the hospital?-- No, no. That would be - that's part of the Otago program.

The point I'm making is John Smith is due for surgery on 1 January 2003?-- Yes.

Does the sheet that's printed up that's given to the surgeon to go on the file - is that done by admin staff or is that

actually - is the name John Smith filled in by the surgeon?-- It's all filled in by the surgeon or the registrar.

When you say "the surgeon or the registrar", part of the - do other parts of the team - or members of the team other than the surgeon play a role?-- The registrars or - you know, the junior staff in training were involved in filling out these sheets, particularly if they operated on the patient. If they were the first surgeon.

Now, this system, if it was working effectively, would generate hundreds of documents - or hundreds of entries a year?-- Yes. Absolutely, mmm.

Another witness will tell us - we understand later on today - that Dr Patel stopped using the system-----?-- Yes.

-----it seems some time during 2003. How soon did it become apparent that this audit system had ceased to be used?-- Well, at the next audit meeting there would be no overheads that are produced by the program for exhibiting in the meeting.

Would the Director of Medical Services and the senior staff at the hospital attend these meetings?-- I think some Directors of Medical Services attended those meetings.

How long had the Otago system been in operation for?-- A number of years. It wasn't immediately available when I started work in 1994. After a few years we bought the program and started it after a few years, and it was in use for two or three years.

Was that an initiative of yours, or did it come through Queensland Health that this system was to be used?-- That is an initiative of mine by direction from the College of Surgeons and from Queensland Health. I mean, everybody is expected to produce an audit in both public and private hospitals.

Thank you.

COMMISSIONER: Thank you, Mr Mullins. Mr Diehm?

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Doctor, I'm Geoffrey Diehm and I'm counsel for Dr Keating. I just wanted to ask you, you make mention in the last attachments to your statement about opportunities missed by administration in recruiting newcomers to Bundaberg?-- Yes.

You make particular reference there to Dr De Lacey and Dr Elphinstone?-- Yes.

Are you aware of what it was that actually happened in terms of any action being sought to be implemented by any of the administration at Bundaberg Hospital with a view to securing the services as VMOs of those doctors?-- Yes, I have some information about both those doctors.

Are you aware that Dr Keating actually made some persistent attempts to secure a position for Dr Elphinstone at the Bundaberg Hospital as a VMO?-- Yes, yes, I'm aware of that.

Is what you are identifying in your statement that when you talk about administration "missing the opportunities", is that somewhere within Queensland Health administration, despite whatever attempts might have been made by individuals within management, that the opportunities were missed?-- Yes, I mean, Dr Elphinstone is still not appointed, is he, after how many years?

Yes?-- Two? That's the problem. The time that passes between local administration making a submission to Queensland Health and getting a reply and some funds - by that time Dr Elphinstone is working beyond his capacity in private. The opportunity is lost.

COMMISSIONER: Mr Diehm, I don't want to interrupt you if it will be unhelpful, but perhaps this might be helpful if I ask this: doctor, you have made comments in your statement about, to put it candidly, incompetence within the management of Bundaberg Base Hospital. I didn't read anything in your statement along those lines as attributing that to Dr Keating. Am I right in thinking that those comments weren't directed to Dr Keating?-- No, they are not directed directly at Dr Keating.

Right.

MR DIEHM: Thank you, Commissioner. Yes, I don't have anything further, thank you.

COMMISSIONER: Glad to be of some assistance.

MR DIEHM: It is.

COMMISSIONER: Mr Chowdhury?

MR CHOWDHURY: Thank you.

CROSS-EXAMINATION:

MR CHOWDHURY: I just want to take you to your statement, in particular concerning Doctors Marsh May, Stumer and Chris Royan paragraph 7. You know what I am talking about?-- Yes.

I take it you yourself were not involved in any of those investigations surrounding those three people, that's correct?-- No, not directly but I am a friend and a colleague of Dr Stumer and Dr Marsh.

So you have been told something by them, and that's where you get your information from, is that correct?-- That's the primary source.

Yeah, thank you. In respect of Dr May, is it your understanding that in the middle of 2000 a review was conducted of the conduct of psychiatry in Bundaberg Hospital by Dr Peggy Brown, the Director of Mental Health Services?-- I am unsure of that.

Not aware of that?-- No.

Not aware that a report was issued by Dr Brown in respect of the conduct of psychiatric services-----?-- No.

At Bundaberg? Thank you. It is around that time, middle of 2000, that Dr May resigned, is that correct?-- I am unsure of the exact date.

In respect of Dr Stumer?-- Yeah.

Were you aware that a complaint had been made by an anaesthetist about a clinical exercise done by Dr Stumer?-- Yes, I saw that letter.

Yes. That was the basis of the investigation into Dr Stumer?-- That's correct.

And are you also aware that the matter was also referred to the Medical Board?-- Yes.

Thank you. Chris Royan is actually a female, isn't it? Christine Royan?-- Yes.

Who is an AO3 administrative officer responsible for admissions-----?-- That's correct.

-----at Bundaberg Hospital. Were you aware that there was a complaint made about her from the Director of Nursing at Childers?-- I thought the complaint was more related to her handling of the billing for option A contracts.

As a result of an independent audit. Did you understand that?-- I didn't know about the independent audit.

All right. And you haven't heard - is this news to you - about a complaint from the Director of Nursing at Childers about Christine Royan?-- I didn't know that. I know she went to Court and was found not guilty of mishandling funds at the Base Hospital.

Were you aware that a confidential agreement was entered into between Queensland Health and Christine Royan by which she left the employ of Queensland Health. Were you aware of that?-- No, I had wondered why she hadn't come back. Was it lucrative?

It is a confidential agreement, so I don't know, you don't know.

COMMISSIONER: You were asked about Dr Stumer and you mentioned that you are aware of a reference to the Medical Board. Do you know of the outcome of that reference to the Medical Board?-- Yes.

And what happened?-- He was exonerated.

But he still left the hospital?-- No, no, he was reappointed.

I see?-- So he still works - he has just - I think - I think he is still working at this time.

And how long was he stood down or out of action whilst that was being investigated?-- At least two years.

D COMMISSIONER EDWARDS: Was he on full pay?-- Full pay, motor vehicle, petrol expenses.

MR CHOWDHURY: Thank you, Commissioner. Now, in respect of the requests for further surgical staff, a further additional surgeon and visiting medical officers, it is the case, isn't it, that you were advised that it was simply a matter of budgetary constraints about funding for those positions when you raised it; that's correct?-- That's the answer I received, yes.

And your specific input was sought by Dr Wakefield, wasn't it, to try and obtain the additional funds so that the hospital could be properly staffed. Do you recall that?-- No.

Don't recall that?-- I mean, I made some earnings in option B. You are not referring to that, are you?

No, I am talking about an application from Dr Wakefield in 2000, who is then the Director of Medical Services, for funding from corporate services, Queensland Health, for a full-time additional surgeon and a four session a week visiting medical officer surgeon?-- I wasn't aware of that. And what was the outcome?

Well, can we take it one step at a time? Do I take it from your answer that this is news to you that you were asked by Dr Wakefield for your assistance to obtain that additional funding?-- I don't - I wasn't - I don't think I was asked for any assistance. I was simply told when I applied for a VMO position that they would - if I resigned they would reappoint another staff surgeon. There would be no VMO job for me.

If you have a look at this document? Can I indicate for the Commission this is a document that's attached to, actually, the statement of Dr Charles Nankivell.

COMMISSIONER: We might have that placed on the document projector so that everyone can see. Whilst that's coming, doctor, how could you have assisted Dr Wakefield in obtaining extra funding? Was it your position? Did you have any influence or capacity?-- I had no influence with Queensland Health upper knowledge at all. I mean, one wrote to them and got cursory replies, as did Dr Thiele, who wrote a beautiful submission to get appointments for Dr Michael Delaney, and got a very cursory answer in the negative.

I think we will have to turn the page 90 degrees.

MR CHOWDHURY: Dr Anderson, are you able to see at least the heading of that document? Perhaps that can be-----?-- No, I am not, I'm afraid. Should it come up here?

COMMISSIONER: It should be on the screen in front of you. Is it switched on? Any luck?

MR CHOWDHURY: It seems-----

COMMISSIONER: Can I ask the operator to put on the lower half of the page so that those of us who have read the top half can catch up with the rest?

MR CHOWDHURY: Dr Anderson, I take it you have just been given a copy by counsel assisting of that document. It is a memorandum to you, Dr Pitre Anderson, Director of Surgery signed by John Wakefield dated 22 May 2000, is that correct?-- Yes, that's right.

Do you want to just take a moment to read that?-- Yes. Yes, I have read that.

All right. Do you recall receiving that?-- I don't.

I accept this is now five years ago and presumably a lot of correspondence would come to you in your position as Director of Surgery, so I don't expect you to fully remember it. There seems to be, do you agree with me, two issues raised in that about the provision of endoscopy services, and then the additional question of obtaining a full-time additional general surgeon and a visiting medical officer surgeon. Accept that?-- Yes.

And in the third paragraph there it stated quite clearly to you that a proposal had been made for additional funding for those two positions?-- Yep.

That's so?-- Yep.

And in the last paragraph you were advised specifically that Dr Wakefield was wanting to enhance the chance of actually getting the money to address the issue and concludes, "Once this has been developed and a brief report, I will seek your advice prior to meeting with the zonal officer on the issue". Do you agree with that?-- Yes.

So your advice was sought in respect of a critical question of care at the hospital and funding for it.

COMMISSIONER: I am sorry, Mr Chowdhury, it doesn't say that. It says that once Dr Wakefield has developed his business case and a brief report, he will then come back to Dr Anderson for his assistance.

MR CHOWDHURY: I thought that's what I was putting to him.

COMMISSIONER: Well, you weren't. You were suggesting that that asks for his assistance and it doesn't.

MR CHOWDHURY: Well, depends on how one construes it.

COMMISSIONER: There is no question of construction at all. "Once this has been developed, I will seek your advice". It is speaking in the future, isn't it?

MR CHOWDHURY: All right. I will rephrase the question. You have given evidence here today that clinical staff were totally alienated from decision making. Doesn't that last sentence indicate there that Dr Wakefield on a critical issue was going to seek your advice on it?-- It appears that that's the case.

COMMISSIONER: Do you recall Dr Wakefield actually ever doing what he said in the last sentence he was going to do; that was to come back and seek your advice?-- No, I don't.

MR CHOWDHURY: But you are unable to say one way or another whether that occurred or not?

COMMISSIONER: He just said he can't recall.

MR CHOWDHURY: Well, probably follows from that. Can I deal with just briefly the issue that occurred in 2000 - I don't want to go into detail about it - return that document if you wish. And this commenced at paragraph 19 in the statement, that is the circumstances leading up to your resignation, all right?-- Yes.

Now, you agree, don't you, that all that occurred when my client, Mr Leck, was not present. He was away on extended leave?-- That's - that's true. I think he had three months away.

Yes. It is quite obvious from the correspondence that is annexed to your statement that the dealings you had were with Kate Young who had been brought in from another region to take over Mr Leck's job while he was away?-- That's correct.

Thank you. On Mr Leck's return, do you recall having a meeting with him in the latter part of 2000 where you wanted to get your job of Director of Surgery back?-- This is after I had resigned?

After you had resigned?-- I don't specifically recall that meeting.

COMMISSIONER: Can I ask you to pause for a moment? If there is someone in the room that has a mobile phone, that sometimes sets off this audio response. So can you make sure your mobile phones are off? The exception is any medical practitioner who is on call or any clinician that needs to have their contact activated.

MR CHOWDHURY: I didn't quite catch your last answer. Do you recall whether you had a meeting with Mr Leck, or not, after you had resigned where you had asked him for your-----?-- I recall a meeting with the zonal manager and I think Mr Leck was probably there.

Right?-- That's Lindsay Pine.

Yes. To put it bluntly, the circumstances that led to your resignation, as the Commissioner has already observed, would have been unpleasant for you?-- Most upsetting.

Yes. And left you feeling bitter about the circumstances of it? Do you accept that?-- My concern was for the welfare of the patients at the Bundaberg Base Hospital and my departure from that place put their lot in serious jeopardy. I am not a bitter person.

There was a reference prior to your resignation of the Crime and Misconduct Commission investigating you, wasn't there?-- Yes. This is an aside, yes, "Maybe you will be charged with a criminal offence and thrown into gaol, struck off the register", all those things. I think that's intimidation.

COMMISSIONER: Who did that come from?-- From - I think it is in the letter from Kate Young.

MR CHOWDHURY: Are you able to refer me to the particular letter? Do you have a copy of that?

COMMISSIONER: You are referring to your exhibit PEA2 which on the second page refers to a reference of the Criminal Justice Commission by the Audit and Operational Review Branch of Queensland Health.

MR CHOWDHURY: That third paragraph there, Kate Young advises that she is required under that relevant section to report matters to the Criminal Justice Commission?-- Correct.

Is the reference to being struck off and being thrown in gaol in that letter?-- That was a verbal aside that occurred when I met with Kate Young.

All right. Yes, I have no further questions, thank you.

COMMISSIONER: Well-----

MR CHOWDHURY: I am sorry, that document I showed him should probably be tendered.

COMMISSIONER: Mr Andrews, you are planning to call Dr Nankivell?

MR ANDREWS: Yes, Commissioner, and that document is intended to be an exhibit to Dr Nankivell's statement.

COMMISSIONER: Just so that the record is clear then, can you identify it for the record as - by its exhibit number to Dr Nankivell's statement?

MR ANDREWS: I can't, because the exhibits to that statement in my own copy don't seem to be marked.

COMMISSIONER: I see, all right. Can anyone else assist us with that? I don't have Dr Nankivell's statement.

MR ANDREWS: And Dr Nankivell, whose statement was prepared by non-inquiry staff, has a statement which makes no reference to exhibit numbers. It simply is accompanied by a large bundle of exhibits. So perhaps it is - this is a case for tendering the document discretely.

COMMISSIONER: All right. The memorandum, exhibit 200, will be the memorandum dated 22/5/2000 from Dr Wakefield to Dr Anderson for copies to five others as identified in that document. That's exhibit 200.

ADMITTED AND MARKED "EXHIBIT 200"

COMMISSIONER: Mr Chowdhury, I feel I should point out that

there is - Dr Anderson's statement, on my reading of it, contains considerable criticism of Mr Leck. This is Mr Leck's opportunity to answer his accuser if he chooses to do so?

MR CHOWDHURY: I understand that. I have asked all the questions I wish to ask, thank you.

COMMISSIONER: All right. I will note there is no challenge to those parts of Dr Anderson's evidence on behalf of Mr Leck. Mr Farr?

MR FARR: Thank you, Commissioner.

CROSS-EXAMINATION:

MR FARR: Dr Anderson, my name is Brad Farr. I am appearing on behalf of Queensland Health. Can I just start with a couple of discrete and distinct issues? You have spoken about Dr Delaney - Dr Michael Delaney. Can I ask you if you can confirm this for me - if you know it: that he became a fellow of the Royal Australasian College of Surgeons in 1998?-- I am unsure of that date.

All right?-- But he certainly is a fellow.

All right. What you do know of him, do you know if it is around about that time?-- Yes, I should think so.

Can I suggest this to you and ask if you would have knowledge of this as well: that he became a VMO, a visiting orthopaedic surgeon at the Bundaberg Base Hospital on the 9th of March 1999?-- Yes, I think initially he was allowed to work some weekends and I think that there were provision within the Department of Orthopaedics to give him sessions, but I think that was at the expense of someone else giving them up.

Right. But is it the case that he has been a VMO at the Bundaberg Hospital since that time?-- I am unsure of the time but I think he is a VMO at this stage.

All right. But he could have been a VMO, for instance, for as long as six years?-- He could have.

Dr Jayasekera you have spoken of?-- Yes.

You have spoken of him leaving the Bundaberg Hospital because of concerns he had for support and workload and matters you have referred to in your evidence?-- I think Dr Jayasekera was more upset with the appointment process which didn't give him the Director of Surgery job. As I mentioned in the statement, he was also very upset early in his appointment. He is an experienced Sri Lankin surgeon who, as I mentioned before, did two years registrar job, passed the Australian College exam and became a full fellow, he was appointed

initially as a staff surgeon at Year 7 wages and that was noted on his contract, and then Queensland Health came back the week after saying, "Sorry, we've made a mistake, back to year 4." Then the year after they came back, "Oh, you only got your fellowship last year. You should be a first year staff surgeon."

All right. So far as any evidence that you might give in relation to Dr Jayasekera, I dare say that you would agree that he would be the best person to speak of the concerns that he had?-- Yes.

All right. And if you have a belief as to a concern that he had which is inconsistent with, in fact, what he himself says, no doubt you would defer to his own opinion?-- I would.

If Dr Jayasekera has said in his own statement this, for instance - I'll just read it to put it in proper context: "I did not leave the hospital at Bundaberg because I was not successful in obtaining the position I applied for. The main reason I left is that I was in the process of moving back towards where my family were living back in Bracken Ridge. I wanted to work closer to them." I take it that you would defer to Dr Jayasekera in that regard?-- Yes, I would. I mean, he has intimated to me quite recently that he thought the process of him not being appointed was racist.

You have mentioned an issue that arose soon after his arrival at Bundaberg. That was over an issue of his rate of pay. My understanding is and, if I understood you correctly, your understanding is that that was settled shortly after his arrival to his satisfaction?-- I think it took months and months to get back from corporate office-----

Ultimately though?-- -----but he was - he was compensated in the end.

Ultimately he received the rate of pay that he felt he was entitled to?-- I think so, yes.

All right. I take it you would defer to this if this is what Dr Jayasekera said as well: "I did not leave the hospital because of any problems/issues that I was having with the management. At the time I was at the hospital Peter Leck was the District Manager and Dr Nydam was the Acting Director of Medical Services. I don't recall who the Director of Nursing was. I did not have any issues with whoever it may have been. While I was working in Bundaberg it was always my intention to return to work nearer to my home at Bracken Ridge where my family were residing"?-- Yes, at one stage he was looking at houses to buy in Bundaberg and was hoping that his wife would join him there. I think you must appreciate that Dr Jayasekera is a polite Asian gentleman and he was made to lose face by the management at the Bundaberg Base Hospital and his departure resulted in that and what he says there is face saving.

Do you suggest that we should take your opinion over his?-- I think you have to take those words into account.

It was the case, wasn't it, that he had family that lived in Bracken Ridge?-- Yes, I think so.

And he did make it known that it was always his intention to return closer to home?-- No, he didn't make that obvious to

me.

Didn't make it obvious to you, all right.

COMMISSIONER: Did he comment on that when he appeared before the selection panel of which you were a member?-- I think at that stage I assumed that if he became the Director of Surgery, that he would move to Bundaberg and live there.

There was no suggestion at that stage that he was already planning to move back to Brisbane and that he would not remain in Bundaberg even if he was offered a permanent position as Director of Surgery?-- There was none.

MR FARR: Did you discuss with the other members of the selection panel that issue?-- Of him staying in the long-term?

Or of him having expressed a desire to return home?-- No, that was never on the agenda.

It was not something that was discussed amongst the selection committee members for instance?-- No.

All right. Now, can I just take you back in time a little and I wanted to ask if you might be able to assist us. You have spoken of things called Option A and Option B contracts I think is the term you used?-- Yes.

You're familiar with those terms obviously?-- Yes.

I'm wondering if you might be able to assist those of us here as to what is meant by each of those terms?-- Yes, I can do that. I can't give you the exact details of financial remuneration but, basically, Option - an Option B contract allows a surgeon, in addition to his staff surgeon wage, to look after private practice in the public hospital, in the Bundaberg Base Hospital, bill Medicare and be paid an additional wage according to the work that is done. That money goes to him up to a limit, I think it was an extra 50,000, is it, and then beyond that the money earnt goes into a trust account of which I think the surgeon gets two-thirds and the hospital keeps the other money to use in improving the hospital.

Well, we'll stick with Option B seeing that's what you've started with?-- Yes.

Each of the options as I understand it is a system that has been put into place that would allow a full-time staff specialist to have the right of private practice. That's correct?-- Yes, yes.

Option B enables that specialist to earn extra income?-- Yes.

Via right of private practice?-- Yes.

The limit in so far as it was relevant, at least at the time that you were there, the limit of that extra income was the

equivalent to 50 per cent of the top rate of pay for a specialist-----?-- Okay.

-----in the system. Does that accord with your understanding?-- That rings a bell.

Then beyond that 50 per cent mark, the specialist is entitled to one-third of anything earned above and beyond that mark?-- Yep.

And the remaining two-thirds goes into a trust account?-- Yes.

And that trust account is then designated for particular uses. You'd agree with all of that?-- Yes, I would, mmm.

And the uses listed are generally to do with research, development, that type of thing. You'd agree with that as well?-- Yes.

All right?-- But I think they were the suggestions.

Okay. It was a system that was designed to encourage permanent staff members to remain permanent staff members but enable them to earn extra money?-- Yes.

Option A also was a system introduced to allow a full-time staff specialist to have a right of private practice. You'd agree again?-- Yes.

It had a different approach in that it would enable the specialist to be paid an extra preset amount?-- Yes.

If they opted for Option A?-- I think 40 per cent of their wage, mmm-hmm.

Can I suggest to you for metropolitan specialists it was 35 per cent of their salary; for rural doctors, 45 per cent. Does that sound correct to you?-- Yes.

But the doctor under an Option A contract does not receive individual income, if you like, per patient; they simply have this extra income from Queensland Health?-- They do, yes, whether they actually-----

And there was a system in place?-- -----make that much money or not.

Yes?-- But they are paid the amount agreed.

That's right?-- Mmm.

And you may or may not be able to help me with this but it would appear on the face of it at least that perhaps the Option A is the option that most reasonably junior specialists might take when in the course of developing their reputation and their practice and that, perhaps, they might then change over to Option B when they're of a view that they might be able to earn more money by adopting Option B?-- Yes.

Is that the way it might work in theory?-- Yes, I think so.

All right?-- Or how energetic you are. You know, when I was doing Option B, they gave me an extra list specifically for private patients.

All right. There are certain conditions of course which attach to each option. That's correct?-- Yes.

And it is stated quite clearly that of paramount importance is the consideration for the public patients?-- Yes.

So that you can't for instance conduct a private practice in some way that might be of detriment to one's public patients. I know it goes into a long spiel of how one might achieve that but that's the intent?-- But nevertheless those who are a private patient did jump the waiting list to be able to get operated on one quicker, and that's one of the patient's incentive to become a so-called private patient.

That's right, because a patient could elect to be a private patient for instance and use your services; is that correct?-- What was the last bit?

The patient can elect to be a private patient?-- Yes.

That would then, effectively, enable them to avoid a waiting list in the public system for instance?-- That's right, but they had their surgery still done in the public hospital.

Yes?-- The bed rate was about $200 a day I think for those patients out of their own pocket.

All right. So each of these options were incentives if you like for full-time staff specialists to earn extra money?-- Yes.

And perhaps also be an incentive to remain a full-time specialist with the right of private practice?-- Yes.

You would agree with me also I take it that the - one of the benefits of having full-time staff specialists is that it is frequently the feeding ground for the private profession in any given area. Dealing with the rural area, frequently the private profession in that rural area started off in the public hospital?-- Yes, correct.

That system enables the doctor in question to get into an area, establish himself or herself, build a reputation, ultimately perhaps with a goal of becoming a private practitioner-----?-- Yes.

-----in that region and have the opportunity of hitting the ground running if you like rather than coming in cold?-- I agree.

It would appear to be the case, and please tell me if you

disagree, that that is a system that has been in place it would seem for some considerable time and has much to commend it?-- Yes.

You would be an example, I take it, of that type of thing, where you'd been to the public hospital firstly before moving on to the private sector within that same region?-- That's correct.

And I take it, in Bundaberg, a lot of people were in a similar position?-- That's right. Most if not every specialist who's in private had an initial appointment at the Base Hospital.

I see. Now, can I take you to some features of your employment whilst you were a full-time staff specialist. You, whilst you worked there, utilised either Option A or Option B at different times?-- That's correct.

And you are able to swap from one to the other?-- Yes.

I think-----?-- At the conclusion of a year's contract.

That's right, and they're each 12 months in duration?-- Yes.

And you in fact did so?-- Yes.

During the time that you were working there, is it correct to say that there were a number of complaints from other staff members that your private commitments were interfering with your public duties?-- Are you referring to the private practice I had at the Bundaberg Base Hospital?

Yes?-- Or outside?

Well, referring to the practice that you were conducting outside the Base Hospital?-- I - I think that brought some resentment in some quarters.

I'm not wishing to and I don't intend to go into the rights or wrongs of any given complaint; I'm just trying to get the chronology?-- Yes.

Okay. But as far back as 1996 there were complaints regarding your private commitments interfering with public commitments; you'd agree with that?-- I can't be sure about that.

All right. Then on the 1st of July 1999?-- Yes.

You changed from Option B to Option A?-- That's correct. After I came back from my sabbatical.

Right. In August of 1999 were you aware that there had been a complaint or complaints made that, again, your private commitments had interfered with your public commitments?-- I can't recall that.

All right. The date in itself is not particularly important but do you remember an issue of that nature arising some time

after going on to the Option A?-- Who was it from?

Dr Little?-- Who?

Dr Little?-- Oh, yes.

Do you remember that now? Does that assist your memory?-- I don't recall him, you know, talking to me or writing to me about that.

Right. Do you remember anyone else raising that issue with you?-- No.

COMMISSIONER: Who was Dr Little?-- He was an anaesthetist who came to Bundaberg and worked there for a couple of years and he was the prime mover in complaining about Dr Stumer.

Right?-- I think he has a history of multiple complaints.

D COMMISSIONER EDWARDS: He was a part-time visiting specialist?-- No, Dr Little was a full-time staff anaesthetist.

MR FARR: Well, do you recall receiving a memorandum from Dr Wakefield drawing your attention to he having received several complaints and reminding you of your obligations pursuant to your employment conditions?-- I - I don't have a copy of that.

No, that's quite all right. I'll ask you, if you wouldn't mind, to have a look at this document to see if it assists you.

COMMISSIONER: Yes, Ms Gallagher.

MS GALLAGHER: If I may, Commissioner, these are clearly matters that have arisen at least or substantiated in those parts of the statement to which you have referred previously this morning.

COMMISSIONER: Yes.

MS GALLAGHER: If Mr Farr has documents that traverse a different position to that which has been put in this statement, given what the Commission's position was this morning, my submission is it might well be appropriate simply to tender those documents, let them speak for themselves and the Commissioners prescribe what weight to them as they see fit in a balancing exercise rather than traverse such issues in Court.

COMMISSIONER: Oh, I think you're being unduly sensitive. I think Dr Anderson is doing a splendid job of refuting these allegations. I'd be inclined to let him keep going.

MS GALLAGHER: Thank you, Commissioner.

MR FARR: Have you had a chance to read that?-- Yes, I have

had a cursory read.

All right. Does that refresh your memory?-- It does.

I take it that document was sent to you back on the 1st of September 1999?-- I think it was, yes. Mmm-hmm.

I just can't remember, was the screen in front of you working when we had it on the machine before?-- No, it's not working.

The effect of that document is that you were advised by Dr Wakefield that you had received some complaints and it was a reminder to you of your obligations and sought to ensure that future problems didn't arise. That would be a summary if you like?-- Yes, that's the advice, mmm-hmm.

All right. I'll just allow it to be read?-- You'd be aware that under the previous Director of Medical Services Dr Thiele, I was allowed to do one session of private surgery outside the Base Hospital and those decisions - but that was in Option B as you've correctly said, but that decision was at the discretion of the Director of Medical Services.

Right.

COMMISSIONER: But the memorandum from Dr Wakefield says, "In the light of this information I request that you cease any private practice during rostered hours outside of Option A." Were you doing private practice during rostered hours other than that which was covered by Option A?-- I was. I was doing-----

And that was the arrangement that Dr Thiele had approved?-- That's right.

So did you take this as effectively revoking the approval Dr Thiele had given you?-- That's correct.

Yes.

MR FARR: I will tender that document, Commissioner.

COMMISSIONER: Yes. That memorandum from Dr Wakefield to Dr Anderson of the 1st of the 9th of 1999, 1st September 1999, will be Exhibit 201.

ADMITTED AND MARKED "EXHIBIT 201"

MR FARR: Thank you, your Honour. Now, would you have a look at this document for me, Dr Anderson, which I think is probably your response to the previous document, dated the 9th of September '99. I take it that is your response to the previous document?-- Yes, that's correct.

And the effect of that is that you were advising Dr Wakefield that you would reschedule your private clinic so that it would take place outside business hours?-- I did that to some degree.

All right?-- As I've laid out in my answering letter.

So-----?-- But I did continue the Wednesday afternoon operating list in private in contrary to Dr Wakefield's instruction.

COMMISSIONER: I was going to ask you that, Dr Anderson. Dr Wakefield's memorandum on the 1st of September said, "The contract clearly states that the specialist is not to engage in any form of private practice in any location during normal working hours of 8 a.m. to 6 p.m. Monday to Friday." But as I understand it, those weren't your normal working hours because you were on-call every second night and therefore you had Wednesday afternoons off; is that right?-- I think the working day is 8 till 6.

Yes?-- Five days a week. I think management could interpret liberally to provide a staff surgeon with a day off, but - with an afternoon off, but that wasn't the case when Dr Wakefield came-----

No, that obviously wasn't Dr Wakefield's attitude, but so far as you were concerned, you didn't normally work on Wednesday afternoons at the hospital, at the Base Hospital?-- That's right. If I played golf, it would have been better than doing private practice. But - but one didn't have a rostered afternoon off. That wasn't part of the contract.

No.

D COMMISSIONER VIDER: Dr Anderson, was your contract with Dr Thiele or the arrangements that you had reached with Dr Thiele regarding employment and availability, was that documented?-- Yes, I think the Option B contract is a more liberal document.

I'm talking about the contract you had under Dr Thiele's-----?-- Yes, that was when I was doing contract - doing Option B, sorry, and does give the Director of Medical Services some responsibility to allow people to do limited private practice outside the hospital.

COMMISSIONER: Dr Anderson, before we waste a lot of time over this?-- Yes.

I just want to make sure that I understand it entirely. I've read the charges, if you like, that were brought against you by Ms Young as Acting District Manager and there is no allegation there of you working on Wednesday afternoons. The only allegation is that you worked on Wednesday morning and you say that was before 8 a.m.?-- That's correct.

It is alleged that you worked privately on Thursday afternoon

and your answer to that was that you weren't working with private patients on Thursday afternoon; you were actually doing your regular endoscopy session at the hospital?-- That's correct, so those allegation were false or trumped up.

I don't see there is any allegation here contrary to what-----?-- I do admit that I did a session on the Wednesday afternoon in private practice.

And all that comes down to is Ms Young or someone taking the position that it would have been better for the patients at Bundaberg for you to be playing golf or scuba diving or having a nap at home rather than looking after private patients at a private hospital?-- You said it.

Mr Farr.

MR FARR: It was more than that, though, wasn't it, Dr Anderson?-- Sorry?

It was more than that. You were aware, were you not, that the allegations involved, for instance, surgical procedures being undertaken by people who were ill-equipped because of your absence?-- No, I refuted those two allegations and I think they're trumped up charges like most of the other things and, classically, the question of the retractor as has been documented, my personal retractor, which I bought when I went to Bundaberg, allowed the other surgeons to use, I take it to use in private and then there's a question of me taking it without authority.

COMMISSIONER: You're charged, in effect, with stealing your own property?-- That's right.

MR FARR: But that was the allegation that was made. You understood it was an allegation?-- Yes.

And you understood also that there were other allegations?-- Many.

One being, for instance, that a particular surgical procedure that should have been concluded in about 45 minutes took two hours because you had to be obtained - had to be brought from another private hospital. Do you remember that?-- No.

Once again, I'm not attempting in any way to determine the correctness of either side. All I'm looking at is the nature of what was alleged and I know that you have made a number of responses to those allegations?-- Mmm-hmm.

But this is the allegation that would have been provided to the management of the hospital as at that time?-- As I put down.

That's right. You understand it as that?-- Yes.

You, in response, gave your version relevant to those issues?-- Yes.

COMMISSIONER: Well, before you did that, I see from Exhibit PEA2 that your first notification of these allegations was that you were suspended without pay pending investigation?-- That's correct.

How long were you suspended without pay pending that investigation?-- Well, there was no investigation because it all went away when I resigned.

Well, how long were you, as it were, on the list at the hospital without pay before you resigned?-- Oh, three weeks I would have thought.

You-----?-- Two or three weeks.

-----promptly responded to the letter of the 2nd of August. I think you replied on the very next day?-- Yes.

You have been given the opportunity to show cause why you shouldn't be suspended without pay. Having shown cause, did you continue to be suspended without pay?-- Yes.

And that continued until you resigned?-- That's correct.

Yes. Yes, Mr Farr.

MR FARR: Yes, thank you very much, Commissioner, but we will continue on nevertheless. You made your response, which is the document you have sitting to your left just there?-- Yes.

I tender that?-- You will appreciate that over this period I was trying to negotiate a VMO arrangement, that I was trying to make the best of a situation that was present.

COMMISSIONER: The memorandum of the 9th of September 1999 from Dr Anderson to Dr Wakefield will be Exhibit 202.

ADMITTED AND MARKED "EXHIBIT 202"

COMMISSIONER: Yes, Mr Farr.

MR FARR: And in response to your letter Exhibit 202, did Dr Wakefield write to you briefly and say there, on the very next day, "Dear Peter, I'm happy to sit down and talk about the issues brought up in your memo when I return from holidays. It would be appropriate if your private commitments during work hours outside of Option A could cease within the next two weeks." You can have a look at it if you wish but-----?-- Yes, that rings a bell.

all right then. And that was the position that was arrived at at that stage. You were allowed the opportunity of ending your private commitments that fell outside of Option A and you were given a two-week period of time to sort things out; is that correct?-- Correct.

You understood that the basis for all of that was the concern that it was a commitment that was impeding upon your ability in the public sector during work hours?-- No, I would dispute that. I mean, I did make concessions and gave it all my best when I was at the Base, and I took one session on the Wednesday afternoon as a private-----

COMMISSIONER: I think Mr Farr's question was Dr Wakefield was motivated by a concern this was impeding your practice with public patients at the hospital. Did Dr Wakefield ever tell you that?-- No.

Would there be any basis for Dr Wakefield to have such a concern?-- I don't think so.

MR FARR: But you were aware, weren't you, that Dr Wakefield had received complaints from other staff members at the Bundaberg Base Hospital on that very issue. You were aware of that, weren't you?-- I don't think I was. The letter from Dr Little, I think, I probably discounted.

Right?-- But I don't think he ever showed me any literature of complaints.

But discounting it means, of course, that you were aware of it. You had a different view about things. I understood that?-- Sure.

But you were aware of the complaints that Dr Wakefield was receiving. That's what I'm asking.

COMMISSIONER: Well, Mr Farr asked you about complaints. You've identified one. Was it Little or Whittle?-- Little.

There's one from Dr Little that you refer to as a serial complainer. Were you aware of any other complainants?-- No.

MR FARR: All right. In any event, that was then, if you like. We've got up to 10 September 1999, I think, was the date, and that was the effective end of that issue at that stage, wasn't it?-- If you say.

Well, does that accord with your recollection?-- The end of what issue?

That issue was then sorted out. You'd written, you were saying you were going to rearrange your private commitments outside of Option A?-- Yes.

Dr Wakefield responded and said, "Look, can you do that within two weeks", and that seemed to be the end of it?-- Yes.

Okay. We then move on to documents that I think you refer to in your own statement which take us through then until August of the year 2000, and that's when you speak of the letter from Kate Young who was the Acting District Manager at the time?-- Yes.

COMMISSIONER: Before you got that letter from Kate Young of 2nd of August 2000, had anyone raised with you suggestions that you had falsified timesheets?-- No.

Had anyone raised with you suggestions that you'd stolen an abdominal retractor?-- No.

Had anyone raised with you suggestions that you were, in effect, negligent for failing to supervise minor operations by the PHO?-- No.

These all came out of the blue, did they?-- They did.

The only thing that had been raised before was this issue about practising privately out of hours?-- That's correct.

And as you understood the situation at the time, you'd complied precisely with what Dr Wakefield had asked you to do?-- No, no, I didn't comply with Dr Wakefield's instruction regarding the Wednesday afternoon.

I see?-- It isn't an automatic afternoon off.

Yes?-- I think Option A states between 8 a.m. and 6 p.m. no private practice should be taken - should be done.

Yes?-- So I am in breach of the contract with regard to Wednesday afternoon.

Yes.

D COMMISSIONER EDWARDS: But it was well known within the system that you were doing that?-- Yes.

And nobody raised with you that it was wrong, in inverted commas?-- Only Dr Wakefield.

Thank you.

COMMISSIONER: And in fact when you look at PEA2, the letter from Kate Young - do you still have your copy in front of you?-- Yes.

You see the first bullet point deals with working in a private capacity at a number of private health facilities, but when you look at the details, the complaint's made about Wednesday morning and Thursday afternoon. Wednesday morning was, you say, before 8 a.m.?-- That's correct.

And Thursday afternoon you weren't at the Mater Hospital, you were doing your regular colonoscopy session - or endoscopy, was it, at the base hospital?-- I used to consult on a Monday evening after 6 o'clock.

So neither of these allegations in this letter had any substance?-- True.

Did anyone approach you before you got this letter and say, you know, "It's being alleged that you're working on Wednesday mornings during hospital hours."?-- No, no, there was no warning that disciplinary action was going to occur.

MR ANDREWS: Commissioner, I do note that in reading the dot point one in that letter, you did what I did the first time I read it and see it as reference to Wednesday morning because it's underlined, and Thursday afternoon, but you will see that on a proper construction it also refers to Wednesday afternoons.

COMMISSIONER: Yes. Yes, you're perfectly right, Mr Andrews.

MR FARR: Dr Anderson, I take it at that stage you were not aware of what information, for instance, Miss Young was in possession of when she wrote that letter?-- No.

And whether she had made inquiries of the private hospitals concerned?-- I think one of the managers at the private hospital had mentioned a phone call.

You in fact had a meeting with Ms Young that day, on the 2nd of August 2000, didn't you?-- Yes.

That was prior to that letter being sent to you?-- That was when the letter was handed to me.

In fact these issues were raised during the course of that meeting. That's correct?-- Yes.

And Miss Young - and there might have been others present as well, but Miss Young certainly gave you the details of the information that she had received in so far as the nature of the complaints are concerned?-- She just gave me the letter.

Do you remember that the letter in fact was delivered to your home at about 2.30 that afternoon?-- No. I think that was her subsequent letter.

In any event, prior to the receipt - or at the time of the receipt, whichever might be the case, you were asked to attend a meeting during which there was a face-to-face discussion about these issues?-- That's right. I was called out of the clinic to come and have a talk with Kate Young, and at that time the letter was given to me.

Right?-- I thought when I was going up there it may well have been something to do with Dr Stumer's inquest.

Now, whether rightly or wrongly, it was quite clear that Miss Young took these allegations very seriously?-- She almost apologised for giving me the letter.

Do you recall - you were-----?-- That's what makes me think that she didn't write it.

You were suspended from duty - you've spoken of that - which, of course, means that your patients would have to be given some information?-- Yes.

And do you understand that the patients were given information simply that you had been called away urgently "and we don't have a date for his return"? Do you remember that being-----?-- I wasn't party to that process. I was out of the hospital.

COMMISSIONER: You're not in the practice of lying to your patients whatever the attitude of management at the hospital might be?-- I try not to.

MR FARR: If in fact the patients had been given that information, that would have been best in so far as your interests are concerned at that time, wouldn't it?

COMMISSIONER: Do you feel it's a good idea to lie to patients?

MR FARR: That's not my question, Commissioner.

WITNESS: I don't.

COMMISSIONER: That's my question.

MR FARR: Perhaps he can answer mine first.

COMMISSIONER: Answer Mr Farr's question?-- It's not a good idea to lie to patients. I felt particularly sorry for the chap who was taking his prep to have his colon cancer resected the day after.

MR FARR: Was there any discussion with you about what your patients would be told?-- No.

And if they were told, "Dr Anderson has been called away urgently and we do not have a date yet for his return", would that have been the most neutral way it could be placed in so far as you're concerned?-- That's not a question for me to answer.

Right.

COMMISSIONER: Would it have been true? Were you called anywhere?-- No, I was sitting at home.

D COMMISSIONER VIDER: Did you have a Wednesday morning operating session at the Bundaberg Base Hospital, Dr Anderson?-- I think the Wednesday morning was an endoscopy session. Yes, that's correct.

Was an anaesthetist in attendance for that endoscopy session?-- I think initially we used to give - God forbid - our own sedation, but I think increasingly an anaesthetist may have come in to be attending that session.

In light of the fact that there's been comment made about your timesheet, if you worked privately on a Wednesday morning, were you-----?-- Wednesday afternoon.

There's a note here that you did this before 8 a.m. on a Wednesday morning?-- Yes, okay, before 8 a.m.

You would have always been available then in the Endoscopy Department by 8 a.m. on Wednesday morning if you had-----?-- That's correct, yes.

If you had done work previously?-- Yes.

Thank you.

MR FARR: You were advised that Miss Young was of the view that she was required, in the circumstances, to notify the CJC. That advice was given to you at some stage, I understand?-- Yes, yes. That's a pretty frightening bit of advice.

Yes, I'm sure it would be. And then on the 7th of August 2000 did you write to Miss Young asking her - or telling her that you were considering resigning and asking about potential future VMO positions?-- Well, there was a letter - did you say the 3rd of August?

The 7th?-- The 7th?

I don't know that it's attached to your statement. Would you have a look at this?-- Yes. I don't know that I've got a copy of that. Yes.

That's your letter?-- Yes.

And in that letter you are advising her of what you are considering and asking about the future employment prospects in so far as a VMO position is concerned?-- Yes, that's right. I had to make a decision to contest the charges against me or to resign, and I was trying to get as much information about my options on that score.

COMMISSIONER: Doctor, do you have a family?-- Sorry?

Do you have a family?-- Yes.

How was Queensland Health expecting you to support that family while you were suspended without pay for as long as it took them to conduct this investigation?-- I don't know.

You see, you're talking about being given options. It doesn't seem to me as if you had any option at all but to resign?-- I think that's correct.

MR FARR: In fact he spoke of asking of his options and asking what the information was. That was the evidence.

COMMISSIONER: Yes.

WITNESS: Yes, I mean, the average investigation takes two years. It would be hard to keep the family - keep the bread on the table.

MR FARR: In any event, in the letter of 7 August you asked about things such as applying for future VMO positions, being able to attend education sessions at the hospital, treating intermediate patients and participating in afterhours call rosters?-- Yes.

You also spoke of, if deciding to proceed to an investigation, could you be given details of who the investigation team would be, if you were found guilty of any of the accusations, the likely disciplinary action that would result. You were, as you say, trying to get as much information as you could?-- I was, yes.

And included in that you enclosed, as I understand it, documents to show that the retractor was something that you had purchased yourself?-- That's correct.

I'll tender that letter.

COMMISSIONER: After you provided evidence that you'd purchased the retractor which you'd been accused of stealing, did you receive any apology or retraction of that allegation from Queensland Health?-- No, although I think there is another letter from Kate - no, I don't think there was any retraction of false charges.

MR FARR: All right. Would you have a look at this-----

COMMISSIONER: To this date have you received, to your recollection, any such apology?-- No.

The letter from Dr Anderson to Ms Young of 7 August 2000 will be Exhibit 203.

ADMITTED AND MARKED "EXHIBIT 203"

MR FARR: Would you have a look at this document, please? Is that another letter of the same date, this time to yourself from Ms Young in response to the letter we've just been looking at? You will just have to answer for the record?-- It is.

COMMISSIONER: The document that's been put down in front of you, is that-----?-- Oh right. Okay.

-----the response?-- Yes, that is a letter I received.

MR FARR: In that letter Ms Young responds to each of the topics that you raised in your own letter of earlier that

day?-- Yes, that's in the event of my resignation.

I beg your pardon?-- That's all in the event of my resignation, isn't it?

Well, firstly she's responding to the questions that you've asked?-- Yes.

That's correct? She speaks of, in response again to a question that you asked, that ordinarily three months' notice of termination is given, but that can be reduced, and please speak to her if you wish to do so. That's a summary of what she says. You agree?-- Sorry, could you talk up a little bit?

Certainly. She speaks of there ordinarily being a three month resignation period, but that can be reduced, and if you wish to do so, please speak to her - come and see her or something to that effect?-- Yes, okay.

She can't assist you in relation to penalty, but she does highlight for you the potential problem that if you proceed to an investigation, or if you resign giving three months' notice, then you would be without pay for three months, whereas if you resign immediately then you can enter private practice immediately. She highlighted that potential problem to you, didn't she?-- Yes, I haven't read all the detail of that.

All right. But that would accord with your recollection? Okay.

COMMISSIONER: You have a clear recollection of being told to the effect that if you didn't resign you'd be off work without pay for at least three months?-- I didn't - I don't have a recollection of that.

MR FARR: I might have misstated the question. If there was a three month resignation period given, then you'd be without pay for three months. That was pointed out to you, wasn't it?-- I don't recall that.

All right. The letter will speak for itself. I tender that letter.

COMMISSIONER: The last paragraph of that letter reads - this is dealing with the Roshards retractor - "You will appreciate that given the allegations raised against you relating to the use of equipment, it is important to correctly establish ownership of such equipment. Accordingly, I will need to have the district records examined and review your evidence of ownership before I can resolve this matter. Should this process establish your ownership of this equipment, I will ensure its prompt return." Were you ever told about the outcome of such an examination of the records?-- Well, I was taken down to pick up the Roshards retractor when I left the hospital.

I see. It didn't come with an apology though?-- No, I'm afraid not.

The letter from Ms Young to Dr Anderson of 7 August 2000 will be Exhibit 204.

ADMITTED AND MARKED "EXHIBIT 204"

MR FARR: You were advised - I think again by Ms Young - that any investigation would immediately cease if you were to resign from that position?-- That's right.

That was something that you wanted to find out yourself, and you were given that information in response, weren't you?-- Yes.

And you did resign on 16 August 2000?-- Yes.

And you entered into financial arrangements whereby you agreed to repay a certain amount of money?-- Correct.

And that then was paid over a 12 month period of time or something like that?-- That's correct. I did that in an effort to keep my - keep the door open at the base hospital. As I have said before, my paramount concern was for the welfare of the patients, and I was hoping that by paying that back I would get the VMO sessions, be able to continue on operating and doing my job.

All right. So, we know that in August 2000 was when you finished up as a permanent staff officer. Then in December 2001 you were offered a VMO position?-- Correct.

At that stage it would appear that Dr Lyn Hawkin was the Acting Director of Medical Services?-- Correct.

And you had a meeting with her?-- It's a male actually.

I'm sorry. It's a male. My mistake. You had a meeting with Dr Hawkin?-- Yes.

And then he wrote to you subsequently offering you two specialist sessions per week-----?-- Three, I think. Three sessions a week.

I'll ask you to look at this document to start off with. There is a response to it which I'll show you in just a moment, but that's the original offer, if you like, after that meeting?-- Yes.

COMMISSIONER: Is that different from PEA11?

MR FARR: It is. Yes, Commissioner. I'm sorry, I better just double check that. I might be giving you a double-up

document, and I don't wish to do that. No, that's the same one. It's the next one that's different. I'm sorry. You've attached that one to your statement. You're familiar with that document. That was the offer in writing, if you like?-- Yes, yes, I think the contract may be slightly different.

Yes. In fact I think it is?-- I hope it is.

Your response is contained in a letter of 10 December which I'll ask you to have a look at. It would appear that, just on reading that document, you were of a view it was three sessions a week?-- Yes.

And I think you've clarified that issue in that document?-- Yes.

And then you were subsequently appointed to the position of Visiting Medical Officer in surgery on a three sessions per week basis and a share in the afterhours call as agreed?-- As agreed, yes.

That was the chronology, if you like, of the appointment as a VMO. You'd agree with that?-- Yes.

I'll tender that final document then.

COMMISSIONER: The letter from Dr Anderson to Dr Hawkin of 10 December 2001 will be Exhibit 205.

ADMITTED AND MARKED "EXHIBIT 205"

COMMISSIONER: Yes?

MR FARR: You have remained a VMO at the Bundaberg Base Hospital from then until the present time?-- I have.

Some years ago, whilst you were still a permanent employee, you - and you have referred to it in your statement - made attempts to obtain a five session per week VMO position for yourself?-- That's correct.

And if I've understood things correctly, was the effect of the response this: "Look, if a permanent staff member leaves then we attempt to replace that person with another permanent staff member."?-- That's correct.

"If unsuccessful, then of course we'd have to look at other options which might include a VMO position, but the first port of call would be to attempt to replace a permanent staff member with another permanent staff member."?-- That was explained to me, yes.

When you left, I understand it was Dr Baker that replaced you?-- Yes, I think there were some locums and then Dr Baker

came on.

And he started on a permanent basis, we've heard?-- That's right.

Upon his appointment there would have been the permanent surgeons working at the Bundaberg Hospital plus whatever number of surgeons there were working in the private profession in Bundaberg?-- Yep.

You then being one of that category?-- Yes.

That would have meant that at that stage there was one additional surgeon in Bundaberg, because Dr Baker had replaced you, you'd stayed in Bundaberg, just gone into the private area?-- Yes.

So in fact there was in fact one more person in that field within the town?-- At that time there was, yes.

Would you agree with me that in so far as VMO positions are concerned, there has to, of course, be the need, if you like, for someone to have such a position. There's no point having a VMO if there's no work for that person?-- Yes. I think it was a financial - a decision made on lack of finance. There was plenty of work for a half term VMO, as I've outlined before.

I understand your position in that regard?-- The waiting list was enormous. There were people waiting for a year to have colonoscopies who were subsequently found to have bowel cancer. I mean, Queensland Health was leaving themselves way open to litigation.

And your appointment as a VMO, if I have understood the chronology correctly, would have been within a few months of Dr Baker's resignation?-- Yes, I think so, that's right.

All right. Can I just pick up on one topic, you spoke and you have been questioned about the Otago audit system. Is that a system you used in your private practice?-- I don't at this stage, no.

COMMISSIONER: Are there systems - you perform surgery at the Mater, don't you?-- At the Friendly Society Private Hospital.

Do they have equivalent systems?-- I - I use a - an ordinary book system. I think other surgeons have their own computer systems.

Yes.

MR FARR: And do you say that it is a particularly good system for the public sphere, not private, or is there-----?-- I think it is equally good in both public and private.

I see, all right. That's all I have, thank you.

COMMISSIONER: Thank you, Mr Farr. Ms Gallagher, any re-examination?

MS GALLAGHER: If I may, Commissioner.

RE-EXAMINATION:

MS GALLAGHER: Doctor, you suggested to Mr Farr, when he asked you a question, there had been the case that a late diagnosis of cancer as a result of a wait for endoscopic investigation, was that right?-- I just made a statement, yes.

Could I please show you this letter? And perhaps you could tell the Commission if this is the patient to which you were referring?-- This is one such case. This is oesophageal cancer, but there are a number of cases of bowel cancer which were diagnosed at a late stage because of the waiting list for endoscopy and colonoscopy at the Base Hospital when I was there.

That's correspondence signed by you?-- It is.

Dated the 3rd of May 2000?-- That's right.

I tender that correspondence, Commissioner.

COMMISSIONER: Doctor, we have heard evidence from Dr Molloy - and I can't help noticing there has been further discussion in the media over the past couple of weeks - about waiting lists.

The suggestion we heard from Dr Molloy is that there is, as it were, an official waiting list, but there is also a waiting list for the waiting list because you can't get on the waiting list until you have seen a specialist or perhaps gone through a private procedure, such as an endoscopy or colonoscopy to get on the official waiting list for elective surgery. Are you able to comment on that situation?-- I am, yes. Patients are categorised as 1, 2 and 3 for surgery, 1 being very urgent to be done within one week - one month. Usually some sort of malignancy or very serious condition. Patients who are referred to clinics for specialist assessment are also given a category 1, 2 and 3, so that patients who may have what's assessed on - by the surgeon on the GP's letter as having a non-urgent condition may wait to see a specialist for a year before getting into the clinic to see the specialist, and that's where the bottleneck is at this stage in providing patient care. Once they have seen the specialist, they then get on to the waiting list and - to have their surgery and these waiting list statistics are reasonably favourable, I think, at this stage, but you are absolutely correct. It is the wait to see the specialist in the clinic which is the critical factor.

And procedures like endoscopies and colonoscopies are generally prophylactic, aren't they? They are intended to identify if there is a cancer or some other problem?-- Yes, they are diagnostic procedure, generally speaking.

Yes, yes. And that sort of diagnostic procedure is fairly worthless unless it is done promptly and routinely. If you are waiting 12 months to be diagnosed for bowel cancer, then you are at risk of the cancer progressing to a state where it is inoperable over that imperative 12 months?-- That's true.

The letter from Dr Anderson to Dr Nankivell of 3rd of May 2000 will be exhibit number 206.

ADMITTED AND MARKED "EXHIBIT 206"

COMMISSIONER: The letter contains the name of a patient and the patient's date of birth. And consistent with the usual practice that's been adopted in these proceedings, I will direct that the patient's name not be published or disclosed or broadcast outside these proceedings. That's exhibit 206.

MS GALLAGHER: Thank you, Commissioner. Doctor, was the position of the waiting list any better, ie were the wait times shorter for investigation for such things as you have just spoken to the Commission about at the time when you were suspended without pay?-- At the time I was suspended, the waiting time for endoscopy and colonoscopy was extremely long.

Thank you?-- Subsequently, gastroenterologists visit Bundaberg and have improved on that situation.

I think we have heard previously there was a blitz in respect of such investigations?-- Say that again?

There was a blitz in respect of such investigation, such doctors were brought to Bundaberg for a period of time, carried out many of those investigations and then went back to where they came from?-- No, I think there was a blitz, as you say, but I think the - one gastroenterologist comes once a week and does a list of endoscopies and colonoscopies at this time.

Doctor, it was suggested to you that you might well be bitter in respect of your experience that gave rise to the circumstances of your resignation and I think you rejected such a suggestion, is that right?-- I am not a bitter person. I am angry that Bundaberg Base Hospital's department of surgery, which I took six years to build up into a model department, has come to nought.

And, indeed, you have been back delivering health care services to the people of Bundaberg in the public sector for four and a half years as a VMO?-- That's correct.

Thank you, Commissioner, I have nothing further.

COMMISSIONER: Mr Andrews, any re-examination?

MR ANDREWS: No, thank you, Commissioner.

COMMISSIONER: I was hoping you would say that. Dr Anderson, thank you very much for coming down to give evidence. Thank you for your time and the concise and precise way in which you have given your testimony, which I am sure will be of great assistance to us. You are excused from further attendance?-- Thank you, Commissioner.

WITNESS EXCUSED

COMMISSIONER: Gentlemen, I suppose you want lunch. Shall we resume at 2.30? Is that enough time?

MR ANDREWS: Very indulgent, thank you, Commissioner.

COMMISSIONER: Not at all? Seriously, is that enough time?

MR ANDREWS: Yes, thank you.

THE COMMISSION ADJOURNED AT 1.37 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.31 P.M.

COMMISSIONER: Thank you, Mr Andrews.

MR ANDREWS: Commissioner, I call Dr David Charles Risson.

DAVID CHARLES RISSON, SWORN AND EXAMINED:

COMMISSIONER: Dr Risson, please make yourself comfortable. Do you have any objection to your evidence being filmed or photographed?-- Yes, I do.

There won't be any photography. What about voice recording?-- That would be fine.

That would be fine?-- That would be okay.

All right. There will be no cameras turned on the witness.

MR BODDICE: Commissioners, we seek leave to appear on behalf of Dr Risson.

COMMISSIONER: Certainly.

MR ANDREWS: Dr Risson, my name is Andrews and I assist the Commissioners. Have you prepared - would you tell the Commission your full name, please?-- David Charles Risson.

Dr Risson, have you prepared a statement dated the 25th of July 2005?-- Yes, I have.

Do you hold the original of that statement?-- Yes, I do.

Are the facts recited in it true and correct to the best of your knowledge?-- Yes, they are.

Are the opinions you express in it opinions you honestly hold?-- Yes.

I tender that statement and I have three copies that can be handed up with it.

COMMISSIONER: In fact, we do have copies.

MR ANDREWS: Thank you. I wonder whether you have also the attachment.

COMMISSIONER: No.

MR ANDREWS: At the risk of giving you too much paper, there is annexed to these copies the attachment that Dr Risson

refers to.

COMMISSIONER: As I indicated, the statement of Dr Risson will be exhibit 207.

ADMITTED AND MARKED "EXHIBIT 207"

MR ANDREWS: Doctor, you graduated from the University of Queensland in 2001?-- That's correct.

And you received a rural scholarship from Queensland Health?-- That's right.

And as part of that you did a year as an intern at the Toowoomba Base Hospital?-- Yep.

And were transferred to the Bundaberg Base Hospital?-- That's right.

So in 2003 you came to work with Dr Patel?-- That's right.

You were on a basic surgical training program?-- That's right. That was my first year of the basic surgical training program.

On rotation in general surgery you worked with Dr Patel for a period - your statement doesn't advise. How long was that general rotation?-- In paragraph 3 it said I did six months in general surgery with Dr Patel. That was in 2003.

Thank you. And is the extent of your time with Dr Patel that six months in 2003?-- That was full-time with Dr Patel as a Junior House Officer and after that in 2004 and for the earlier part of 2003 I was involved in doing some surgical on-call and weekend on-call, sometimes with Dr Patel.

Thank you. Now, you observed Dr Patel to be a particularly hard worker, putting in long hours?-- That's correct.

And mostly, with respect to junior staff, he was supportive?-- Yes, he was.

But there were exceptions?-- Occasionally there were exceptions to that.

Can you describe whether Dr Patel differed from other surgeons with whom you have worked?-- I haven't spent too much time with many other surgeons but from what my perception of what a surgeon would be, maybe he was a little bit more gruff in some circumstances.

Now, at the time that you worked with Dr Patel, your expertise was in its developmental stage?-- That's correct.

Were you in much of a position to assess whether he was or was not a particularly competent surgeon?-- I - because I was in the formative years of my training, I didn't have many other opinions of other surgeons to compare him with.

No, of course not. You speak at paragraph 8 of your experiences with respect to a particular patient. I think this is the one who had a laparoscopic procedure. I gather you don't recall the identity of that patient?-- I don't recall her name, no.

Can you tell us, please, what it was about that patient that you regarded - or Dr Patel's treatment that you regard as noteworthy?-- Sorry, could you repeat the last part of that question?

What is it about Dr Patel's treatment of this patient that you regard as noteworthy?-- Dr Patel had performed a laparoscopic cholecystectomy, a removal of the gall bladder on this lady. Soon after the procedure she developed a bile leak which is something that's abnormal after a gall bladder removal and it indicates that there is a removal or one of the clips have fallen off where a bile duct has been cut or a bile duct which has been cut inadvertently. Now, this lady was requested by Dr Patel to be sent down to Brisbane. I thought that she had been - that Dr Patel wanted her to go down to Brisbane for definitive treatment, so a repair of the transected duct which was leaking. However, he later told me that his wish was this lady was to go down just for a diagnostic procedure and then for her to be transferred back to Bundaberg Hospital for definitive treatment.

And when he first learned that you'd interpreted him differently from the way he intended, he became quite angry with you?-- That's correct.

What sort of diagnostic treatment would have been done to determine the source of the leak?-- Dr Patel had asked - he said later that he had wanted this lady to be referred down for an ERCP.

I see. Am I right to assume that when first he asked you to send the lady to Brisbane, if he'd mentioned to you that he wanted her to have an ERCP you'd have remembered it?-- I can't recall now what he said in the first instance, but my understanding was that he wanted her to go down for definitive surgical treatment.

Now, once he determined that you'd sent the lady for definitive surgical treatment, not for diagnosis in Brisbane, did he tell you something about your future working relationship?-- He said to me that he didn't want to work with me ever again and that I was to go up to Darren Keating's office to let him know that and alternative arrangements would be worked out for me.

Now, did Dr Keating put you at ease?-- Yes, he did.

What did he say?-- Dr Keating - I can't remember exactly his words but after he had discussed the matter briefly with Dr Patel, before I went in the room, he said to me that everything would be okay and I would continue working with Dr Patel.

Do you recall whether Dr Patel treated any other Junior House Officers with the same disdain or discourtesy as he treated you?-- I can remember a few occasions where he did but I can't remember the exact details of those occasions.

So your treatment wasn't unique?-- No.

Now, you recall a few occasions when you dealt with patients who you thought would be better treated in Brisbane?-- That's correct.

You don't recall their names but can you recall the kinds of procedures that you formed this opinion about?-- There was a couple of patients that they had been operated on and they were in the Intensive Care for - usually more than 48 hours, and it was my understanding that the ICU in Bundaberg was only capable of maintaining someone in a ventilated state for no more than 48 hours. However, Dr Patel had wanted on a few occasions to keep patients there to manage them himself.

Now, your understanding about the 48 hour ventilation limit in the ICU, that's an understanding you had even in 2003, isn't it?-- That's correct.

Where you observe you thought that the patients would be better treated in Brisbane, were you thinking about the well-being of the patients or the rostering convenience for ICU staff?-- I think it probably - probably would have been from the point of view of looking after the patients.

Now, if you'd chosen to voice your concerns, I suppose your line manager was Dr Patel?-- That's correct.

It would have been unorthodox for you to leap over Dr Patel and make complaints about this to Dr Keating, I expect?-- Normally you would talk to the person involved, so your direct line manager, and then if there was no satisfaction with the result after talking with that person, you would talk to the next person up, which would have been Dr Keating.

I assume you didn't cross Dr Patel about the difference in opinion that you held?-- No, partly because I was a fairly junior member of the staff at that time as well.

Well you don't get more junior than a JHO, do you?-- No.

Yes, was there another reason?-- I can't-----

Now, the Otago surgical audit system, you recall that surgical teams were using it when you arrived at the hospital?-- That's correct.

Dr Patel told you there was no need to continue using it?-- That's correct.

Had you been familiar with that system beforehand?-- In the first half of the year before I started doing a full-time general surgical term with Dr Patel, the surgical PHOs had been using that system and I was just starting to learn how to put in the data for recording both operation types and complications.

Doctor, were you then or as a result of any subsequent experience, are you now in a position to say whether the Otago system which Dr Patel directed would no longer be followed was as efficient or effective as the system that Dr Patel then called for?-- The Otago system seemed to provide a more objective way of recording data, both operations and complications, and in the future when Dr Patel had said to stop the Otago audit system, it was up to individual PHOs to record their own data about such complications, and there was always the possibility of not having complete records.

D COMMISSIONER VIDER: Doctor, what sort of data was Dr Patel suggesting that you keep for the purposes of the audit, using his framework?-- When Dr Patel said to keep our own records, it was more as a case discussion time. So any cases of note where there had been complications or deaths, we were to record those and - just mainly as a case presentation. But I was told that there was no need to keep any numbers.

So there was no actual audit tool that you had with each case?-- That's right, there was no compilation of numbers or of complication types or anything like that.

So, therefore, you had no way of taking that subjective data through an individual audit sheet and putting objectively and benchmarking it with anything else?-- That's right, yes.

MR ANDREWS: In your opinion was the system that Dr Patel instituted less useful than the system he replaced?-- I think it probably would have been a little bit less useful, just from the point of view that there was a possibility of not being as objective as if the numbers had been - numbers of complications had been entered each time they were recorded.

D COMMISSIONER VIDER: When you comment on the fact - did I hear you correctly to say that Dr Patel said it wasn't necessary to document everything?-- I recall when I was doing an orthopaedic PHO term in 2004, I - under the direction of the orthopaedic specialists that were involved, I compiled the data from the District Quality Support branch in the hospital and I was able to have definite figures of complications, return to theatres within 28 days of an operation, and those sort of figures, but Dr Patel had said to me, after I presented the first audit like that, he said that those numbers weren't necessary because those figures were held up in the main office.

D COMMISSIONER EDWARDS: You undertook the audit at your own

decision? Nobody directed you to take that audit?-- When I was working in the orthopaedic term the orthopaedic surgeons required specific numbers and I remember-----

Which was part of it?-- That's right, yes.

Thank you.

MR ANDREWS: You raised at a Morbidity and Mortality meeting wound dehiscence that you observed in an orthopaedic patient?-- That's correct.

Dr Patel was present at that meeting?-- That's correct.

What did Dr Patel say about that topic?-- I presented a case of a gentleman who had had a hip fracture repaired and he - and subsequently had a wound dehiscence, so the superficial sutures in the skin had fallen apart after a few days due to oedema or swelling in that leg that was affected. I presented the case as a wound dehiscence and Dr Patel said at that meeting that we had to be careful what we called a wound dehiscence.

Well, to a lawyer that sounds like sensible advice. Why did it disturb you?-- Well, I presented the case of a wound dehiscence and Dr Patel seemed to think that it wasn't a dehiscence, and it concerned me a little that because he was changing in my mind a definition of what was a wound dehiscence that there was an attempt to try and minimise the number of complications that were seen in the audit.

D COMMISSIONER VIDER: Given that we have had before us evidence that the acceptable definition of wound dehiscence was the one in the Miller & Keane textbook, what was Dr Patel's definition of wound dehiscence?-- He didn't say at that meeting what was a wound dehiscence and didn't go into many lengths of what was a dehiscence.

So you were told to be careful about how you defined it but he didn't define it for you?-- That's correct. I can't recall him doing that, no.

MR ANDREWS: Doctor, do you mean that there was no room for doubt that this was a wound dehiscence you were reporting about?-- In my mind, yes, that's correct.

By the way, who was the surgeon involved with this orthopaedic patient?-- I can't remember who did the surgery initially. It might have been when we were on call with another orthopaedic surgeon on call, so I couldn't comment who was involved initially with that gentleman.

So this will have been a dehiscence that Dr Patel may not have had any involvement in?-- That's correct.

During your time in general surgery you say that there were - there seemed to be a considerable concern among the nursing staff about wound dehiscences, wound infections and

post-operative complications. Now, your timing in general surgery - I wonder which period you're speaking of, your six months in 2003 or-----?-- It would have been both of those periods, so both - when I was working full-time in 2003 with Dr Patel and also when I was orthopaedic PHO in 2004. I was aware of what was going on in the ward because I was occasionally on call for the surgical ward, both on the weekends and during the week.

So it is not simply dehiscences, but wound infections and post-operative complications?-- That's correct.

And were the staff concerned about them because, as nursing staff, they're concerned about anything that is relevant to their patients' welfare or were they concerned that there was an abnormally high number of each of these?-- I believe it was the fact that there was an abnormally high number of the complications.

COMMISSIONER: Was that your observation as well, that the number was abnormally high?-- I felt it was. There always seemed to be someone on the ward that hadn't recently had surgery but had returned as a readmission and had a complication from surgery. I don't have exact numbers of those but that was a general feeling, both an opinion of myself and the nursing staff.

Did you discuss this with other junior doctors in the hospital? We have already heard evidence for example from Dr - Mr Andrews, you will have to remind me of the name.

Athanasiov. I think he was there at the time you were?-- Who was that sorry?

I think it was Anthony Athanasiov?-- Athanasiov.

He was there at the same time and presumably there were other junior doctors?-- He was there in 2004 when I was working there, yes.

Right. Were these things discussed amongst the junior doctors?-- I remember at - yes, they were discussed at the audit meetings.

Yes?-- Or the Morbidity and Mortality Meetings but there didn't seem to be an investigation as to what the cause of these high numbers of wound infections or complications-----

I am just trying to get the sense of whether it was such an obvious problem that it became the subject of comment or discussion amongst-----?-- Yes, it did.

-----the medical staff?-- Both - I suppose, both on the Surgical Ward and also in Emergency I observed there to be a few comments made about people returning after they've had surgery with complications.

And did you also have sort of surgical outpatients where

people who had been operated on came back for - to have their wounds inspected or-----?-- Yes, we did.

-----that sort of thing? And is that another location at which you would see these patients?-- Yes, that's right.

D COMMISSIONER VIDER: Who chaired the Morbidity and Mortality Committee?-- I don't know that there was a specific chair for that committee. But Dr Patel certainly led the meetings and led any case discussions that we had about any problems that the patients had experienced.

MR ANDREWS: Since departing that hospital, are you able to say whether you have had the opportunity to see how commonly surgical wards in - I beg your pardon - yes, surgical wards or ICUs in other hospitals have received patients with post-operative complications?-- After I left Bundaberg Hospital I went and currently am working at Dalby Hospital and we only have a small surgical list once a week, so I am not really able to comment about that.

Thank you. Was there a - there was an occasion when Dr Patel made a joke with Dr Kariyawasam?-- That's correct.

Can you tell us about that?-- What - just if you could-----

Paragraph 17?-- Okay. At one stage some of the information that was coming out of the Morbidity and Mortality meetings indicated that at one stage, when Dr Sangeev was working with Dr Patel, that there was a few infections - post-operative infections, wound complications, and Dr Patel had commented to Dr Sangeev that he was joking that maybe Dr Sangeev was responsible for these, which was obviously untrue, yeah.

And this was to do with infections as opposed to dehiscences?-- That's right, yes.

COMMISSIONER: But the only occasion for such a joke would be if it was recognised that the rate of complications was higher than-----?-- That's correct.

-----ordinary, yes?-- So by saying that, Dr Patel, in my view, was acknowledging that there was a high rate of infections.

MR ANDREWS: You assisted Dr Patel with oesophagectomies in Bundaberg. Do you recall other doctors expressing opinions about whether they should be conducted there?-- That's correct. Some of the anaesthetic staff had concerns about the scope of the procedures that were being carried out there.

Was there concern for the patients, for the staff? Can you amplify the answer?-- Well, I think it would have been for the patients and maybe that by being operated on in Bundaberg by Dr Patel, then the outcomes wouldn't have been as good as if they had been operated on in a larger centre such as Brisbane.

COMMISSIONER: Doctor, this might be an unfair question but if you or one of your family needed to have an oesophagectomy, would you consider having it at a place like Bundaberg?-- No.

You'd want the resources, the ICU and the other facilities of a major tertiary hospital?-- That's correct.

MR ANDREWS: Do you recall after complications in the surgery to Mr Kemps, Dr Patel expressing some concern?-- Yes. There was - Mr Kemps was returned to theatre soon after an operation. I wasn't part of the surgical team that was operating on Mr Kemps at the time but was asked to come and give assistance soon after Mr Kemps had returned to theatre with a post-operative bleed.

And you understand that to be an oesophagectomy?-- That's right, yes.

What did you hear Dr Patel say?-- I remember Dr Patel saying, when he couldn't find the source of bleeding that, "Maybe I should think about giving up doing these procedures."

D COMMISSIONER EDWARDS: He said that publicly?-- Yes.

Was there any response from anybody else?-- No.

That may have agreed or didn't agree?-- No, because the situation was so dire, there was - I didn't see there was any time to make comment.

But it was a public comment made for - so people could hear?-- Yes, it was.

MR ANDREWS: During the efforts to locate the source of Mr Kemps' bleeding do you remember Dr Sanjeev Kariyawasam

making some suggestions?-- Yes, he did. He - Dr Patel seemed to be very concerned and seemed to be out of his depth, he couldn't find the source of bleeding, and Dr Sanjeev, just trying to be helpful, was just trying to offer suggestions as to where it might be coming from.

And what's noteworthy about that?-- Well, I suppose it illustrated to me at the time that Dr Patel did seem out of his depth and the fact that a more junior doctor was telling him how to perform the surgery was - that was of concern.

In telling Dr Patel what Dr Kariyawasam thought might have been the source of the bleeding was - I don't understand him to have been telling him how to perform surgery?-- No, that's right.

Was making this suggestion still something unorthodox?-- Only because at that time Dr Patel couldn't find the source of bleeding and the fact that Dr Sanjeev even felt he needed to offer suggestions was - was a concern.

D COMMISSIONER VIDER: Was one of those suggestions the fact that it might be the aorta?-- I can't remember who made that suggestion but it - yes, that was suggested during the surgery.

And given that you were a Junior House Officer but given the extent of the bleeding, and we've had evidence of that given for this case, would that have been a reasonable suggestion to you?-- Yes.

MR ANDREWS: Now, you discussed afterwards with Dr Berens whether there should or should not be a post-mortem?-- That's correct.

Were you suggesting that there should or that should not?-- I was suggesting that there should have been a post-mortem. I wasn't directly involved with Mr Kemps' care at the time as I was working in orthopaedics but I felt that the cause of death wasn't known, so there should have been.

And in cases where the cause of death is not known, is that an indication that a post-mortem is required?-- I think it would be.

And is that the basis that you expressed the view that there ought to be a post-mortem?-- When I was talking to Dr Berens, yes.

The death of Mr Kemps you feel was a direct result of the procedure performed by Dr Patel?-- That's correct.

That seems a fairly obvious statement. I wonder whether there's some other point you're trying to make?-- No, the fact that he had bleeding so soon after an operation made it just - the time effect made it likely that - or it seemed likely to me that that would be the cause of death.

COMMISSIONER: I think, Doctor, this is one of those situations where there's a language barrier between lawyers and the medical profession. When you say that Patel's surgery was the cause of Mr Kemps' death, you could mean that simply in the sense that physically, if he hadn't had that procedure, he wouldn't have died at that moment in time or you could mean something further, namely, that Dr Patel was somehow wrongfully responsible for the death because of some incompetence or negligence or inappropriate conduct on the part of Dr Patel. That's why Mr Andrews is trying to narrow you down?-- All right. All I'm saying is that I believe that Mr Kemps died from a post-operative bleed as a result of having an oesophagectomy. Now, a post-operative bleed in these sort of operations is not unheard of and it is a complication which patients are counselled before they have an operation but I do think that the bleed which Mr Kemps had after the operation did lead to his death.

Doctor, can I approach the matter a slightly different way?-- Yes.

We have had other witnesses suggest two things. One is that Mr Kemps wasn't a suitable patient for an oesophagectomy at all, that he should merely have had palliative care and so on?-- Sure.

Do you have any view on that subject?-- I wasn't aware of Mr Kemps' condition before he had the operation, so I wasn't involved, so I couldn't inform an opinion about what would be an appropriate treatment for him.

The other suggestion that's been made is that if Mr Kemps were to be subjected to an oesophagectomy, his chances of survival would have been much higher if he had been transferred to Brisbane rather than having that operation performed in Bundaberg. Do you have a view about that?-- That may be but, again, I'm not - you know, I'm not aware of the information, like, the anaesthetic risk that Mr Kemps had before he had the operation, so I couldn't really comment on that either.

Do you agree, though, generally with the suggestion that oesophagectomies are probably on the outer limit of complexity for a hospital the size of Bundaberg?-- Yes.

MR ANDREWS: At paragraph 31 you speak about another patient, patient P34.

COMMISSIONER: Mr Andrews, I think that's a name that's already been released. P34 on my list is Eric Nagle.

MR ANDREWS: Eric Nagle is P34. I couldn't recall whether it had been released. Mr Nagle is someone you recall because you took him through the consent procedure?-- That's correct.

Can you explain the complication that you brought to his attention?-- I mentioned that one of the complications which could be a result of having a large catheter inserted into the vessels around the heart is death, one of the complications

was death.

The catheter that's inserted in such cases has a rounded head, am I correct, a J-tip?-- That's correct.

I don't suppose you had to go in the explanation to Mr Nagle to the extent of explaining the shape of the thing that would be inserted?-- No, not to that extent.

Are you able to say what the complication rate is for the insertion of such catheters?-- Oh, I couldn't give you a definite figure.

If you were asked to speculate on what the complication rate would be if it was - if the J-tip was introduced the wrong way round, would you able to make an estimate?-- I couldn't make an estimate because I don't think anyone would have done a trial of a J-tip, that complication resulting from doing that procedure that way.

Would that be because if it was inserted the wrong way round it would be almost guaranteed to cause a complication through perforation?-- I - I don't know that I could say almost guaranteed to cause a perforation but there is a higher chance, obviously, if the J-tip was reversed.

As a result of things you were told, do you believe that the J-tip was reversed when it was inserted?-- That's what I was told.

And do you recall who told you this?-- It was either Dr Martin Carter or Dr Nadine Low. I can't recall exactly who told me what had happened in surgery.

Nadine Low, L-O-W-E?-- L-O-W.

Thank you. And Nadine Low, do you recall where she works now?-- I think she works at Royal Brisbane Hospital.

Thank you. Dr Nagle passed away shortly after the procedure; is that the case?-- Mr Nagle.

Mr Nagle?-- Yes.

Were you ever advised as to what was the cause - said to be the cause of death?-- It was presumed that he had a pericardial tamponade, which is a collection of blood around the heart not allowing the heart to fill up properly and pump blood as it should.

And would that-----

COMMISSIONER: Would that be consistent with the J-tip having been inserted the wrong way around?-- That would be a complication from doing the procedure that way.

Yes.

MR ANDREWS: Would that be a complication consistent with any kind of perforation of the vessel wall?-- Yes.

A patient P26 was the young man involved in the motorcycle accident.

COMMISSIONER: Mr Andrews, just before you get on to P26, I notice, Doctor, from paragraph 36 of your statement, it's pure curiosity on my part but you refer to discussion between Dr Miach and your brother. Do you have a brother who is also a doctor?-- He is a radiographer at the Bundaberg Hospital.

I see, right. Yes.

MR ANDREWS: Patient P26, you were present for one of the operations upon this young man?-- That's correct.

Was that the first surgery?-- That - I assisted for part of the first surgery. Again, I was working in another term at the time and this young fellow came in in quite a bad condition and was transferred immediately through emergency to the operating theatre and as I saw him going in, I asked Dr Patel if he needed any - an extra pair of hands to assist. So that's - that's how I became involved in the first surgery.

Tell me, at that stage were you in a position, after the first surgery, to make a judgment about whether patient P26 ought then to have been transferred to Brisbane or did you not have sufficient experience to make a judgment about those matters?-- Immediately a post-operative - after patient P26 had the first procedure done there was concern then about his left foot being a motley colour and I feel that after the bleeding was controlled, the optimal treatment would have been for P26 to have been transferred to Toowoomba - to Brisbane for definitive treatment with a vascular team.

When you say after the bleeding was controlled, do you mean immediately - well, as soon after the first surgery as the patient was stabilised?-- As soon as the patient was stabilised and there was no other life threatening injuries so that he could be transferred down to Brisbane.

Now, at that stage you were a PHO, am I right?-- That's right, in orthopaedics.

As a PHO, it was your opinion that the patient should have been transferred at that time?-- That's correct.

But the Director of Surgery, what, had a different opinion?-- I believe that Dr Patel thought that he could be managed at Bundaberg.

D COMMISSIONER EDWARDS: Could I ask, Commissioner, you're making that statement as a result of what you saw in the operation, that is the repair of the femoral vein, or are you making the statement as the first diagnosis which was a tear in the femoral vein?-- After the tear had been repaired there was still concern about circulation in the left leg and-----

But not life threatening?-- No, not life threatening, but because - because there's not much time for a vascular injury to be repaired, then I believe it should have been dealt with very soon after the first surgery, after the life-threatening matter had been dealt with.

D COMMISSIONER VIDER: Were you suspicious at that stage that the vessel had been ligated not repaired?-- I'm not really - yeah, I can't remember that I had any suspicions. I was just involved with the first surgery and then the surgical team took care of him after that, yep.

Mmm?-- Yes.

But it was reported that had the foot had no pulse and in appearance it was mottled; is that correct?-- That's - that's correct.

MR ANDREWS: When you say that you were aware that after vascular surgery there's not much time, I think your words were, to do subsequent repair or-----?-- Yes.

-----words to that effect, is there a time that's said to be the maximum time within which one has to act in case there's a need for further vascular repair?-- I think certainly the sooner the better but usually within six hours.

And is six hours known as the orthodox limit of the amount of time that within which further repair must be done or else there is a significant risk that a limb might be lost?-- That's correct.

COMMISSIONER: Would six hours be sufficient to transfer the patient to Brisbane with airlifting; so, preparing the patient, getting the patient on to a helicopter or a fixed-wing aircraft and getting the patient down to Brisbane and into an operating theatre in Brisbane?-- Certainly six hours isn't - it certainly is attainable to do that. If - if Brisbane's aware that it is an emergency, they will go to an extra effort to try and accommodate that.

I suppose, thinking about it, you're in a not dissimilar situation now in Dalby?-- Mmm, sure.

You're perhaps a bit closer to Brisbane?-- Yes.

But not significantly closer?-- That's right.

And from Dalby, I imagine you'd have a lot of transfers to Brisbane?-- Yes.

Serious cases?-- Either to Brisbane or to Toowoomba.

Yes?-- Yep.

MR ANDREWS: Would you have recommended, and had you been in a position to decide these matters, a transfer of patient P26

after the first surgery as a precaution in case there became a need for further surgical vascular repair?-- Yes, I would because I felt that would have been appropriate at the time.

Did you feel confident enough to urge that upon Dr Patel at that time?-- I know that - I know that it had been discussed with Dr Patel and because I wasn't directly involved with the care of P26, it wasn't my position to make any comments directly to Dr Patel but I know that it had been mentioned.

When you say it had been mentioned, do you mean the topic of transfer or the topic of transfer within six hours?-- The topic of transfer, and I'm fairly certain that it was mentioned within six hours.

And can you say how many persons were against transfer?-- I couldn't give a number.

But are you sure that Dr Patel was against it?-- He was against it.

COMMISSIONER: Do you recall if there was anyone supporting Dr Patel's view?-- I remember - I remember there being a lot of people concerned about the fact that he wasn't transferred early, including the nurses in intensive care, but I can't remember which doctors in particular had supported Dr Patel actively.

Yes.

MR ANDREWS: Do you recall-----?-- I can't recall if there was anyone that supported actively Dr Patel's decision to leave the patient in Bundaberg.

Thank you. You recall at the end of the operation that there was some concerns about the circulation of blood in the patient's foot?-- That's right.

Katrina Zwolak - Z-W-O-L-A-K - asked you if the foot appeared normal?-- That's right.

Did you think it appeared normal?-- No, no, I didn't and there was a few other people in the operating theatre at the time that were also of the same opinion, and I know that - I'm fairly certain that Dr Patel was also aware of the situation before he left theatre.

You say fairly certain. Do you mean you can't be sure whether he was aware of it?-- Well, he was aware of it very soon after the surgery had been completed.

So at the completion of the surgery, your attention was drawn to the patient's foot and its abnormal appearance?-- Mmm-hmm.

By Katrina Zwolak?-- That's correct.

Had Dr Patel left by the time you had your attention drawn to it?-- I think at that time that he may have already left

theatre but I'm fairly certain that there was some other doctors that also had concerns at the same time prior to Nurse Zwolak making that comment, and Dr Patel was aware of it very soon after the operation.

COMMISSIONER: We've heard, for example, that - let's see if I can get the name right this time - Dr Athanasiov-----?-- Yes.

-----drew attention to the absence of a pulse from the foot. Now, you may not recall that specifically but is that consistent with your memory, that there were some doctors there raising concerns about the patient's condition?-- That's right, yes.

MR ANDREWS: Did you yourself observe there to be no pulse in the foot?-- I - I can't remember, you know, directly palpating the pulses in the foot but I know that there was a - I do recall that there being concern that there was no pulses, but I can't remember myself-----

D COMMISSIONER EDWARDS: Doctor, could I ask you: do you think that the pulse being absent at that stage was due to swelling of the leg rather than what it appears was the wrongful ligation of the femoral vein because the pulses are related relative to arterial matters rather than venous?-- Yes.

I'm having some difficulty in understanding why there the pulses were suddenly not detected because the femoral vein was ligated?-- I think in subsequent surgeries it was found that there was an intimal tear in the femoral artery with some thrombosis.

So that could have been contributing rather than the surgery as well?-- That's right, yes.

COMMISSIONER: So the issue - I'm sorry, Mr Andrews, I just want to make sure I get this straight in my own mind and unlike, Sir Llew, I don't have the advantage of being a doctor. It may be that the ligation of the vein wasn't the cause of the loss of pulse but what the loss of pulse told you is that there was something going wrong that should have been repaired and it was only later found out that that - that there was an entirely separate cause for that, which was the interruption of the artery?-- That's correct.

The thrombosis?-- The fact that there was no - well, there was a concern about the circulation in the foot and the pulses in the foot would have at least shown to me that there's a need to investigate that with other modes of investigation which aren't available at Bundaberg.

Well, that's really what I was going to ask. It just strikes me as unfathomable that you would have a patient in the operating theatre, perform an operation, find that there's no pulse in the foot and then just send them into ICU as if there was nothing wrong?-- I agree.

And if there wasn't something that could be done at Bundaberg,

the only solution would be to second the patient to Brisbane?-- That's my feeling as well.

D COMMISSIONER EDWARDS: Very quickly?-- Yes.

MR ANDREWS: Well, when it appeared that the patient wasn't being transferred, it seems you nevertheless spoke with Dr Berens and made a suggestion. Was that suggestion about having a stenographer perform an abdominal ultrasound to do with the tachycardia?-- That's - that's correct. Dr Berens still had concerns about the patient being a very high pulse rate and because the patient was rushed to theatre to control the life-threatening haemorrhage, there wasn't time to complete any other investigations as to the source of tachycardia. So the abdominal ultrasound, when it was, you know - it was performed fairly promptly, gave a - it was a screening test to detect if there was any free fluid or blood in the abdominal cavity that was causing that tachycardia.

And none was found as a result of the ultrasound?-- That's correct.

Dr Berens, did he agree with you that an ultrasound was a worthwhile exercise?-- Yes, that's right.

When Dr Patel saw that this had been done, he became angry with you. That's the case?-- That's right.

He expressed the view that ultrasounds were of no value because they are operator dependent, and he was critical of the sonographer?-- That's correct.

Did he criticise the sonographer because of the way he'd performed this ultrasound, or did he have a criticism based upon prior experience with this sonographer?-- It wasn't the sonographer that performed the investigation that Dr Patel had an issue with. It was just that Dr Patel felt that ultrasound examination of the abdomen wasn't as sensitive a procedure as other forms of investigation like CT scanning.

And is that-----

COMMISSIONER: They're not mutually exclusive, are they? There's no reason you can't do both?-- No, there's not, and the patient had - was waiting to leave theatre, and I felt that it wouldn't delay his further definitive investigations such as a CT scan if we performed an ultrasound.

And maybe by good luck you'd pick up something that you missed?-- That's right, yep.

MR ANDREWS: In any event, later that afternoon P26 went back to surgery for fasciotomies?-- That's correct.

You didn't assist in that process?-- No.

But you went back to check?-- Yes.

And when you arrived, Dr Patel was performing the fasciotomies?-- That's correct.

Were you able to form an opinion about the competence of the fasciotomies?-- No, I wasn't. I wasn't there as a scrubbed assistant so I couldn't form any opinions about the adequacy of the fasciotomy.

However, you rang Dr Neil Robinson who had been present at the - for a short time during the first operation. Why did you do that?-- I felt Dr Robinson might have some more expertise that he might be able to offer in this particular regard. Sometimes fasciotomies are performed by either general surgeons, but they can also be performed by orthopaedic surgeons, and that's why I called Dr Robinson, just to see if there was anything else that he might be able to offer.

What seems curious is that your Director of Surgery was performing the fasciotomies and would have been in a position

to call for Dr Robinson if he'd formed the opinion that he needed that person's help?-- Yes, that's right.

Is it unusual for you, who at the time would have been a PHO, to have been contacting Dr Robinson without first checking with Dr Patel?-- I suppose it would have been a little bit unusual, but I just wanted in my own mind to consult with a more senior person to myself that what was happening was appropriate.

COMMISSIONER: And you were actually in orthopaedics at the time, weren't you? You were doing your orthopaedic term?-- That's right, yes.

Dr Robinson would be the natural person for you to talk to about it?-- That's right, yes.

D COMMISSIONER VIDER: Had you come across compartment syndrome before?-- We've had a couple of patients that have had suspicious compartment syndrome, but haven't turned out to be compartment syndrome.

MR ANDREWS: The fact that you called Dr Robinson suggests that you lacked some confidence in either Dr Patel's judgment about his own capacity, or you lacked some confidence in Dr Patel's capacity to perform the fasciotomies. Is that-----?-- I think it might have been a little bit of both. I hadn't seen Dr Patel perform fasciotomies in the past and, yeah, I'm sure that he has in the past, but there was the concern that because this was such a young fellow being operated on, and there was also the concern about the compartment syndrome and not being a definite diagnosis made as to why there was a compartment syndrome, I just wanted to consult someone a little bit more senior to myself.

Well, you've mentioned his being a young fellow. Is the youth of patient P26 in fact a matter which creates more danger for him, if there's a vascular problem in the leg, than there would be for a much older patient?-- Oh, I would have still made the same decision had the patient been much older than P26.

Good, but can you answer my question about whether the patient's youth put him in more danger than an older person would have been?-- I don't believe he would have been in more danger from having a fasciotomy performed, no.

COMMISSIONER: In fact probably being younger and fitter, he would have had less danger?-- That's correct, yes.

But I think, doctor, you'd only be human if you weren't gravely concerned about the risk that a 15 year old boy was going to lose his leg?-- That's right.

That was, no doubt, one of the issues anyway going through your mind?-- Yes.

MR ANDREWS: Doctor, are you able to comment upon what I understand to be a proposition that an older patient, and indeed someone who might even be a smoker, might have an advantage with this sort of surgery that a healthy 15 year old mightn't have because they've been forced to compensate for poor circulation in their limbs because of their age and ill-health?-- That seems a reasonable suggestion, but I couldn't give an expert opinion on that.

COMMISSIONER: You disappoint me, doctor. I was really looking forward to saying there was an advantage to being a smoker?-- Definitely not.

MR ANDREWS: Commissioner, I think you'll hear that in one respect there is.

COMMISSIONER: Thank you.

MR ANDREWS: After the fasciotomies, you didn't see patient P26 for a time, did you?-- I wasn't directly involved in his care for the remainder of that week, that's right.

And about a week later at 5 p.m. on a Friday afternoon you happened to pass through the surgical ward. Is that the position?-- That's right. I was just getting a handover of some of the patients that were on the ward before I started weekend on call for surgery over the New Year's weekend.

You saw P26's blood test. Is this before you saw the patient himself?-- That's right.

And did the blood test itself cause you alarm?-- It caused me alarm in that a septic screen that had been performed by the surgical team hadn't come up with a definite source of the rising white cell count and the temperatures that P26 had, and given that he did have an ischaemic limb, it was a concern for me that that indeed was where the source of infection was.

COMMISSIONER: A rising white cell count simply means an infection, doesn't it, or it's a strong indicator?-- That's right, either infection or inflammation.

And there was here an undiagnosed infection - or that was the indication?-- Yes.

And you suspected it was somewhere in the limb?-- Yes.

MR ANDREWS: And did you inspect patient P26 at the time?-- I can't remember whether I did that immediately.

Do you mean you did inspect patient P26, it may not have been on that Friday afternoon?-- It might have been later on the Friday night or first thing on the Saturday morning. I can't be certain.

Having seen the elevated white cell blood count, what did you do?-- I spoke with Dr Gaffield either on the Friday evening or the Saturday morning and raised my concerns with him and

the fact that there was the ongoing concern about the ischaemia that was in the limb, and I suggested that P26 needed to be transferred to Brisbane.

And did Dr Gaffield argue with that proposition?-- No, he didn't. He said, you know, that would be a good idea, and just to call the - for me to call the vascular team to see if I could organise this patient to be transferred.

COMMISSIONER: Mr Andrews, would that be a convenient time for a 10 minute break?

MR ANDREWS: Yes, Commissioner.

THE COMMISSION ADJOURNED AT 3.40 P.M.

THE COMMISSION RESUMED AT 4.04 P.M.

COMMISSIONER: Mr Andrews.

DAVID CHARLES RISSON, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Dr Risson, you spoke with a member of Dr Gaffield's team on the Friday afternoon and then that evening perhaps with Dr Gaffield about the condition of patient P26?-- That's right, either that evening or-----

Or Saturday morning with Dr Gaffield?-- One or the other, yes.

You make that clear in paragraph 48. I gather by Friday evening you had looked at patient P26?-- I can't remember whether I looked at the patient on Friday night or whether it was first thing Saturday morning. I know that one of the members of Dr Gaffield's team had spoken to him on the Friday afternoon about the raising white cell count.

Now, the raising white cell count caused alarm to you?-- Mmm-hmm.

When you saw patient P26, was there anything about his visible condition that caused you any concern?-- The state of P26's left leg was of great concern in that the fact that the - it was mottled and cool to touch and also not all the pulses were palpable.

Well, it had been mottled a week before?-- Mmm-hmm.

Pulses weren't palpable a week before. Had anything changed apart from the temperature of the patient's leg?-- I think the main thing that had changed was he was becoming very quickly unwell from - from this - the ischemic leg and I thought it was logical that he be transferred very soon.

D COMMISSIONER VIDER: Dr Risson, did the limb have an odour by this stage?-- I can't recall an odour but I do remember comments being made about an odour, yes.

COMMISSIONER: Did you consider the patient's life was at risk at this stage?-- Yes.

D COMMISSIONER EDWARDS: Certainly his leg was?-- His leg and because - yeah, and as a result of his leg being very - very bad, then his life was at risk as well.

Such as septicaemia?-- Yes, that's right.

COMMISSIONER: The leg had now been pulseless for over a week,

so-----?-- I think, looking over the notes, there was occasional records of there being pulses palpable and this sort of thing but there was definite infarction of the leg.

Yes.

MR ANDREWS: When you saw patient P26 after a week, did you - on that Saturday morning at the very latest you'd spoken with Dr Mark Ray of the RBH with a view to transferring the patient?-- Yes.

So you may have spoken with Dr Ray either the night before on the - that is the Friday night?-- That's right.

Or on the Saturday morning?-- Yes, one or - one or the other.

Did you form a view about whether the patient should have been transferred earlier? Now, I do understand that you'd had the opinion immediately after the first surgery that as a precaution it would have been wise to transfer the patient?-- Yes.

But a decision having been made to retain the patient in Bundaberg, we come to another stage?-- Mmm-hmm.

Stage 2 I suppose, which is to watch and see what happens to the patient?-- Yes.

How long into stage 2 was it reasonable to wait before forming the view that this patient should have been transferred?-- Well, I believe that the appearance of the foot had been fairly alarming from the very first day and as I was preparing the letter of referral to Dr Ray I remember there being a lot of comments in the chart about there always being a concern about the circulation in the foot. So I can't say that - yes, I think it still would have been more appropriate for immediate transfer.

Are you able to explain why it was that this patient, with the obvious concerns about circulation in his leg and foot, remained there for a week?-- I can't explain why nothing was done. I can't understand that.

Are you able to say whether, for instance, it was because only inexperienced JHOs were there and-----?-- I believe Dr Gaffield had taken over care of Dr Patel's patients and Dr Patel would have - would have passed on a handover about his patients.

Now, Dr Gaffield-----

COMMISSIONER: Mr Andrews, I see that paragraphs 49 really through to 52 contain a lot of what would strictly be hearsay from Dr Ray. We will be hearing from Dr Ray, won't we?-- Yes, you will, Commissioner.

So it is probably unnecessary to hear Dr Risson's second-hand account of those things.

MR ANDREWS: Certainly. I'll move on, Dr Risson. Can you tell me, in the time that you were doing your rotation in general surgery what proportion of surgery was undertaken, for instance, by Dr Patel and what proportion by Dr Gaffield?-- I can't remember the numbers as such but Dr Patel generally did the larger types of surgery. So any larger abdominal cancer operations or colon cancer operations, for instance, would have been performed predominantly by Dr Patel. Dr Gaffield had a plastic surgery interest and a lot of his cases were geared towards that side of the speciality. Of course, he still did emergency operations, but most of the larger elective operations were performed by Dr Patel.

Are you able to say why patient P26 was in the surgical ward as opposed to the ICU?-- I don't know.

Are you able to say whether the condition of patient P26 when you saw him was such as to explain why he was in the surgical ward as opposed to ICU?-- No, I thought that at the very least he should have been in ICU, if he remained at Bundaberg.

Now, you spoke with Dr Patel about patient P26 after Dr Patel returned from vacation?-- That's correct.

Is that the case? Were you in fact called up to see the District Manager, Mr Leck, in respect of patient P26?-- No, I wasn't but soon after Dr Patel had come back from leave, he told me that he was being asked to go and see Mr Peter Leck and he had asked me what that was in concerning or - or what - if I knew why he was being called up there.

Did you speculate to him that it was in respect of patient P26?-- Yes.

What did Dr Patel say to you? I think your memory may be refreshed from paragraph 55.

COMMISSIONER: Fifty-four.

MR ANDREWS: Thank you, Commissioner?-- Yes. Dr Patel said, "If these non-clinical people start getting involved with the way that I care for patients or influence my decision making, then I'm going to resign." Mmm-hmm.

Now, you had a meeting with Mr Leck and Dr Keating you say some time before late 2004. Do you recall whether it was before or after the episode relating to patient P26, which I understand to have occurred in late December 2004?-- The meeting with Mr Peter Leck and Dr Darren Keating was on the 2nd of November 2004.

Thank you. Do you recall the identity of the patient - oh, no, you don't, the lady's whose arm had complications as a result of vascular surgery?-- No.

The notes of that meeting which were made by Dr Keating appear as an exhibit to your statement?-- Mmm-hmm.

Do they accurately, so far as they talk about your meeting, record what was discussed?-- Yes, that's right.

COMMISSIONER: Were you satisfied, Doctor, that both Mr Leck and Dr Keating were genuinely concerned about the issues that had been raised by them and genuinely trying to get to the bottom of it?-- I feel that they were concerned. I didn't get any follow-up after that as to what had happened to try and solve some issues.

But you were given the opportunity and encouraged to speak openly and freely about any concern you had?-- Certainly, yes.

D COMMISSIONER VIDER: Can I just ask a follow-up question to that. We've had some comments made about Dr Patel generally and incomplete documentation at times?-- Mmm-hmm.

So it was really what wasn't put in the medical record as opposed to what was put in the medical record?-- Sure.

And comment had been made at times that some of the surgical complications were communicated in verbal handover but not necessarily in the record. Did you ever have any experience of that?-- I can't remember any specific occasions, no, but I wasn't - wasn't sort of directed to write anything down differently than what had actually happened.

Did your surgical audit quasi M&M committee meet frequently enough for you to have viewed enough medical records for the case history presentation to have had the opportunity to compare what you knew of a case to be a fact and what was in the record?-- We usually had the M&M meetings every three months and it was really, you know, our recollection of what had happened during that time, but we can certainly go back to the notes and refer to any complications.

COMMISSIONER: I think the Deputy Commissioner's question was when you went through that process and you were trying to bring to mind the circumstances of a particular patient, did it ever become apparent to you that what you recall simply wasn't recorded in the notes?-- Oh, I can't remember there being any instances like that, yep.

D COMMISSIONER VIDER: Was it very often the practice then that it was the JHO or the PHO that wrote up the notes?-- For the audit-----

For example, after surgery, who'd write an account of the operation?-- Yeah, it was mostly the surgeon. So, mostly Dr Patel. For some of the smaller procedures such as cholecystomies or hernia repairs, they would be written up by the PHO or the JHO.

You had no experience then of a patient who went to theatre say for a lap choly but ended up having a splenectomy, the splenectomy part was recorded as well as the nominated

elective procedure?-- That would be recorded. I can't remember - is there a specific patient that you're talking about?

No, no, it's just a general statement that's been made about the fact that it wasn't always recorded in the documentation. It was handed - it was a verbal handover, the communication went on-----?-- Right.

-----but it wasn't necessarily documented?-- I can't - I can't really comment on that.

Thank you.

MR ANDREWS: Dr Risson, you wrote a letter to Dr Ray dated the 1st of January 2005. I have a copy here of what appears to be your letter although I've started to de-identify the patient by putting blue markings on some of the words. That letter seems to be compiled by you from the hospital charts; am I correct?-- That's correct.

I tender that document.

COMMISSIONER: The letter from Dr Risson to Dr Ray on the 1st of January 2005 relating to patient P26 will be de-identified and become Exhibit 208.

ADMITTED AND MARKED "EXHIBIT 208"

MR ANDREWS: Thank you, Commissioner. Dr Qureshi, you had to teach him how to do a surgical scrub. Is that unusual, that he wouldn't know how to do such a thing?-- I believe Dr Qureshi was employed as an SHO at the hospital and I thought that was unusual that he wouldn't know how to do a surgical scrub at his stage of training.

So that I can comprehend this, anyone walking into an ICU, any visitor, any relative, is obliged, are they not, to wash their hands and thoroughly?-- That's correct.

And there's usually a sign next to the antiseptic dispenser that explains to them how that can be done. Is a surgical scrub something more complicated than that?-- It's - it is a little bit more complicated than that. Usually of a longer duration than a - just a hand wash prior to going into a ward where there's patients that can't handle any infections.

What was it about that longer process that Dr Qureshi seemed unable to do until he had your instruction?-- He - he didn't seem to know the process of a scrub and where to start or what - what parts of the hands needed to be thoroughly attended to.

Is that elementary?-- It's one of the things that we're taught

in medical school usually.

Have you seen any graduate of medical school who has been unable to follow that procedure aside, perhaps, from Dr Qureshi?-- Not - not in the last couple of years that they've been unable to perform it. Usually when you go to a different hospital, sometimes the scrub sister will go through a scrub, just to refresh your memory, if you're a very junior staff member.

Thank you. I have no further questions, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. Doctor, a number of people at the Bar table may have questions for you but before that happens, I want to take advantage of your presence here to ask you some general questions but not particularly related to Dr Patel or your experience in Bundaberg. I note from your statement that you're currently completing your final year of your rural scholarship training?-- That's right.

Am I right in understanding that that involves a whole range of specialties, orthopaedic, gynaecological and so on?-- Yes, it's a bonded period of time where Queensland Health pay you an allowance while you're going through university and you pay back Queensland Health the same amount of time in service at rural or regional areas, and usually in the first year or two you spend time in a larger hospital to try and gain skills that would be more useful in a smaller rural hospital.

And this is particularly designed, is it, for the sort of small rural hospital that has the traditional medical superintendent who is a jack of all trades?-- That's right.

Who does everything from fixing broken legs to delivering babies?-- That's right, yes.

As you say, you're in the last training segment of that and then you spend a number of years as it were paying back the health department for its support, do you?-- That's right.

You would expect then to be sent to a small rural hospital perhaps even smaller than the current one you're at, Dalby?-- That's right, yes, yes.

Do you know how many doctors or medical students there are at a time going through that process?-- I think in our year we had about 30 students that were bonded scholars.

As one who is someone who is currently going through the process albeit near to the end, is it something that you have found beneficial?-- Most - most of the experiences have been beneficial. By being a senior doctor in a smaller hospital, there are a lot of situations where you can be placed in situations where you're out of your depth and there have been a few occasions where I've been concerned that there's a possibility of litigation.

Yes?-- And that has been a worry for me. But on most

occasions there's been someone that is easily contactable that can come fairly soon and give assistance.

At the end of this scholarship process you don't have a specialisation as such. You're not a member of one of the colleges?-- No. I - I started doing basic surgical training-----

Yes?-- -----in 2003 and because of the nature of the hospitals that I've worked at, and Dalby especially is too small to do surgical training, so that's been deferred.

Yes?-- Yes.

But you expect eventually to finish off that specialisation and seek registration as a specialist surgeon?-- Well, for a number of reasons I've decided not to continue with that.

Yes?-- And to - I'm going to take up another field next year.

Splendid. We have been told, and I don't think anyone disputes the fact that there is a shortage of doctors world-wide, a shortage of doctors in Australia, a shortage of doctors in Queensland and, most particularly of all, a shortage of doctors prepared to work in rural and non-metropolitan areas in Queensland. Again based on your recent and current experience, is there anything that you can usefully say to us about that situation and what is needed to address it?-- I think the system of bonded scholars is becoming outdated, mainly from the fact that you're sending people - you're forcing people to work in a small area where they may not be adequately prepared.

Yes?-- A lot of the time there's not adequate support for you and where I'm currently working, there's very minimal time allowed for dedicated training. So any dedicated teaching or education time, mainly because there's just not enough staff to relieve for that.

In Dalby, does that work as a base hospital? Are you getting referrals from Chinchilla or Miles or Wandoan or any of the-----?-- We get referrals from Miles and Jandowae. There are a lot of areas that are around Dalby where we get referrals from, including the GPs in town.

Right. And then you have the capacity to refer patients to either Toowoomba or Brisbane if that-----?-- That's right.

-----level of care is needed?-- That's right. So if there is any patients that I feel are better managed in a larger centre, we'll organise transfer to Toowoomba or Brisbane.

What medical resources do you have in Dalby? Do you have specialist gynaecologists, specialist surgeons?-- We have a visiting specialist surgeon from Toowoomba hospital. He comes once a week. He conducts a morning theatre session and usually he'll do one large case such as a lap choly or - and then he'll have a few skin excisions that aren't able to be

done by the GPs.

Right. For any emergency surgeries such as an emergency appendicectomy?-- Yep.

Does that have to be done by doctors like yourself?-- No, that would be referred through to Toowoomba.

I see. If there wasn't time, if the situation was time critical, do you have the resources to perform emergency surgery in Dalby?-- There are procedures in place for emergency surgery to be completed. If - if I was on duty at the time, there'd be a - far more experienced general practitioners who may be able to assist with emergency surgery. But a lot of emergency surgeries are able to be deferred until they are transferred either to Toowoomba or Brisbane.

You don't have any private specialists in Dalby?-- No, there's not.

Or any private hospitals in Dalby?-- No.

So you're it, in essence?-- Yes.

But arrangements exist, do they, for local GPs to help out at the hospital where necessary, particularly in emergency situations?-- That's right. And the GPs have a good on-call system where they can be second on-call for the hospital. So if there's any anaesthetic emergencies in accident/emergency for instance, they're easily contactable and you can call them for help. If there's any obstetric emergencies, there's always a couple of GPs on-call that can be called in as well for those.

Mr Boddice, do you have any further evidence-in-chief?

MR BODDICE: Just a couple of matters, thank you, Commissioner.

EXAMINATION-IN-CHIEF:

MR BODDICE: Doctor, just on that last point, you said that you have decided to follow another field. Is it your intention to remain within the rural system?-- Yes, it would be. I hope to get a pediatric job at - for next year to start training and I'm hoping that I will be able to go into a smaller centre either rural or a more regional centre than in Brisbane.

So ultimately you intend to specialise but still remain in rural locations?-- That's right. Yes.

Doctor, you were asked some questions about the mortality and

morbidity meetings?-- Mmm-hmm.

Could any case be raised by any person in that meeting?-- Yes.

So was it a situation where the doctors who attended would raise cases they had been involved in-----?-- Mmm.

-----and there'd be a general discussion then about those cases?-- That's right, yes.

And that, even though the Otago system was not working, it still applied in that way. That is, that you could raise cases?-- That's right, you could still discuss any cases that you felt need to be discussed.

And you gave some evidence also in relation to the discussion you had with Dr Patel concerning the wound dehiscence?-- Yes.

Now, you just made - when you were giving your evidence, you said that the wound had superficially broken down, I think was the word you used?-- So it hadn't broken down right to the level where the implant was in the leg but certainly the superficial skin layers had broken down.

But you considered it still a wound dehiscence?-- I did, yes.

And Dr Patel didn't. Did Dr Patel indicate to you why? Was it the issue of whether it was superficial or was there no discussion about that?-- No, he - Dr Patel wasn't familiar with this gentleman that I was discussing, but he just mentioned that we had to be careful about, you know, what we class as a wound dehiscence.

And at paragraph 30 of your statement you speak of the procedure when signing death certificates and you speak of occasions when Dr Nydam would ring. Was that in circumstances where a specific cause of death had not been given?-- That's right. The - or the process leading to death was given but not the - the cause of death that led up to that process. For instance, someone might have documented heart failure but not written as to why that heart failure had occurred. So Dr Nydam would just clarify some issues. There was no instances where Dr Nydam would direct you to put a certain misleading diagnosis on the certificate though.

It was more an occasion to try and have more specificity to the cause of death?-- That's correct, yes.

That's all, thank you.

COMMISSIONER: Thank you, Mr Mullins?

MR MULLINS: Thank you.

COMMISSIONER: Doctor, Mr Mullins represents the patients at Bundaberg.

CROSS-EXAMINATION:

MR MULLINS: Briefly, Dr Risson, firstly the Otago audit system you raised in your meeting of 2nd of November 2004 with Mr Leck and Dr Keating - and I think you expressed a view that you were concerned about the transparency of the current surgical audit process after the Otago system had been abandoned, did Mr Leck and Dr Keating in that meeting express surprise that the Otago database system had been abandoned?-- I can't remember that they were surprised, no.

Did they tell you they knew it had been abandoned?-- No, they didn't give me any indication that they knew that.

Did they indicate to you that they understood what the system was about?-- I can't remember that there was much discussion about that. I had just mentioned that it had been disbanded and I can't remember there was too much more discussion about it.

You mentioned that in 2003 you had commenced learning that system?-- Yes.

When Dr Patel had indicated to you it was to be effectively abandoned?-- Mmm.

Can I just clarify one point: the data was completed on a sheet of paper?-- Correct.

And the data was inputted into a computer system?-- That's right. We completed the data as soon as an operation - this was how it was supposed to work - you completed the form after an operation was completed or a complication on the ward was found. There were these forms on the ward as well that you could fill out, so they were in theatre and also on the ward, and when we had completed those, we were to give them to one of the administration staff and that would be compiled into the information.

And the sheet that you completed-----?-- Yes.

-----did it have the basic patient details on it? Can you remember?-- I can't remember that there was any patient identifiers on the sheet.

The reason I ask is this: if it was - if the form wasn't filled out after the surgery, would it be then that the form hadn't been filled out further down the line because the fields in respect of that surgery wouldn't have been completed on the computer?-- It would need to be completed very soon after the surgery, just so no-one would forget to complete it at a later date.

COMMISSIONER: I think what Mr Mullins might be driving at is that unless someone has already inputted the patient's name into the system prior to the surgery, if nothing was done to enter those patient's details after surgery, that patient might be forgotten from the system altogether?-- That seems reasonable to happen, yeah.

MR MULLINS: So there was no cross-referencing between admin staff admitting people through and the process of creating a file and the creation of this Otago database?-- I am not too sure about-----

We will ask somebody else about that?-- Yes.

Thank you. One last matter: the mother of P26 is here, and can I just run through a couple of things in relation to P26? Firstly, you recognised very soon after the first surgery that it was best that he go to Brisbane?-- Uh-huh.

That's correct?-- Yes.

And one of your concerns was, as I understand it, the lack of a vascular surgeon to operate in an emergency situation?-- Yes, or a lack of investigations that could get to the bottom of P26's problem.

Is it the case that, despite yourself and maybe others having that view, the dynamic that existed with Dr Patel being both the Director of Surgery and having a personality that we know he had - we have heard that he has, once he said, "No, he is not going", that was pretty much the end of the discussion?-- That's how I understood it, yes.

COMMISSIONER: Doctor, is there any failsafe within the system that if you, as the most junior doctor in the hospital, think that the Director of Surgery is doing something fundamentally wrong, you can go and see the Director of Medical Services, or the District Manager, or someone else and do something about it?-- That would be the next person to see after - if you weren't able to discuss it with Director of Surgery.

I am sure you will understand I don't mean any criticism in asking this, and I certainly don't, but why did you choose not to escalate the matter in relation to patient P26 by going to see Dr Keating or someone else up the ladder?-- I suppose I was still - even though I was a PHO, I was still at a junior

level, the decision had been made by the senior surgeon not to transfer. I also - I wasn't directly involved with the patient's care. I had orthopaedic patients that I was responsible for, and there was a surgical team that was responsible for the care - the surgical patients. It wasn't usual - you know, if a surgical team person had concerns about an orthopaedic patient, they wouldn't come and criticise me. There wasn't that toing and froing.

And I think to be fair to you, doctor, you also raised your concerns with another senior medical practitioner, namely Dr Robinson, and I guess that was a - an informal way of expressing to someone more experienced the fact that you were unsettled about what was happening?-- Yes.

MR MULLINS: You didn't have ongoing connection with P26 really until 30/31 December, 1 January?-- That's right, yes.

When again, even after Dr Patel wasn't there, you then began to lobby, as it were, to have him taken to Brisbane?-- Yes.

Nothing further, thank you.

COMMISSIONER: Mr Allen?

MR ALLEN: Just briefly, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Doctor, John Allen for the Queensland Nurses' Union. Just briefly in relation to patient P26, do you recall entering the theatre towards the end of the second operative procedure?-- It was during the second operative procedure, yes.

And you have said that medical staff, including nurses, expressed concern about the lack of pulse in the left leg?-- Yes.

Do you know a theatre nurse named Damien Gaddes?-- Yes.

He was one of the nurses who expressed concern to yourself?-- Yes. Before the first surgery was completed, while I was scrubbing, nurse Gaddes had - I had a discussion with him about whether or not we should call Dr Brian Thiele, a vascular specialist. I didn't tell Dr Patel that I had tried to call him but we tried to reach Dr Thiele, but unfortunately he was on leave at the time.

And towards the end of the second operative procedure, or at the end of it, do you recall speaking to Damien Gaddes about the lack of pulse in the left leg and indicating that you would contact Dr Robinson?-- Yes. I can't - I can't definitely remember that I said that to Damien Gaddes but I

know that I did contact Dr Robinson.

As a result of contacting him, was there an occasion between the second and third operative procedures when you were in the ICU at the patient's bed along with Dr Patel, Dr Robinson and Dr Athanasiov?-- I can't remember there was a time between the second and third procedures when I was in ICU, no.

The following day was Christmas eve and are you able to say whether or not Mr Gaddes may have inquired of you at that time in relation to patient P26 and you told him that the patient still had no pulse in his leg?-- I can't remember talking to Dr Gaddes on the 24th.

Could that have happened?-- It certainly could have happened, yes.

Okay. And I suggest to you that on that occasion Mr Gaddes expressed concern to you as to how Dr Patel was handling the case, and that you agreed it would be in the patient's best interests if he was transferred to Brisbane?-- Yeah, I wouldn't be surprised if I did say something like that to Damien.

And you have already explained the sort of steps you took to voice your concerns?-- Yes.

And that it wasn't ultimately within your power, as you understood it, to facilitate a transfer. Do you recall having a conversation with Damien Gaddes early in the New Year after you had both become aware that the patient had in fact undergone an amputation in Brisbane?-- I spoke to Damien Gaddes a few occasions. I know that he and I were both concerned about the care that P26 had received, so, again, that would have been something that I probably would have said to Damien.

During such-----?-- But I-----

Sorry?-- But I can't remember exactly saying those words.

Are you able to say whether during such a discussion Mr Gaddes may have asked you whether you would be prepared to stand up to Patel and make a statement about what had happened?-- I can't remember being asked by Damien that specific question, no.

I suggest that you indicated that you would be willing to do so?-- Well, yes, it is something, looking back at the question, yes, it would be something that I would have done.

And that you were prepared to do so?-- Yes.

Despite any risk to your career?-- Yes.

And, in fact, you did speak to hospital management about that matter at some stage?-- Have you got records to say that I did or-----

Were you interviewed by either hospital management or by anyone else from Queensland Health?-- I think I predominantly spoke to Steve Rashford, the clinical coordinator - a Queensland Health employee. Also Mark Ray.

COMMISSIONER: I think Mr Allen is asking, though, whether you were asked in an investigative sense whether someone investigating from Queensland Health has asked you about patient P26?-- I can't remember. Like, soon after the incident happened and before I left Bundaberg, I can't remember there being an investigation by management, yep.

MR ALLEN: And when was it again that you actually left Bundaberg?-- It would have been about the 15th - 14th or 15th of January.

And certainly before Dr Fitzgerald was on the scene at Bundaberg?-- I am not too sure what time Dr Fitzgerald arrived at Bundaberg.

Did Dr Fitzgerald contact you in Dalby?-- No.

Thank you.

COMMISSIONER: Mr Devlin?

CROSS-EXAMINATION:

MR DEVLIN: Just a couple of questions, Dr Risson. Ralph Devlin, I represent the Medical Board of Queensland. Do you agree you reviewed the patient P26 daily with Dr Gaffield after Dr Patel departed on vacation leave for two weeks?-- Do I agree with that?

Mmm?-- No.

Did you - do you have any recollection of seeing the patient at all, in terms of a formal ward round, from Boxing Day to New Year's day?-- No, from my recollection I had a couple of days' leave. Normally you have either - you either work the Christmas break or the New Year's break, and I think I had from New Year's eve off for a few days and then started again later in the week.

COMMISSIONER: Mr Devlin, I don't want to cut across you, but it seems to me there might be some misunderstanding. You were doing your orthopaedic rotation at this stage, weren't you?-- That's right.

So if Dr Gaffield were doing surgical ward rounds-----?-- Yes.

-----you wouldn't have been involved in that anyway?-- No.

MR DEVLIN: And you were not the surgical PHO at that time?-- No, not that I can recall.

Thank you. And so looking at that period before you did go off on your leave on new year's eve then, you don't have any particular recollection of checking the patient between Boxing Day and new year's eve?-- No.

So that you were not in a position to concur or otherwise with the proposition that the patient was slowly improving?-- No.

You certainly didn't concur with that view?-- When I was preparing my letter of referral to Dr Ray in Brisbane, looking through the notes there was an occasional mention of some improvement, but generally there was a decline.

Yes. And that was the message you sought to convey to Brisbane?-- Yes.

Thank you, I have nothing further.

COMMISSIONER: Thank you, Mr Devlin. Mr Diehm?

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: My name is Geoff Diehm and I am counsel for Dr Keating, Dr Risson. I just want to ask you firstly about the Otago system, audit system. Piecing together a few things that you have described at different times to different questions that have been asked of you, firstly, is it right to say that it was just a one-page document that was required to be completed, or were there several pages?-- I think it was either a single-sided page or double-sided but it was just - I am sure it was just one piece of paper.

And in terms of timing for its completion, was it a document that would be potentially updated over a period of time, in the sense that ideally you would obviously complete the information about the surgery itself on the document very soon after the surgery was performed?-- That's right.

But that if there was a complication, would you come back to the document and add something to it?-- As I said earlier, there were the audit forms that were available in theatre to be filled out contemporaneously, and then there was also audit forms available on the ward, so that if there were any complications, such as patients had been discharged and then they came back with a complication, they could be recorded on the form, on the ward.

So if there was a complication that happened during the surgery, that could be done contemporaneously?-- That's right.

With the surgical report?-- Yes.

But a second document would be utilised if there was something that developed when the patient was in the ward or, indeed, after they had been discharged?-- It would be the same form but there was a place on the form for a complication to be recorded.

Sorry, so the original form you have completed stays with the patient's file, does it?-- No, it might be - I think it might be a different form because the first form I think probably would have already been sent off to administration, and then you just fill out another form if there was a complication.

Yeah?-- Keep in mind that this was disbanded fairly early on when I started working there, so we didn't have a chance to fill out too many.

Okay. And you said that the information was provided to an administration officer, I think was how you described it?-- Yes.

Was that person a relatively junior administration officer?-- I think we were told to send the forms to - it might have been Sue Hutchins up in - no, she wasn't really junior, but I am not too sure where the forms went after that, yep.

You don't know whether the person who processed the forms thereafter had any medical or nursing qualifications at all?-- No, no.

Do you have any knowledge about the degree of compliance that there was with this ideal way of forms being completed and information being provided?-- I know that there was probably a few occasions where they weren't completed straight away but, yes - so any system's only as good as the time that people take to fill out the forms.

Yeah?-- Writing when something happens.

I take it from the way you have given your evidence that - I will withdraw that and I will put it to you this way: were you aware of there being problems with the use of the Otago surgical audit system because documentation was not being completed properly?-- Again, we hadn't had an opportunity for very long to fill out the forms and it might have only been a period of weeks before we were told not to use them.

Now, when you were talking about that, are you talking about only a short period of time because of the length of time that you had been working in this area of the hospital?-- That's right, yes.

The system had been in place for quite some time-----?--

That's right.

-----as far as you are aware before your arrival?-- Yes. And I wasn't in a position to make any comment about how the system functioned prior to me starting work at Bundaberg.

Yes, okay.

COMMISSIONER: Doctor, even assuming that there wasn't 100 per cent compliance with filling in the forms and logging the data, would you have thought it was better to have some system, even one that wasn't being operated with 100 per cent compliance, rather than no automated system at all?-- Yes. I think having a formal system in place would still give better and more timely information than just relying on your memory to recall any operations or complications that had occurred.

MR DIEHM: Doctor, was there also available to you, after the Otago system was abandoned, data that could be retrieved from DQDSU?-- That's right, and that's where I got the information I needed to compile an orthopaedic audit when I was working orthopaedics, yes.

The information - and tell me if you know or don't know this - the system that DQDSU ran was known as transition 2. That was the program they ran-----?-- Yes.

And the information that you could retrieve from that system, was that quite similar to the information you would expect to be able to get out of the Otago system?-- Yes, it would be. I think the information that DQDSE got, that was reliant on discharge summaries being filled out correctly. There was a few people in the hospital that specifically went through the charts to compile any information for DQDSE, so they went through operation reports or discharge summaries and that - those sort of sources, yeah.

So they, looking at these various - and just so I understand properly, you are not saying that they looked only at the discharge summaries, they looked at discharge summaries, surgical reports, or whatever else they chose to look at?-- That's right. That was my understanding.

And they would compile from that data similar to what you would expect to retrieve from the Otago system if it had been operating?-- That's right.

COMMISSIONER: And, doctor, of those two systems, which would you regard as preferable and why, the system of having the surgeon himself or herself filling in the Otago data or having the DQDSU staff, the appropriate people fill in the data from discharge summaries, medical notes, clinical notes and so on?-- I feel that it is still probably a better system having the Otago system in place. The - as I said, the DQDSU still relied on information on the discharge summaries and sometimes they wouldn't be completed for, you know, a couple of weeks or so. So by the time that you went back to fill those discharge summaries out, your memory might not have been as good.

Whereas the Otago system, there was still the possibility that you might not fill the forms out straight away but there was a system in place that allowed you to do that.

Probably the best thing would be to have both?-- Well, yes, yes.

MR DIEHM: Doctor, again you may not be in a position to be able to answer this question because of the length of time that you operated with the Otago system, but if I can suggest to you and invite your comment on the proposition that at the time the Otago system was abandoned, the problem was that it was the results that were being produced from it because of problems with the data going into the system was such that it was suggesting virtually perfect results even though that wasn't the case in truth?-- Well, yeah, I could see how that could happen if the forms weren't filled out. That certainly would happen.

Now, you've mentioned that you expressed your concern to Dr Keating and Mr Leck in November of 2004 about that system not being used anymore. Are you aware of whether there were any other doctors, specifically surgeons, who were concerned about that system having been abandoned in 2003?-- Oh, I can't remember there being any other doctors that forged that opinion as well.

Moving ahead, after the episode with P26 and before you left Bundaberg in mid-January, as you have described, I suggest to you that Dr Keating did speak to you about the management of P26 and any concerns you had. Are you able to recall whether that happened, or, if it did happen, you don't recall?-- I can't recall it. I can't recall being called up to the office to - to his office or not, but, yeah, it certainly may have happened, but I am not disputing that. I just can't recall that.

I will suggest to you that there was a discussion between you and Dr Keating and you articulated your concerns regarding the management of P26 as being concern about the delay in transferring P26 to Brisbane, and not just initially but, indeed, throughout the long time that he was in Bundaberg Hospital before ultimately you arranged for his transfer?-- Right.

If understand your answer, you can't recall specifically whether you had such a conversation, but if there was a conversation you had with Dr Keating about the issue, would that be the very matter that you would express to him?-- Looking back, yes, it would have been.

COMMISSIONER: Well, those were your concerns?-- That's right.

So if Dr Keating had asked you what you were concerned about, no doubt that's what you would have told him?-- That's right, yes.

MR DIEHM: Finally, doctor, picking up some questions Deputy Commissioner Vider asked you earlier on, was it your experience that the surgical records, the surgical notes in the time that you were involved in general surgery, tended to accurately reflect what had happened with the patient's management?-- Yes, I can't remember there being any occasions where there were deliberate inaccurate recordings of any problems that occurred with patients.

And if there was an unexpected complication that happened during the course of surgery, your experience was that that was documented?-- That would be recorded usually in the M&M meetings.

Yes. Was it documented in the patients' records?-- Yes, as far as I can remember there was no occasions where there wasn't an adverse event that wasn't recorded in the patient's record.

And you were never told to write something differently than your perception as to how it had happened?-- No.

I have nothing further, Commissioners.

COMMISSIONER: Thank you. Just on that last point, if you still have your statement there with the attachment, which is Dr Keating's note of your meeting with Dr Keating on the 2nd of November 2004 - I am sorry, Dr Risson, I am going to ask you a question which involves interpreting someone else's note of your conversation, so you may not be able to help. See the last paragraph reads, "Dr Risson had never been told to not write anything on discharge summary and had attended surgical department meeting where wound dehiscence and superficial infection had been discussed." Now, the first part of that sentence with the two negatives in it, "Dr Risson had never been told to not write anything", is the effect of what you are saying to Dr Keating this: there was never an occasion when someone said to you, "Don't write such and such on a discharge summary."?-- That's right.

MR DIEHM: Thank you, Commissioner.

MR CHOWDHURY: I have no questions.

COMMISSIONER: Thank you, Mr Chowdhury.

MR BODDICE: No Commissioner.

COMMISSIONER: Mr Andrews?

MR ANDREWS: No, thank you, Commissioner.

COMMISSIONER: Doctor, thank you so much for coming down and giving evidence. Having driven the road many times myself, I know it is a fair way from Dalby so we do appreciate your effort, and also the fair and concise and cogent way in which you have given your evidence. Much appreciated. You are excused from further attendance.

WITNESS EXCUSED.

COMMISSIONER: Now, gentlemen, 9.30? Does that suit everyone?

MR ANDREWS: Yes, Commissioner. Indeed, it is proposed now to start tomorrow with Dr Janette Young. And to follow her evidence with the evidence of Dr Nankivell - Dr Rashford second, Dr Nankivell third, and it is hoped that the evidence of Dr Fitzgerald will commence tomorrow afternoon.

COMMISSIONER: Splendid. 9.30 it is then.

THE COMMISSION ADJOURNED AT 5.05 P.M. TILL 9.30 A.M. THE FOLLOWING DAY