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Transcript of Proceedings

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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 26/07/200

..DAY 27

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THE COMMISSION RESUMED AT 9.30 A.M.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: Good morning, Commissioner. Commissioner, it is proposed, as we explained yesterday, to call as a first witness Dr Jeanette Rosita Young.

COMMISSIONER: Certainly.

JEANNETTE ROSITA YOUNG, SWORN AND EXAMINED:

COMMISSIONER: Dr Young, please make yourself as comfortable as possible?-- Thank you.

Do you have any objection to your evidence being photographed or video recorded?-- No, I don't, Commissioner.

Thank you.

MR ATKINSON: Witness, would you tell the Commissioners your full name and your business address?-- Yes, my name is Jeannette Rosita Young. I am the Executive Director of Medical Services at the Princess Alexandra Hospital in Brisbane.

Dr Young, would you have a look at this statement? Dr Young, is that a statement that you provided to Queensland Health for the purposes of this Commission?-- It is.

Have you had a chance to look through that statement recently?-- I have.

Are the facts and opinions set out within the statement true and correct to the best of your knowledge?-- They are.

Commissioner, I tender that statement.

COMMISSIONER: Yes. Dr Young's statement will be exhibit 209.

ADMITTED AND MARKED "EXHIBIT 209"

MR ATKINSON: Dr Young, you mention in paragraph 4 of your statement that you're currently the Chair of AMWAC?-- That's correct.

Now, there is a body called AHMAC, that's the Australian Health Ministers Advisory Council?-- That's correct.

And that committee of Health Ministers, effectively it set up AMWAC and AMWAC advises the Health Ministers on medical workforce issues?-- It is not quite like that, if I may correct you.

Of course?-- The Health Ministers sit in a council and under them are AHMAC, who advise the Health Ministers, and then AMWAC has been set up by AHMAC to advise AMWAC about issues related to medical workforce planning.

Health Ministers, AHMAC, and then AMWAC below that?-- That's correct.

And effectively as chair of AMWAC, one of your roles is to advise in due course the Health Ministers about medical workforce issues as they arise Australia wide?-- That's correct.

So I imagine what you are about is planning for the future in terms of shortages here and excesses there?-- Yes, yes.

Dr Young, I also notice in paragraph 3 that you're the Executive Director, Medical Services at the Princess Alexandra Hospital?-- That's right.

In the old language that means that you are the medical super?-- That's correct, yes.

You mention there that you're responsible for ensuring all medical staff observe the highest professional and ethical standards at the hospital?-- That's correct.

I am curious if you could tell us - explain to us exactly how you go about doing that, maintaining clinical competence standards at the hospital?-- Yes, I am a member of the executive of the hospital and as part of the executive I am responsible for the medical staff, and one of my most significant roles is ensuring that all medical staff are appropriately qualified and credentialed, and then the correct clinical privileges are given to those medical staff, and that's medical staff ranging from the most junior interns through to the most senior consultants.

If I can just go through that, there is two processes you mentioned. One is credentialing?-- Yes.

The other is privileging?-- Yes.

I understand, is this right, that the PA Hospital has its own policies about those two concepts?-- It does. They're based on the Queensland Health policies.

And credentialing from the PA's point of view is the practice of ascertaining that a practitioner, whether it be a nurse, or a doctor, or sonographer, has the qualifications in terms of documentary evidence that they say they have?-- Yes.

And then privileging, is this right, is the practice of working out, given that person's on-paper qualifications and their practical experience, telling them what their individual scope of practice will be?-- That's correct. There is another part to that. There is also the practice carried out within the hospital, so the role delineation, or the service capability framework is the correct term of the hospital. So just because someone is qualified and they have the credentials to do something, doesn't necessarily mean they will do it in every hospital. For instance, the PA Hospital is an adult hospital, so we may have doctors who are quite capable of treating children but we would not give them the privileges to treat children in our hospital.

It may be that someone comes to you and they are a well qualified spinal surgeon but you might say to them, "You're confined to doing laminectomies", for instance?-- Yes, we may do that. It would be unusual.

As you say, a further limiting feature is the service capability framework of the hospital itself?-- Yes, that's right.

How often does a doctor have to submit himself or herself to privileging?-- When they are first appointed at the hospital to determine their initial privileges, and then, at a minimum, every three years we review that doctor's privileges. We can do that at any time at the request of virtually anyone.

So even if you are somebody who is the head of their field, like, for instance, Michael Whitby at your hospital, infectious diseases, every three years a doctor is required to be privileged anew?-- Yes, yes.

Now, I imagine that it is the case that from time to time at a hospital, particularly a large hospital, a doctor might go off the rails to some extent, might be some personal setbacks. How do you monitor dips in competence, if you like?-- We have a lot of processes. Essentially, if there are any incidents or complaints about the doctor, they would be looked into. There are standard audit processes that pick up issues, their colleagues most frequently would pick up if there is an issue and they would notify someone, usually myself.

Right. Can you tell me about the audit process?-- Yes, we have a lot of audit processes that look at complication rates of the work that's done within the hospital.

And can you elaborate upon that?-- Well, they are various audits, so some of them may be spot audits, some of them may look at all work that's done. Usually we'll have systems in place that will collect the data within databases and they will be looked at regularly. So that all our units in the hospital will have regular mortality and morbidity meetings that they will discuss the outcomes of the work that they have been doing.

Do you have some kind of checks and balances to make sure that

when a surgeon does an operation, the outcome must appear in an audit? Or is it the case that sometimes the surgeon may just be too busy and say, "Well, I just don't have time to document that particular surgical event.", or else he marks himself softly so it doesn't get through to the audit?-- It is not usually the surgeon themselves that will do things like that, it is picked up by other people; patient safety officers in the hospital that do audits, we have a lot of systems that work with people to collect data, but it is not always the individual. Maybe if I could give an example, if our death audit processes - that's the ultimate outcome that's very easy to measure, any death that occurs in the hospital is picked up by a death clerk who then notifies our quality and safety unit and they will send a form out to the doctor who is responsible for that patient, so the treating consultant, and they're asked to go through the chart and notify any issues that have occurred. Then that is sent to the director of the department.

Sorry, who goes through the chart; the death clerk or the treating doctor?-- No, no, the doctor who looked after that patient who was responsible for that patient. For instance, if a patient has come into the hospital and died before they have even seen that consultant, that consultant is still responsible and will go through the chart and look at what happened to that patient right through the course of their illness, not only the final episode that led to death but all their episodes of care leading up to that process.

Right?-- So that's the first process. But then it would go to the director of the department and they would put it through their mortality and morbidity meeting so that all of the consultants within that department would look at it.

Right?-- And they would go through that and report on that. And from there it will go to the - back to the quality unit, and they're tracking that this is occurring at this stage so it doesn't get lost in the process. It would then go from there to our death audit committee which would be looked at by a group of senior doctors within the hospital.

The reporting through the death clerk, that occurs independently - makes its way to management independently of the mortality and morbidity meetings?-- Yes, because all patients need to go through our system so that a funeral home is notified or they go to the Coroner. So we know all deaths that occur in our hospital.

You mentioned, doctor, that death is an easy one because people are dead or they are not dead, but some are more qualitative, I imagine, like wound dehiscence - this is the ICD10 definition of wound dehiscence, and then other people have a more general catholic view of wound dehiscence. How do you make sure you have picked up episodes of wound dehiscence within your hospital?-- Because we have got separate systems in place that actually go look at the patients and determine those. Maybe another example I could give you is infection control. You mentioned Michael Whitby's name earlier and he

runs the infection control process for the hospital. So that his staff in his unit go around looking at patients to see if they have infections after theatre. It is not self-reported by the surgeons or the clinicians treating the patients, totally separate group that goes in.

D COMMISSIONER VIDER: Could I just ask for clarification in the process of taking matters to the privileges committee? If you had an issue with clinical competence of a medical officer, who actually takes that to the privileges committee?-- Anyone can bring it to the notice of the committee, ranging from the district manager to any member of staff in the organisation, through to the DG. It is a very broad group of people who can actually take anything of concern to the committee and they would do it through myself as Chair of that committee.

So the Chair of the committee would know this is an issue to be brought up in a privileges committee?-- Yes.

Would that - how often does the privileges committee meet?-- Once a month.

Would that then necessitate the calling of a special meeting of the privileges committee?-- If it needed to occur outside that time-frame, yes, we would call a special meeting. Otherwise it would happen at that monthly meeting.

And would issues of clinical - I will say clinical incompetence in its broadest sense, always go before a privileges committee, or would there be occasions when you would exercise your authority as the Director of Medical Services?-- There are times, of course, I will do something before that committee meets. I might suspend someone's privileges immediately when I am aware of something having occurred. It is sort of degrees of what the issue is.

Do you then work in conjunction with the colleges if you want to provide supervision or supervised practice for somebody at that level, you know, who has already attained their specialist qualification?-- Yes.

But you may need them to work with another practitioner?-- Yeah, the colleges have input into our privileges committee. I leave it up to individual colleges, whether they wish to turn up in person, and some do, or whether they would like to put their advice forward in writing. So we always have the colleges involved at every privileges committee. Of course, the relevant college to the doctor that we're discussing. Then if we do have an issue that's determined at the privileges committee that someone needs additional supervision, we'll work through that with the college. Or sometimes with our own medical staff because we're in the fortunate position of course at PA that we have a lot of senior medical staff in the organisation.

Then you work through the process in the first round and then there are occasions after that where you would contact the

Medical Board if further disciplinary action is required?-- Yes, if someone should resign while they are going through a process, so we're no longer able to monitor what they are doing, or if we ever felt we needed to sack someone, or suspend them on grounds of ill-health, something along those lines, we would let the Medical Board know.

Do you have practitioners at times whose services you utilise at PA who may have conditions on their registration?-- Yes, we certainly do.

Thank you.

COMMISSIONER: Dr Young, I apologise in advance for asking you what may be a difficult question. You would appreciate one of the central focuses of this inquiry is the situation in Bundaberg involving Dr Patel, and I am sure, like most Queenslanders, you know at least something about that situation from the press and media. Are you confident that your credentialing and privileging protocols at PA would have picked up Dr Patel's chequered history in America had he applied for employment at the PA rather than Bundaberg Hospital?-- I believe it would, although I don't believe necessarily it would have been the credentials committee. It would have been the selection panel that would have sought references and would have picked it up at that point.

Does it follow from that that at least one of the inadequacies in Bundaberg was an inadequacy in the selection or credentialing process?-- I think it would follow. At PA we are very fortunate in that we don't need to use agencies to recruit staff, so we will do a lot of work that I am sure other hospitals who use agencies would expect the agency to perhaps have done. But I am not sure of those issues.

I am interested you say that because I have found it curious, since I first heard evidence about that, that regional hospitals use agencies. And you now mention that the PA has the capacity to do its own recruitment processes - and I assume other major hospitals like the Royal Brisbane, it also would have that capacity. Surely there would then be some advantage in having those sort of recruitment services provided centrally from Queensland Health's corporate office, not only for the benefit of PA and RBH, but for the benefit of hospitals around the State?-- I think there would be benefit to that.

It would probably save money, too?-- I don't know the economics behind it but I wouldn't be surprised.

Well, I think we've heard - Mr Atkinson, you might help me on this - but I think we've heard that recruitment agencies usually charge something like 10 or 15 per cent of the first year's salary, which seems a lot of money when you have the capacity at PA to do that sort of recruitment work in-house?-- We have got a lot of advantages at PA. We're a large hospital, we're well-known internationally, we have had a lot of doctors come to us over the years and they go back and talk

about us. So we sort of get a lot of recruitment through word of mouth, and also we don't employ a lot of overseas-trained doctors as a percentage of our total staff.

That's another of the problems that we have to wrestle with at this inquiry, and I am sure Queensland Health has to wrestle with as well, in a sense the most prestigious hospitals like the PA and the Royal Brisbane are the ones that don't have the problems attracting Australian-trained doctors, and that seems to have led to the consequence that overseas-trained doctors go to regional and rural hospitals where the occasional rogue can do the most damage. Does that suggest to you that maybe centralised recruitment would be the solution to a lot of the problems, not only in the metropolitan areas but throughout the State?-- It depends on how that would impact on those central hospitals because although we don't have anywhere to the degree the problems they have in regional centres, we still have difficulties, particularly in some specialties. So it could cause problems that we're sort of struggling and we're managing at the moment, but if we started also recruiting so that we, for instance, provided services across the State, may cause some problems with the recruitment to the larger hospitals.

I think we've heard suggestions that there are problems, for example, with recruitment of anaesthetists and possibly pathologists. Is that the situation at the PA?-- Yes, also radiologists.

Yes?-- There are some other areas we've had difficulty. Indeed my own area, medical administration, we've struggled to recruit; oncology, we have had difficulties recently; cardiology, we have just had to get an overseas-trained doctor from England to fill a spot. So it is becoming more and more widespread. Our advantage is that we don't have difficulties recruiting very good doctors from overseas into most of our positions that we advertise.

But I suppose that if even the PA can't attract good Australian anaesthetists, for example, that makes the situation so much worse for provincial and rural hospitals?-- Absolutely.

Yes, Mr Atkinson?

MR ATKINSON: Dr Young, can I return you to this issue of maintaining the highest professional and ethical standards. You spoke about credentialing and privileging. They are not concepts that were created by the PA Hospital or, indeed, by Queensland Health?-- No, no.

They exist across the world?-- Yes.

To maintain practices?-- Yes.

You mentioned that you always endeavour to involve the colleges for the relevant specialist?-- Yes.

If the colleges decline to be involved, or if they don't act promptly in nominating a practitioner, do you go ahead and find somebody yourself?-- Yes, we do. The colleges have, to date, usually been involved, although they've not been as timely as we might want them to be.

So if it happens that, for instance, you want to credential or privilege an oncologist - and I guess the college of physicians is the relevant body-----?-- Yes.

-----and they are not prompt, it has been your practice in the past that you would - you have the advantage, as you have said, of many senior doctors on staff and you would just nominate one of them to do the exercise?-- No, what we would do is we would credential and privilege that doctor and we would put a proviso that "assuming that the college agrees with this decision", and then we would continue to follow up the college to get that decision.

And that provisional decision that you make yourselves, who carries out that assessment?-- As I said, we've got all the other systems in place, so the college is one part of it. When we credential a doctor, the things we look for are their registration status, so we ensure they have got the appropriate registration with the Medical Board of Queensland. We check their references. So if they're an in-house doctor coming for a third year review, we will get those references from in-house, from outside we will get them from the references that have usually been attained through the selection process. So we don't duplicate that work that's already been done at the selection process. Then we will also ask the college, and that is sort of the third line, and we continue to endeavour to get a response from the college, and it has taken us up to 12 months to get that response but we will continue to get it.

I am more interested in the privileging issue than the credentialing. Credentialing is, I understand, the gatekeeper sort of role?-- Yeah.

But in terms of privileging somebody, if you don't have the college's involvement, how do you go about that?-- The college doesn't tend to get involved in that side.

Right?-- Their side is saying what the credentials of the doctor are and what the doctor can do. So they will confirm what the doctor is capable of doing. It is up to the hospital to determine what services should be delivered in the hospital, and we do that based on our service capability framework. So the college doesn't get involved in that side of the equation. They can, but to date they have chosen not to.

It is just not the service capability of the hospital, it is also the capacity of the individual practitioner?-- That's what's been determined through the first part of the process, determining their credentials determines the capacity of the individual.

Right?-- That's where the college has been involved.

Right. But, as you say, in lieu of a close involvement, you do the thing yourselves and provisionally?-- Yes, yes.

COMMISSIONER: I guess, once again, you have an advantage over provincial and rural hospitals because the fact of the matter is that many of the full-time and visiting medical specialists at the PA are themselves senior members of the colleges, often officebearers of the colleges, so you have a close relationship with the colleges?-- Yes, we are very fortunate. Every single department as its director has a fully qualified Australian doctor who is a Fellow of the appropriate college.

Yes.

MR ATKINSON: The other quality or clinical competence measures you have - I guess besides the credentialing and privileging, you have peer review?-- Yes.

So, for instance, if a doctor is acting outside the scope of his practice or if someone is better at that - I think Dr Woodroffe will give evidence you might get a tap on your shoulder from your colleague saying, "Actually, endoscopies are better done by the fellow down the corridor."?-- That would come to me. They would bring that issue to me and I would take it through the credentialing and privileging processes.

You run CME courses at the hospital?-- Yes.

You, of course, are a recognised training facility?-- Yes.

That means, I guess, you have the advantage of senior registrars?-- Yes.

Teaching is interactive, as the Commissioner said yesterday, you learn from teaching yourself, but also those registrars are relatively senior people who can advance opinions and make judgments about clinical care?-- Yes, and they often make judgments about their supervising clinicians and we ask them to.

That's helpful?-- It is very helpful.

And you have the auditing process you mentioned?-- Yes.

With its own checks and balances?-- Yes.

And you no doubt have adverse outcome reports and sentinel event reports?-- Yes, we do.

Doctor, I was interested to see in your curriculum vitae that from 1994 to 1999 you were the medical super at Rockhampton Base?-- That's correct.

This comes back to a question that the Commissioner has asked.

I mean, is it unrealistic to expect those same measures that you can adopt at a primary - sorry, a tertiary hospital like the PA, is it unrealistic to expect those same measures at Rockhampton Base, as an example?-- I would expect there to be a degree of those measures occurring. They're often different in how they're carried out. A lot more technology is used, in terms of continuing professional development may be done via video conferencing, for instance, rather than onsite. There are different ways of achieving very similar outcomes.

I mean, straight away one can see problems, for instance, with peer supervision. Whereas you have the benefit of senior people like Dr Woodroffe on your books-----?-- Yep.

-----and senior registrars like Mark Ray, for instance, who - I understand in a hospital like Rockhampton, for instance, your problem is you may tend to have senior doctors and then JHOs and PHOs and no registrars?-- I am not sure what's in Rockhampton now, but certainly when I was there there were quite a number of registrars, a lot of the disciplines were accredited with the relevant college of training. I am not sure what it is now.

COMMISSIONER: But Mr Atkinson is taking the example of Rockhampton because that's somewhere you have practised yourself?-- Yes.

In a sense, Rockhampton is probably not a particularly representative example of provincial hospitals as well. It is one of the better resourced of the provincial hospitals, if that's a fair way to put it?-- Yeah.

Rockhampton would be streets ahead of Bundaberg in terms of the resources and facilities that they have?-- It would be a bit. It is a similar size type of hospital serving fairly similar size populations, but I am not sure if there is a direct comparison between the two hospitals.

MR ATKINSON: If it helps, in 1989 Bundaberg had 217 beds and now it has 136 roughly?-- Uh-huh.

That equates to your recollection of Rockhampton?-- When I left Rockhampton, which is now going on seven years, it had 260 beds.

Okay. Can you comment, both as a medical super and as a result of your work with AMWAC, on something that the Commissioner mentioned earlier there is this paradox in the Area of Need issue that overseas-trained doctors who are most in need of supervision get sent to regional areas where they're least likely to get it?-- Yes. It is a significant problem. Part of the ability to declare an area an Area of Need is the fact that you can't recruit anyone to it and, of course, we're more able to recruit doctors to PA than somewhere like Bundaberg or even Rockhampton. So that's the paradox that we take - we accept a different standard of qualifications for doctors because there is a requirement for a doctor due to it being an Area of Need but you can only

appoint them where no-one else wants to work.

Dr Risson, who works at Dalby, gave evidence yesterday, mentioned that usually if you are lucky enough to get a rural scholarship as an Australian doctor before they send you into the regions, they send you to a tertiary hospital for a year to keep your skills up and make sure you are competent?-- Yes.

Is that something that could happen with overseas-trained doctors?-- Of course, yes. If I could go back to maybe my example of Rockhampton, given that I worked there, that's what we did with a lot of senior doctors. We sent them down to Brisbane for one day a week to be supervised so that we got feedback about how they were going. Also assisted them to gain their qualifications with the college because our aim was always that we wanted these doctors to gain full fellowship of the relevant college. So that certainly can be done.

COMMISSIONER: Doctor, one of the thoughts that's crossed my mind over the past few months - and I am really only thinking aloud - is that when overseas-trained doctors come to Queensland there would be a potential for a period of working under supervision in a major hospital such as the PA, not so much to determine whether or not to let the doctor work in Queensland but at least to determine whether he or she - the level of his or her skills and such a process might, for example, with Dr Patel, have determined that he was a competent surgeon at a particular level but not at the level of competence required to be the person in charge of a surgery facility at a hospital the size of Bundaberg.

I know it would probably be unattractive to the PA to be used as - to have the guinea pigs there testing them out but do you see some merit in having that sort of probationary period at a tertiary hospital?-- Absolutely, Commissioner, and we already do that. The PA does act as a site for assessing the competency of doctors that have been of concern.

That's a bit like-----?-- After the event.

Yes, shutting the door after the horse has bolted, isn't it?-- And we have also done it for doctors who have first come to us and in ways it has been done as a period of orientation for that doctor. So I would see no problem with hospitals like the PA and the Royal Brisbane taking on that role.

MR ATKINSON: Dr Young, there has been some evidence that there seems to be a preference in Queensland Health for staff specialists over VMOs and that, in consequence, perhaps there is this resource, that is VMOs, that's not being used as keenly as it might be?-- I haven't seen that preference. I mean, they're two totally different groups of doctors with different skills and abilities and they really need to both be involved in the public health system. I think we'd be-----

COMMISSIONER: And to be fair, I think the evidence suggesting that has been focused again principally on the provincial and rural hospitals rather than major tertiary hospitals?-- I'd suggest, Commissioner, that in the provincial areas it's even more important to have both because you can't just have a full-timer. They can't possibly cover the place 24 hours a day seven days a week but you also, I think, struggle if you only have the VMOs because again they will have difficulty providing the full breadth and continuity of cover. For instance, for training of junior medical staff you really need that mentorship, that person who is there consistently. So I really think in the regional centres it is probably even more important to have a good mix of both groups.

That's certainly the suggestion we have heard from a number of witnesses, that at a place like Bundaberg, for example, whilst you need to have a Director of Surgery who is full-time, when you also have in the town very senior and experienced and respected surgeons, and some of them have already given evidence, it's a crying shame not to have them as visiting surgeons at the hospital to take advantage of their skill for teaching purposes, for the exchange of ideas between them and the full-time surgeons and simply because they bring an extra level of expertise?-- I totally agree. I think it's essential.

D COMMISSIONER EDWARDS: Are they willing to do that - sorry. We get the impression that some of the so-called visiting medical specialists have become frustrated with the system and so forth rather than either teaching or performing clinical duties. Have you a view on that, that we are too - I think we're asking too much in that area rather than actually teaching and treating patients?-- I think it's very difficult at the moment, there's so much stress on the system, the fact

that we just don't have enough doctors that we're pushing the doctors that we do have too hard. So it becomes very unattractive for them. I think they just get overwhelmed when they come to the hospital in terms of the patient load that's there and they just struggle with that, so that they can't do all the other things that they feel that they need to do and we need them to do - you know, the teaching aspect, the clinical audit aspect.

So you feel it is really a manpower issue?-- I believe it is. I think that a lot of our problems at the moment are just that we don't have sufficient doctors in Queensland so we're struggling to make the best use we can of the ones we've got.

And could I ask one more question?-- Yes.

Have you a view as to why this is the situation in Queensland, particularly in regional areas where we cannot attract doctors except overseas? Is it we're not training enough? And some suggestions in another role I have suggest that we're - have that major problem in putting out 220 or so graduates this year whereas in five or six years' time we'll have about 600 graduates a year. Is that the kind of program that will start to improve systems dramatically?-- It will but it's got an enormous gap to make up?-- I mean, Queensland's just - as you've said, has had the same number of graduates every year for the last 30 plus years and our population has increased enormously. So I think that's just a basic - we've not had enough medical graduates and we know from the work that AMWAC has done that medical graduates tend to stay where they trained, so it's hard to recruit them from elsewhere.

COMMISSIONER: I just wanted to pick up on a point of Sir Llew's. I think everyone accepts that there is this - I won't use the unprofessional term "manpower" but this personnel shortage problem across, really, all areas of medicine in most parts of the world but some of the suggestions we've been hearing over the past couple of months draw a contrast between the public hospitals, and again this may be more specific to provincial public hospitals than places like the PA, as compared with private hospitals. That the sense that we're given is that in the private hospital system, the patient of course is the most important person as is in the public person but the next most important person is the clinician providing the medical services, particularly visiting specialists, and we heard some comments from Dr Thiele a couple of weeks ago about Queensland Health's drive to use the word "clients" instead of patients, but the private system really treats the visiting specialists as their clients?-- Yes.

And works hard to attract them and keep them and look after them and take away the administrative burdens and the difficulties and constraints under which they work. Have you seen any sign of a concerted effort by Queensland Health to treat their VMOs the same way as visiting specialists are treated in the private system, as people that are important to the system, need to be attracted and retained and looked after

and treated with courtesy and aren't?-- I believe that's becoming clearer to Queensland Health and there are things that are happening to try and move that forward. It is a very different environment between the public and the private sector.

Yes. Are you able to enlarge, and I know I'm putting you on the spot for which I apologise but are you able to enlarge on the sort of things that are happening or should be happening to change that situation in the public sector?-- Maybe if I could give a very minor example.

Yes?-- It seems so minor that it's silly, but provision of parking for instance. VMOs at the PA used to have parking quite a distance from the hospital and people recognised that that actually impacted on the time that they could spend with the patients. So they were given parking underneath the new main building, although initially that was reserved purely for patients. So things were taken on board and differences made.

I'm not sure that that is a minor example because it's something that I've heard independently with private specialists saying, you know, there's no point leaving their rooms in Wickham Terrace to drive to the PA if they've got to go round the block five times looking for a car park or paying $20 to for a car park in a public facility across the road. I realise that's quite a specific example but are there any other general points you can make?-- Over a number of years, corporately, Queensland Health has taken on an increased role in providing assistance for professional development for VMOs so that they've actually - they've always given them four weeks but they now give them some monetary assistance to do that. So that's one example that's been taken on board. And I believe that the current VMO agreement that's been negotiated, there's been some hiccups with it but there's certainly been some delving down in that agreement as to how things could be made more attractive for VMOs to work. So rather than just salary conditions, looking at the other conditions, more the bureaucratic side of their employment process.

I'll be quite candid about this at the risk of people saying that I'm biased or I've already made up my mind about things, but hearing the evidence that we've heard from Bundaberg specialists like Dr Thiele and Dr Anderson, who gave evidence yesterday, it does seem a tragedy that Bundaberg had some highly respected specialists like Dr Thiele, Dr Anderson, Dr Nankivell, the Sri Lankan doctor who I can't pronounce-----

MR ATKINSON: They call him Lucky but his full name is Jayasekera.

COMMISSIONER: Yes, but all of them left apparently, so far as we've heard this to point, because they just couldn't handle the administration bureaucracy. That strikes me as something that really has to be addressed?-- I completely agree Commissioner.

D COMMISSIONER VIDER: Could I ask a question regarding the two particular specialists group that we've heard are in short supply in the public seconder?-- Mmm-hmm.

And that's the anaesthetists?-- Mmm-hmm.

And, certainly in the provincial areas, radiologists?-- Yes.

From your discussions and general information, do you have any ideas as to why those particular groups are hard to attract into the public sector?-- I think the anaesthetists, a part of that is the increased work occurring in the private sector as the Commonwealth government's changed its focus, if I can put it that way, so that it is very attractive for anaesthetists to go out and work in the private sector. They don't have a lot of the other costs that private specialists have. They don't have to maintain rooms to the extent. It's much easier for them. And I think that the work is very similar in the private or the public sector for anaesthetists. Whether you're providing anaesthetics in a public theatre or a private theatre, really - I mean, from my point of view, looking from outside, I don't think there's a lot of difference in that work, so why not go out into the private sector where you earn significantly more than the public sector and you also don't have those other issues that have been alluded to. So I think that's one reason. There's also that we've probably got our workforce numbers wrong. There's an increased number of women going into anaesthetics and we all know they work significantly fewer hours and they do less out of hours work. So I think that that's - that's an issue as well.

That will have to be addressed?-- It is being addressed. It has been taken on board and if I might also say the bit that we got totally wrong in AMWAC is that we didn't appreciate the fall in hours of younger men. They've dropped their hours a lot more than younger women. Women have come from a lower base but they've only dropped their hours a small amount. Men have come from a higher base but they've significantly dropped their hours, and that's part of it. And given men are still 70 per cent of the workforce in Australia, that's a lot of hours that have been lost.

COMMISSIONER: It's also been suggested to us, and I don't want to be politically incorrect about this, but with the increasing feminisation of the medical profession, and I think we have heard some statistics that medical graduates, university graduates, have fallen from something like 80 or 90 per cent men in the 1960s to now something like over 50 per cent women, there will of course be a percentage of the female graduates who spend their entire working life in the medical profession but there is going to be a percentage who drop out either temporarily or permanently. Presumably that's something an organisation like AMWAK takes into account as well?-- Yes. If we look at overseas experience, and Australia does tend to follow particularly the UK, 70 per cent of their graduates are now women. So that, we're taking that on board and looking at the impact that will have on our future numbers

of doctors.

One of the other factors that's been suggested to us as to the difficulty in attracting specialists to Queensland is at least a perception that pay scales are inferior to other states and I see that in the final paragraph of your statement you refer to there being at least a perception. Would I be right in thinking you've expressed that very carefully. When you say "at least a perception", you're not admitting that it's right but you're not saying it's wrong either?-- At the time when I wrote that I wasn't sure, because it's actually very, very hard to find out what doctors earn in other states.

Yes?-- Particularly Victoria, which tends to have individual contracts, and it's also difficult to work out comparing what they earn with what Queenslanders earn because of the subtle differences in the package. So it's really - it's not comparing like with like.

Yes?-- They're quite different. Since writing that I've actually had some very clear evidence from other states through some other work that I'm doing that shows that certainly in Victoria they - the doctors are paid significantly more.

There were some increases announced by the government, I think within the last fortnight or so. Will that go very far towards addressing that imbalance?-- We haven't had discussions about the full-timers. There have been some agreement reached about the VMOs.

That's limited to VMOs at the moment?-- Yes. We're going through the enterprise bargaining process with the full-time medical staff at the moment.

One other suggestion that's been made to us is that Victoria in particular attracts a lot of medical practitioners who might otherwise come to Queensland by offering them contracts which involve working in the public sector three or four days a week and having a limited right of private practice for the balance of the week, allowing them to earn a significant outside income. Is that a strategy that is being considered in Queensland?-- Yes, it is. Yes.

Is it one that you would support?-- Absolutely, yes.

D COMMISSIONER EDWARDS: That doesn't occur at all at the moment?-- A very limited way. Emergency physicians at the moment are not restricted to working 8 to 6 Monday to Friday, which is the case for everyone else. They can work shifts. So that in most hospitals, they would work shifts covering up to 16 hours a day seven days a week, but that was a one - a specialised agreement reached with the union and only for that group. It doesn't occur with any other group of full-time medical staff, senior medical staff.

COMMISSIONER: Dr Young, again I'll apologise in advance for what may be perhaps a difficult and unfair question but you've

answered a number of our questions this morning by saying, "Well, that's being looked at", or, "That's being done", or, "That's being considered." Are you in a position to tell us why it's needed an incident like Dr Patel to get those things considered; why it hasn't been happening for the last 10 or 20 years?-- I think some of the things have happened. We've always known the restrictions that the current award places on Queensland Health in terms of employing staff but we're waiting for the enterprise bargaining process. So I think some of the issues have been discussed over the last one to two years.

Yes?-- But they - if I could say, Commissioner, they've certainly been brought to the fore with the incidences happened in Bundaberg.

Yes. Yes, Mr Atkinson.

MR ATKINSON: Thank you. Doctor, in the Queensland Health submissions in which you've had some role?-- Yes.

At paragraph 1.4.8 you talk about the crisis in the workforce in terms of how many doctors there are and you make reference to four factors which seem to be the central ones?-- Mmm-hmm.

Tell me if I'm right, that the four that you nominate, one is the workforce will apply generally in getting doctors into Australia. Another is the ageing of the workforce?-- Yes.

So I notice that the mean age of doctors has gone from about 44 to 47 even over about the last 10 years. Another is the increasing participation rates of women?-- Mmm-hmm.

That's not a problem per se. I understand what you say is that women have other things to do and they tend to do them in terms of outside - keeping them away from working 80 hours a week?-- Certainly.

The third problem is that even the blokes are starting to think that working 80 hours a week isn't a good thing?-- That's right.

And you talk about the generational trend away from historical patterns of work in favour of a work/life balance?-- Yes.

And that's a relatively new phenomenon but it means there's less doctors available?-- Yes. We've noticed it since about 1999.

That just means doctors working less hours so they can have a balanced lifestyle?-- Yes. There's two issues. One is, certainly, they want to work less hours and want a balanced lifestyle but also we have put in place safe working hours. There's a lot of evidence from around the world that working when you're fatigued is not good for the outcomes of patients. So it's been those two issues working together, I think, that have really reduced the hours that younger doctors work.

COMMISSIONER: It strikes me, being someone outside the system, that it's extraordinary we have laws that stop truck drivers from working excessive hours but we don't have laws that prevent surgeons from doing the same?-- Yes. And that has occurred overseas. A European working hours directive has impacted on the UK. So that although the UK didn't put in place reduced hours of work, they're bound to follow the European directive. That's caused them a lot of difficulty with their medical workforce.

I did see Mr Mullins smile when Mr Atkinson talked about 80 hours a week because he's been trying to cut back his hours to that.

MR ATKINSON: Doctor, we heard evidence from a junior health officer in Bundaberg that he was working 100 hours a week, sometimes for a four-week stretch he said. One hundred hours a week you would say is unsafe?-- Extremely unsafe.

What do you think is a safe number of hours per week?-- It depends on the roster that they're working. If they're working 9 to 5, it means that you can actually work more hours. If you're working shift work, so you're going from day to evening to night shifts, then you need to work less because it takes more time to recover. Probably around the 50-hour mark.

I guess you'd like your consultants to be on-call about one night in four?-- Yes, depending how much on-call they do. Some of our consultants I think need to do less of that. For instance, anaesthetists are there most of the night when they're on which is why we really need to look at the change in the working pattern so that we can have senior staff working in shifts rather than having to work overtime to work outside 9 to 5 Monday to Friday.

The Commissioner Morris asked you questions about pay in comparison with Victoria and you spoke about the bargaining process that's going on independent of Dr Cartmill and the VMOs?-- Yes.

You're actually personally involved in that?-- I am on the management team for that process, yes.

For Queensland Health?-- For Queensland Health, yes.

So when you say that Victorians, for instance, get paid better, you're keenly aware of that?-- I am.

You were asked a question about VMOs and regional areas and you mentioned that you think it's very important that you integrate VMOs and staff specialists, I guess people who deal with fluctuations in workplace needs in regional areas?-- That, but also that you're far better off with a larger group of people working together because that's when issues of competency and clinical care come through. If you've just got a larger group of doctors, so - I think it is appalling if that town can't work together with the doctors working as one

unit.

Can I take that one step further and ask you this: do you agree that it's important in those regional areas that the private and public systems be well integrated in terms of resources?-- Yes, they need to work together, yes.

Is there any moves afoot to make the two more integrated?-- Certainly, that's a more recent strategy of Queensland Health, to work with their partners more closely, and that's all sorts of partners. So that's private sector, non-government agencies and all the people that really provide health services.

Doctor, you mentioned in your statement and in the Queensland Health submissions that there's a world-wide shortage of doctors?-- Yes.

I understand one of the particular problems for Australia is that we used to be able to poach doctors from Ireland and Britain and Canada but we're not competing as well as we used to to attract those doctors?-- There's a couple of reasons. We're possibly not competing as well given the exchange rate and those sorts of issues but also they've changed their training programs in those countries so that doctors can't just exit the system for a couple of years and go back and get back into it. So they're re-assessing how they're going to come - if they're going to come to Australia, how and at what stage, because they've got shortages in the UK, very significant shortages, made worse by the European working hours directive. So they're looking at how they can keep their staff and they're tightening up their training programs.

COMMISSIONER: We have heard, I think from the recruitment consultant, mention of the fact that there is a bit of a practice of young English doctors coming to Australia for, in essence, a sort of gap year or backpacker's holiday or something and Victoria seems to attract a lot of those young doctors. It was suggested to us that that was a good market because you're getting a very good quality of graduates, English speaking, experience in a medical system which is comparable to our own and so on. Are you familiar with that employment market?-- Oh, yes, yes. And certainly, when I was in Rockhampton, I recruited quite a lot from England. I still, at the PA, recruit a significant number from England. It's just we're going to have to change how we recruit them because they're all telling us that the new training processes there are limiting their ability to come.

MR ATKINSON: What's happened in consequence, is this right, Doctor, that Australia has tended to source its doctors more from Third World countries?-- That's right, yes, we're sort of moving away from that traditional market that we're used to.

That creates a particular problem because we're not as au fait with their training standards?-- That's right.

If they're taken from Fiji or Cuba, we don't know nearly as

much as we do about Ireland and Britain?-- Yes.

COMMISSIONER: There are other problems too, aren't there? There are associated political problems, that Australia shouldn't be taking doctors away from countries that can't afford to lose them, and I don't ask you to comment on that, but there's also a problem in that they come from systems where the medical technology, the practice of medicine may be very different from our own?-- Indeed, the diseases are often very different to our own. We have chronic illnesses such as diabetes which some of those countries don't have. So it is a major problem.

MR ATKINSON: Australia has a problem competing and then, of all the Australian states, Queensland has the lowest number of doctors per head?-- We have the lowest number of doctors per head of population, yes.

Right. As the Commissioner said earlier, there have been - we've been seeing a lot of very well credentialed and very talented doctors working in Bundaberg and it seems as if it's not so hard for regional areas to attract doctors as it is for Queensland Health, the public hospital system, to retain doctors. Can you comment on whether there is a problem or a perceived problem, a cultural problem, within Queensland Health that doctors find it less attractive quite apart from money issues?-- The money issue is significant. There's a big differential between what Queensland pays and what Victoria pays but there's even bigger differential between what Queensland Health pays publicly and what doctors can earn privately in Queensland. We have to remember that we're short of private doctors in the private sector in Queensland so that, really, there's a market dragging them in. And a doctor can walk out in Queensland into a private practice and make a living day 1. They don't have to build up the practice. There's so much untapped work out there for them. So that makes it-----

But in the past there has been a sense of responsibility and obligation from doctors to the public health system?-- Yes, and I believe that's still there. I just think that people are - there is a whole host of reasons why I think people go into the private sector. The first one is they're a lot older. The average age of a doctor who's graduating as a specialist is now in their late 30s. So they've already got families. I would suggest a lot of them are paying off HECS debts that certainly didn't exist 20 years ago. Mortgages I believe in Queensland are approaching the costs of southern states which they didn't in the past. So I think they've got a lot more financial issues. Then there's - they're working very hard in the public sector. That, there are so few doctors that the ones that are there are really struggling because there's so much work to do and doctors feel obliged to do the work that's in front of them, and sometimes I would suggest it's easier to turn around and go where you've got a bit more control over what's coming through the door.

Some of the things that make it difficult for doctors in the

public sector, and nurses for that matter and other professionals, is, first of all, that they might be under-resourced and that leads to low morale if you can't treat the patients as well as you'd like?-- Yes.

The second problem I suggest to you but it is a question is that in the public health system, the management isn't as responsive as in the private system to doctors' concerns about clinical issues or at least there are more pressing budgetary issues in the public system?-- That's correct. In the public system you're given a budget by government which are its obligations, and I'm part of management, to follow and it's our obligation to tell government what we believe is needed. There aren't those restrictions in the private sector. For instance, there are limitations on the drugs that doctors can use in the public sector because there are some very expensive drugs. Some of that's been addressed by the Commonwealth giving public hospitals in Queensland access to the PBS, so that made a marked improvement, but there are other access to other things as well that can't always be given to every patient in the public sector. We're well aware of that, which is another reason it makes it easier to work in the private sector.

Yes. Sorry, I didn't mean it as criticism but certainly Dr Molloy gave evidence about having a concern about an instruction happening that was affecting people in his ward and raised it with management and the problem was addressed, and Dr Woodruff will give evidence about how sometimes in the public sector he found people who weren't clinicians taking patients from category 1 down to category 2 or 3 for budgetary reasons?-- I would hope that's not happened. That should not happen and I certainly wouldn't be supporting that happening in PA, my hospital.

Of course. The last question I'll ask you, again about this - which one's more attractive, private or public, is that would you agree that there's a perception in the public system that where doctors raise complaints, that to some extent complaints aren't welcomed and responded to immediately?-- Can I - I can only speak about PA, that's the hospital I work in and am responsible for, and we welcome complaints. We go out there asking for complaints continuously because that's the way to improve.

Right?-- And we make it as easy as possible. Doctors can give a verbal complaint over the phone to anyone they choose. There's patient safety officers or myself, or other senior staff. They can give written ones, a piece of paper, they can do it electronically, and we thoroughly advertise that throughout the organisation. That's for our staff, and also for patients, because - I mean, that's how you find out what's going on in the organisation, is through the complaints.

There is some tension at the hospital at the moment that's been publicised?-- There is, yes.

That's not about complaints?-- No.

That's the evidence-in-chief.

COMMISSIONER: Thank you. Doctor, there are a few things in your statement I'd like to clarify. They may not be important, but it's, in a sense, important that I know what's going on. The first is, I'm sure, quite trivial, but in paragraph 3 your position is described as Executive Director Medical Services. We've heard of the position in other hospitals simply described as Director of Medical Services. Is there a difference?-- There's no difference at all, Commissioner.

Just a different title?-- Yes.

Okay. Paragraphs 7 to 10, and particularly paragraph 9, you deal with the registration system for overseas trained doctors. Obviously what is written here was written before the recent changes which were announced by the government, I think only last week?-- Yes.

Are you familiar with the changes propounded by Dr Fitzgerald-----?-- I am.

-----as Chief Health Officer?-- Yes, I am.

And do you accept those as satisfactory?-- Yes, I do.

In your CV, I noticed the last page of your CV - I see you presented a paper two years ago on International Medical Graduate Immigration Issues for Australia?-- Yes.

I'm not sure that we have a copy of that paper. Would it be of interest to us? Is it relevant to the issues we're dealing with here?-- It's not any more. There's been significant changes in the immigration process for doctors in Australia. They're now on the skills shortage list, which means that they get totally different visas. So that was relevant at that time, and it was purely about the system in this country for getting doctors through the immigration process, and we were comparing it to the system in the United States, United Kingdom and Canada at that time. So I don't - I'm more than happy to provide it.

That's why I asked. If it's old news then-----?-- I believe it is.

-----we wouldn't trouble you to let us have a copy. On the same page, the third last item is a congress on Strategies to Overcome Health Staff Shortages for Now and the Future?-- Yes.

Again, would that be of any continuing relevance to us?-- It could be. It's similar to some of the things I've already discussed, but I certainly would be happy to provide that.

Well, if you think it's covered in what's already in the Queensland Health submission or in your own statement, then again we won't trouble you, but-----?-- It's probably already in the submission. It was more just setting out the facts for where we were heading with medical workforce in terms of numbers, hours worked and so forth.

Going back to an earlier point in your CV, page 6, the previous page, I see that you have, in effect, been on the administrative side of medical practice really since you finished training?-- Yes, since '92. I spent some time training in emergency medicine.

One of the points that's been flagged in the evidence to date is that until about 20 years ago - not being precise with that date, but about two decades ago medical superintendents in our hospitals in Queensland were generally either practising clinicians in the sense they were still working in the theatres and the wards, or people who had been practising clinicians and had been promoted, if you like, from a clinical role to a managerial role. With your long experience in administration, are you able to offer any comments on the advantages or disadvantages of the current model of specialist administrative medical practitioners rather than clinicians doing administrative jobs part-time or as a retirement job?-- Yes, I think you hit on it, Commissioner, when you said "specialist medical practitioners". Being a Fellow of the College of Medical Administrators is a specialty, and we have a very strict training program that involves some clinical experience and then a masters degree in administration of some sort and then going through an exam process. So there's a training involved, and I think that it's so difficult now understanding all the legislative requirements, all the human resource requirements and budgetary requirements, that it would be a lot to ask an active clinician to take on that role, and it would also be a lot to ask a clinician who has retired from clinical work to just take it on board without having the opportunity to do all that training. I think that it's unfair on individuals to ask them to do jobs that they're not trained to do, and that's where medical administration is headed. It has become a specialty and there's - there was obviously seen to be a need for it at some point and it developed.

Right. What's been suggested is that whilst I think everyone accepts that you need specialist medical administrators - I

don't think anyone doubts that for a moment - it's nonetheless suggested that not only the figurehead, but the ultimate decision maker in any hospital environment should be a clinician rather than someone with an administrative background?-- That's absolutely clear, because the same thing works the other side. I haven't been in clinical medicine since 1992, so I'm not the right person to decide whether we need a PET scanner at PA or - I mean, the two have to work in harmony and very closely together, and it is active clinicians who have to make those very important resource type decisions and work out the strategic direction of where services are going. But they need to do it with advice from someone like myself who has had the training in the other issues. For instance, I wouldn't ever expect an active clinician to go through the human resource process required to retire someone on the grounds of ill-health. They wouldn't understand that, but they would expect me to understand that. They would expect they could come to me and say, "Dr so and so is having difficulties because he's had, you know, a brain tumour and we don't think he's working effectively."

Yes?-- "Would you sort that out?" It's the two working together that I think gives us the best result.

Righto. But then let's look at a very practical example. We had yesterday Dr Risson, the young doctor from Dalby, giving evidence about his experience at the Bundaberg Hospital, training under Dr Patel, and I think everyone here felt considerable sympathy for the situation he went through there. One of the difficulties that emerged from that is that Dr Patel was the Director of Surgery. If he had problems with Dr Patel at a clinical level, there really was no-one in the administration above Dr Patel in a clinical sense. There were medical administrators and there were administrators without a medical background, but there was no-one in the nature of a chief of medical staff or a medical superintendent in the traditional sense that was seen as the head or the flagship of that hospital. Do you see any merit in having something like a medical chief of staff or a - even a clinical chairman or chairperson, or something like that, so that within the administrative structure there was someone at least on the same level, or perhaps even higher than the Director of Medical Services, who is a practising clinician?-- Yes, and a lot of hospitals have that in place.

What title or role is given to that sort of person in other hospitals?-- Maybe I could explain the structure at PA.

Yes?-- We have a District Manager who is overall accountable, and under that is myself, the Director of Nursing, Director of Corporate Services, Director of Clinical Support. So administrators covering those areas. Then we also have a Chair of Medicine, one of surgery, and a mental health person. Now, those two chairs - there's two in each area - a doctor and a nurse, and they're active clinical people.

Right?-- So we have - and they're in the same level. So that group of people I've just described forms the executive of the

hospital. So we have an active clinician there representing surgery and medicine.

I want to follow up, if you will permit me to, a few of the other issues that have troubled us. If you will forgive me for saying so, your evidence over the last hour has been so helpful that I really would appreciate your input on a number of these other points. We've had suggestions again and again about waiting lists, and the proposition has been put to us that published waiting lists are misleading because the true position is that there is a waiting list for the waiting list, that you have to go on a waiting list to see a specialist in outpatients before you get on the official waiting list, or you have to go on a waiting list for a diagnostic procedure such as a colonoscopy or an endoscopy before you get on the official waiting list. I don't want to embarrass you by asking you something that would cause you difficulty, but do you feel able to comment on that issue?-- It's a clear problem within our system that we do have waiting lists for patients to be seen in outpatients, and that's a resourcing issue, that frequently we can't get the doctors that we need for those areas. So one of the biggest waiting lists, for instance, is for ophthalmology.

D COMMISSIONER EDWARDS: That's specialists?-- Yes, yes.

COMMISSIONER: The suggestion that's been made to us goes further - and I have to be clear, no-one, I think, has yet said that this applies at the PA, but at least at some hospitals the waiting lists to see specialists and outpatients are manipulated. You've got the specialist sitting there ready to see patients, but you can't get on the waiting list because as soon as you do, and as soon as you see that specialist, then you will go on the waiting list for the operative procedure, and that will look bad in a statistical sense. So there's the allegation that there's an actual manipulation of the waiting lists. Do you know of that?-- I'm not aware of it personally. I have heard those allegations, of course.

Yes. And you would say that doesn't happen to your knowledge at the PA?-- Except - it doesn't - we don't actively do that.

Yes?-- But I know that the wait for mainly Category 3 patients - I don't believe it is the case for Category 1 and 2 because they're urgent patients, but certainly there is a wait for Category 3 patients for theatre once they're put on the list. There also is a wait for those patients to get into outpatients, because we triage all our outpatient referrals, of course, and the category 1s and 2s are always going up the top of the list, and it means that the Category 3s are waiting for inordinate times.

Moving on to another issue, various witnesses have talked about the so-called Code of Conduct and, in effect, the condition of employment that prevents Queensland Health staff from speaking publicly on issues of concern to them. The proposition has been advanced quite forcefully to us, that the

Code of Conduct, whilst obviously it's important that patient privacy and matters of that nature be protected, that the Code of Conduct is really used by Queensland Health to prevent criticism and to suppress public discussion of problems in our publicly funded hospitals. Again I won't press you for an answer if it would embarrass you to do so, but do you have any comment on that?-- I think so. I think it's a very difficult issue, because bringing up public criticism of our hospitals - although it's very important, and it certainly has occurred in this environment, means that it reduces the faith of the public in the hospital. So I think that a better mechanism is for people to bring up those issues locally and try to get them solved, and if that can't happen, to bring them up corporately. We do have a Chief Health Officer who is very approachable. We've got other senior staff in Queensland Health as well who are very approachable, and people should try and use that mechanism to sort out the problem internally. But I do understand, Commissioner, what you're getting at.

Well, the difficulty with the approach that you mention is that what is said to us is that these problems are raised again and again, and Bundaberg is put forward as a case in point where people like Dr Anderson have been rattling the cages for years, saying that something has to be done, but it's only when the matter goes public, when you have the Patel incident and you have nurses like Toni Hoffman and politicians like Mr Messenger putting the matter in the public arena that there is a reaction, and you said yourself within the last half hour that there has been a real acceleration in addressing these workplace problems as a result of the Patel issue?-- Yes. I think something that would be useful to come out of this is for people to have another structure. As I was saying, we do have a Chief Health Officer and Chief Nursing Officer. Maybe if people were encouraged that if they couldn't get the results they felt that were needed at a local level, they had another avenue to go to. I think that would assist.

Well, one of the ideas - and I'll admit I've been pushing this with a number of witnesses, and I'd be happy to get your input - is to have an office, which for discussion purposes I'll refer to as a health ombudsman, whose function isn't so much to investigate complaints as to ensure that they're dealt with in the appropriate way. So that if someone has a complaint, it gets reported to the ombudsman, the ombudsman then tells the hospital, "I want a report in 60" - or 90 days, or whatever it is - "as to how this has been resolved." If it isn't resolved within that 60 or 90 days, it may be escalated either to Corporate Office or the Medical Board or the Health Rights Commission or whoever is appropriate. How would you feel about that solution?-- I think that would be superb. I think that would be a very good system.

The other suggestion that we keep hearing is that the centralisation of administration has, in a practical sense, deprived the community of their opportunity to raise these issues at a local level, just as you've said. We keep getting told that the district councils are toothless tigers and they

achieve nothing, and the suggestion has been made that a greater level of regional autonomy within rural and regional hospitals would achieve a lot of things in giving people back control of their own local hospital, giving them a transparent and accessible avenue of complaint and redress, and also allowing funding and other priorities to be determined at local level having regard to local requirements. Particularly based on your experience in Rockhampton, do you have any views about that?-- I think we'd have to be careful not to lose the good things out of the current structure. I think Queensland, from speaking to my colleagues interstate, has got a very cooperative arrangement between its hospitals. We don't set ourselves up in competition at the moment, which sometimes can be to the disadvantage of the local people in that - for instance, at PA we will frequently assist smaller hospitals. That means taking resources out of PA, because there are so few we don't have spare capacity to go and assist Roma or Charleville or wherever it's needed, and if we made it very strictly a regional system - as, for instance, the regional system that was in place around nine years ago - it then becomes very competitive again, as when I first came to Queensland about 10 years ago when the regions were in place, and my one concern about it is it was very hard getting help from elsewhere. You really were quite reliant on your own region, and that may be okay if there are enough resources in each region, but if we're struggling, as we are at the moment, it could actually set up a degree of competition again.

I don't want to put words into your mouth, but is it then your view that we need a balance between central cooperation and central organisation of issues that are common to all areas, together with an obvious and apparent local administration which can be responsive to local means?-- Yes, I would agree with that.

Doctor, the other thing I was going to ask is simply, but fundamentally this: sitting here over the past few months, I guess it's a bit like reading The Courier-Mail, because good news is never published and we don't hear about all the good things that happen in Queensland hospitals, but even taking that into account, it does strike me that there are some very serious problems, and you've hit on a number of those yourself this morning, with recruitment and even the state's greatest hospitals being unable to get specialists in so many areas - in anaesthetics, in radiology, cardiology and so on. I just wonder where we've gone wrong. I mean, from everything I know about the history of public health in Queensland, going back to the days of the Hanlon public health system when it was brought in in the thirties, and Sir Raphael Cilento and so on, until living memory anyway - until the last 30 years or so - we probably had the flagship medical public health system for Australia, and quite arguably the best in the world in terms of our public hospitals. What's gone wrong? Is it just that not enough money has been spent or that we've lost sight of the priorities?-- I still think we do have a stand-out health system. There are problems, there's no doubt about that, but I think we have the core of a very good health system in Queensland. I think our basic problem is that we have

insufficient doctors, and that's not just the public sector, it's also the private sector, and because of that the private sector is putting more pressure on the public sector because there aren't the doctors out there, specifically general practice. So we know that there's an increased load on the public sector. So I really think it's as simple as having insufficient doctors in the system.

Now, I guess one solution is to pay more, but putting that to one side for the moment, what other ways are there to address that problem?-- Well, we've already done it. It's more medical students. Unfortunately that's going to take another five years to happen, but we absolutely have to make sure we keep those medical students in the system, and we're going to struggle the next five years to do it because we don't have the senior consultants there to train them. So one way or - we're just going to have to put in place systems that we can do it.

Dr Molloy, perhaps showing his tendency to be overly dramatic, refers to it as eating our young, but there is some truth in the suggestion that by not having the training positions in place, we're not educating the next generation of specialists and we're destroying our own future?-- Yes.

How can that be addressed, or is it being addressed?-- It is being addressed. I mean, we've already had support from the Minister - the previous Minister in terms of making sure there are enough intern training places, so funding has been given to Queensland Health to make sure that we can train that additional cohort coming from James Cook, and there's been reassurance that we will be able to create more training places for that level. The next level I don't see as such a problem because we're currently employing around 500 overseas trained doctors into junior medical officer positions. So we've immediately got those positions available for those interns to move into. Then similarly registrar positions. Once we've got more people needing them, I believe there will be the support to create those training positions.

There's been some speculation in the press about what I guess would be regarded as a stopgap measure of having nurse practitioners performing some roles of medical practitioners, particularly in rural areas. I know that wouldn't affect you at PA, but do you have views of that?-- It will.

It will?-- We currently have a nurse practitioner in our oncology unit who is superb. The doctors have found it absolutely excellent, and patient care has improved. It's a very good system, and I personally wouldn't see nurse practitioners as a stopgap measure. I see that as moving on and involving them as more as part of the team in provision of health care. I think it's very important.

I think when I use the expression "stopgap measure", I was talking about the situation that has been touted of having country hospitals that can't attract medical practitioners using nurse practitioners to write prescriptions and do things

that at the moment only doctors can do?-- Yes.

What's your views about that sort of approach?-- Again I think it's very important. I think we need to put in the training programs and to look at how that can advance health care. I believe it can. I think it has to be managed, and we have to have good training, and it shouldn't be purely because we're short of a doctor. We should work out the best way of doing it, and that's already started in Queensland. It's started in other states as well, and overseas.

I guess that's - again being very candid in my views, that's my concern about it, that it's being spoken of as a means of addressing the shortage of doctors. If it's a good thing to have nurse practitioners, then we should have nurse practitioners?-- Yes.

But it's not a replacement for having more medical practitioners?-- No, it's not. I mean, it will assist in the process, and it might well assist in the distributional issues of - we do at the moment have medical staff working in very small towns that you've got to question that there's enough work for them to maintain their competency and is that the best use of them. So I think that we need to look where we've got doctors working and whether that's the best system.

Sir Llew?

D COMMISSIONER EDWARDS: You've heard no doubt, as we have - perhaps not as much as we have - about the incidents of Dr Patel and his now, it appears, gross incompetence for some time. Are you convinced from your own hospital that such incidents of incompetence could be brought to somebody's attention, and if so, would you care to share some of those views with us so that we could consider them in the process that will be in place to prevent this kind of dramatic and tragic events that have occurred in Bundaberg?-- I mean, the most important review to prevent something like that occurring is peer review, and it sounds to me like that's the problem at Bundaberg. I mean, if he was made Director of Surgery, which is a senior position, that means there's no-one else to have done that. So he just didn't have that peer review going on, and although, of course, we've got audit systems in place to pick up issues of increased complications, increased infection rates and so forth, often it's that peer review, someone saying, "Look, this just is not right", and taking that to myself as Chair of the Credentialling Committee or to their medical chair of the division of surgery, for instance, for a surgeon. So I think the problem with Bundaberg is they just didn't have those other surgeons there standing next to him knowing what he's doing.

In passing through various areas that we have, we have been told there are other incidents of Patels in other places throughout Queensland. If your statement is correct - and I'm sure it is - how can we be certain in the health system that there are procedures in place that will prevent so-called other Patels occurring and not being detected, and if

detected, no fear on those who reported those incidents?-- Within the last six months Queensland Health has set up a Patient Safety Unit, which is very new for Queensland. We certainly had a Patient Safety Unit at PA, and our director from that unit has gone into Corporate Office to direct up that unit, and that gives me a lot more confidence in the system, that we will have systems in place across all hospitals in Queensland that are not dependent on that peer review process, that start looking at critical incidents and picking them up and putting them forward.

To whom does that group report, the patient safety group?-- The director of that unit is John Wakefield, and he's a medical practitioner.

He reports to-----?-- He reports to Mark Waters. Mark Waters is off doing another role, but Mark's substantive role.

One of the things that appears to me as a non-practising doctor, but still remembering those days, is that there were warning systems - and I mentioned this in passing briefly before - there were warning systems in place about the competence of Dr Patel, and perhaps there are other stories coming out as a result of this. Are you certain that at your hospital there are adequate warning systems should a similar kind of incompetence in some areas appear to be developing?-- Yes, I'm very sure that there are systems.

And are there mechanisms by which you could deal with it very quickly at your level or does it have to go into the bureaucracy of health to get someone-----?-- No, I can make the decision that someone is unsafe to practise and immediately suspend them. I do that through the district manager but the district manager is not medically qualified and will take my advice, and I have never had a problem.

Can I ask you a bit more about the centralisation - sorry, the privileging and sharing of information?-- Mmm.

It seems to us - and perhaps my fellow Commissioners may not necessarily agree - it is all being done at local level and there is just information. There is not quite the sharing that some of us perhaps would like to see, and I mentioned this in passing before. Could you enlarge on what you think would be, perhaps from your view and your experience, an ideal model so that that privileging sharing of information can be far more adequate in the future?-- Right. The clinical privileging process is based on a hospital. I actually chair the process for not only PA but QEII and Logan, so that all three hospitals go through.

So it is a district region?-- So that's historical from the days when we had regions and that committee looked after a whole region's doctors, and Logan and QEII decided to stay within the PA process because there are more resources to do it, we have more senior medical staff. Other hospitals would have their own process. So, for instance, Redlands at Bayside does all its own credentialing and clinical privileging, similarly Gold Coast. Now, for the very small hospitals there is currently a zonal process, so there would be one committee for each of the three zones that looks at rural and remote doctors and looks at their privileges so they can share that information.

Finally, in some of our discussions with medical practitioners over an evening in Bundaberg there was a repeated statement to me, particularly - I can't say it was made to my colleagues - that there were so many committees in the hospital none of them worked, and, secondly, the patients were, therefore, not being considered as the most important part of the hospital. Have you a view about the large number of committees, both within the system and also within a hospital, that are forced upon you by bureaucracy and by rules and regulations from central office, and have you a view that you would perhaps like to give to us separately as to the easiest way by which we can have fewer committees, greater efficiency and the best service to the patient?-- It is difficult. I mean, whenever there is an issue, the answer is often to set up a new committee. The reason being that you bring together all the experts so that you do get that wide knowledge. Because everything is so specialised nowadays, it is very hard for individuals to make decisions, so you bring together a committee. The important thing is to work out when that committee's need to exist ends and to stop it. A lot of committees are actually put in place more by our requirements to meet ACHS accreditation processes rather than corporate

office. I mean, corporate office has requirements for us to have certain committees, such as the credentialing and clinical privileging committee. That's a corporate office requirement. It is also an ACHS requirement. But there are not many committees that I think that corporate office says you must have to run your hospital. There are functions that you need committees to exist to actually carry out that function, because that's the most efficient way of doing it rather than having one person do that role and have to try and catch all the various people that need to have input into the process. But it is absolutely a problem and it is something we struggle with at PA all the time. We're forever reviewing our committees and determining whether we still need them, or is there another way of doing it, or can we combine committees together?

COMMISSIONER: Just following up on that point, if I may, it has been suggested to us - again perhaps in an overly dramatic way - that bureaucracy has just mushroomed within health administration over the last two or three decades. One suggestion was that even at a hospital the size of the Royal Brisbane, 20 years ago it was run by a handful of administrators, now they fill up several floors in a building. Is there any truth in that, and, if there is, how can we get back to focussing on patient care rather than administration for its own sake?-- There is a lot more administration. I believe that we're a lot more accountable now than we were 30 years ago. It is also a lot more complex. There is a lot more things we can do to patients now. Also, the workload coming through is a lot higher, the turnover of patients. I mean, even my own days as an intern we would regularly have patients staying in the hospital for three, four weeks. Now the average length of stay is five days. So there is just a lot more work which makes it a lot more complicated, which means that unless we want clinicians actively doing the administrative work, that we need other people to do it for them. I think that's why there has been a significant increase in the administrative support.

Well, I hear you say that but what's been suggested to me is that mushrooming in bureaucracy hasn't happened at least to nearly the same extent in the private sector, and one comparison I was given was between the New Farm clinic, which is a psychiatric institution, and the psychiatric ward at the Royal Brisbane, that the two institutions have almost identical numbers of beds and patients and yet there is something like four or five times the number of bureaucrats needed to run that clinic at the Royal Brisbane as compared with the private facility. Similar comparisons have been made to us in relation to the Greenslopes Hospital as regards the time when it was a public facility and once it was privatised. I think we were given the figure of something like $10 or $12 million were saved in the first year simply by streamlining the bureaucracy. Does any of that ring a bell with you?-- It does. I mean, there are different issues. For instance, in the private sector they don't employ the doctors so they don't have all those issues of employment to manage. So there are different issues. Also the patients - that example of the

private sector in psychiatry, public versus private, again, the patients are different. The patients in the public sector are regulated often, they are a lot sicker, so there are different requirements under legislation to meet. They're the only examples I can think of.

I understand what you say and I don't want to have an argument with you over this, but, you know, it seems, at least from my experience, that when you are paying for medical services at a private hospital, you expect a higher quality of patient feedback and response and so on. You know, we haven't heard anyone suggest that, you know, the Wesley or St Andrew's, those hospitals are somehow letting down their patients by not having enough administrative support to meet the patients' requirements. It just does seem extraordinary that - you could understand maybe a 50 per cent higher bureaucracy in a public hospital, but three or four times the level of bureaucracy just seems unnecessary?-- I can well see how you would see that. I think that we have different responsibilities to government that we then have to manage and report on, so that requires some additional resource. And, again, if I could go back to that employment issue, it does require more staff because we're employing doctors, rather than in the private sector, the contract is between the patient and the doctor. The hospital is not involved in that. So there are different issues. But I couldn't comment about how much more administrative support you need in public compared to private.

D COMMISSIONER VIDER: I have got one question for you and it is going back to the waiting lists, because that's been a thing that concerns me in the evidence that we've heard. It concerns me because I think primarily the function of a health department is to care for the sick. Would you imagine a time when there would be a cultural shift to the provision of services - and I would start with out-patient services - in an attempt to reduce that long waiting list to get to an appointment to a clinic, whereby we would extend the hours of those clinics, run them into the evenings, run them on Saturdays so you actually could say you have a patient-centred focus on the services you were trying to deliver. So it wasn't a doctor model, or a nurse model, or an organisational model; it was making it available at times when patients could come after work, not during work hours, et cetera, and also including in the outpatients' department would be diagnostic services, predominantly endoscopy and radiology, and speed that up. Now, I understand that that can't happen tomorrow because of the reasons we've talked about this morning, namely the availability of staff-----?-- Yeah.

-----and money?-- Mmm. I mean, it already occurs to a certain degree. There are some areas that we do run clinics out of hours because we know we won't get the patients during hours. For instance, sexual health clinics, they will run out of hours. One of the major limitations, as you have alluded to, is really the hours of work that are award for medical staff - full-time medical staff in Queensland is very restrictive that they can only work between the hours of eight

and six.

Perhaps the first assistance with the cultural change in that then is stop referring to them as out-of-hours clinics?-- It is to change, I would suggest, change the hours. Why can't doctors-----

If you change the hours and change the title we might end up changing the culture?-- It would make sense. We already do extend hours. For instance, our radiology department runs till late at night so that out patients can come in. That was partly to improve access to very expensive equipment that otherwise sits idle, but it also assisted patients in that they could come in after work. So where possible we've tried to do things like that but we certainly need to do a lot more and it needs to be a lot broader through Queensland.

I think that's a very public way then to demonstrate the availability of the services that are there for people?-- Yes.

Thank you.

COMMISSIONER: We might take the morning break now, if that's convenient, and resume in about 10 or 15 minutes.

THE COMMISSION ADJOURNED AT 11.10 A.M.

THE COMMISSION RESUMED AT 11.38 A.M.

JEANNETTE ROSITA YOUNG, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Sorry, Dr Young, there was one other thing that I did want to ask you about. We have also heard a lot of evidence referring to so-called bullying within Queensland Health, particularly people who step out of line, perceiving what they regard as trumped up or trivial charges. Have you yourself any experience, either in support of or to refute those sort of allegations?-- I have seen evidence of bullying in Queensland Health.

Do you feel comfortable about offering examples of that, or would you prefer not to?-- I would prefer not to, if that's possible, Commissioner.

That's fine. Just finally, there has also been a lot of debate in the evidence so far about the desirability of non-clinical administrators participating in things like ward rounds and visiting the functional areas of hospitals. Do you have a practice yourself in that regard?-- I think it is a

good idea to walk around, see what's going on, to keep in touch. I see it as a benefit because then I can see the good work that's being done and it reassures me about why we're there.

Yes. Thank you, Mr Atkinson.

MR ATKINSON: Doctor, can I ask you one last question before I hand you over to the other barristers, and it is this: in an exchange with the Commissioner you mentioned that - or the Commissioner mentioned that once the Queensland Health system was the enemy of the world. In terms of preserving what's good and cutting out what's bad, what are the features of the Queensland Health system which do still stand it in good stead and make it something in some respects better than other jurisdictions?-- I think there is a strong cooperative ethos within Queensland Health, because it is so centralised, that really there is a lot of support we get from each other. There isn't that degree of competition that does occur in some of the other States that I am aware of.

Between different geographical districts?-- Yes, between hospitals struggling for a place. Queensland, in many ways, has continued to keep its services centralised. For instance, we only have one renal transplant unit in Queensland, whereas New South Wales has a large number of them, so they're competing for patients between the units rather than getting a cohort of experts together working cooperatively. They are very competitive in how they manage it. So I think we've got a lot of strengths in that way. We've got one burns unit at the Royal Brisbane, so it is able to develop a significant degree of expertise in it, and the other thing is we're able to help the smaller hospitals. They're able to come to us and we work with them because we know that if they can't manage, that we will then get that additional load of patients that we then need to manage, and we can't do that. So we work with them. So I think that's a real strength of Queensland.

In short, that there are real benefits in centralisation?-- There are a lot of benefits. There are some disadvantages, and the Commissioner has alluded to those, and I would agree with those. There are also a lot of benefits.

And the benefits, to some extent, are dependent on good channels and protocols of communication?-- Yes.

Between the central areas and the regional areas?-- Yes.

And having some autonomy in the regional areas?-- Of course.

Nothing further.

COMMISSIONER: Thank you, Mr Atkinson. Mr Fitzpatrick?

MR FITZPATRICK: Thank you, Commissioner. Commissioner, I neglected to mention that I appear for Dr Young.

COMMISSIONER: Yes, thank you.

EXAMINATION-IN-CHIEF:

MR FITZPATRICK: Dr Young, you said in answer to some questions from Deputy Commissioner Sir Llew Edwards that you thought there was satisfactory credentialing process involved in place for very small hospitals?-- Yes.

You have also given evidence I think at your own hospital, which is a tertiary hospital that you run your own credentialing process as well?-- Yes.

Does that imply, in your view, that for the medium size hospitals, specially those in the regional areas, there might be, in your perception, some difficulties in achieving a satisfactory credentialing process?-- There may be. I think it would vary from hospital to hospital as to how they have put it in place and how they have enacted it.

Are there any factors that spring to your mind that might cause problems for those hospitals in having in place a satisfactory credentialing process?-- If they don't have Australian qualified Fellows of the relevant college, it may be difficult for them to have the expertise on the committee. So, for instance, if the Director of Surgery, as in Bundaberg, was not a Fellow of the college, you really don't have that expertise within the hospital to assess other surgeons.

COMMISSIONER: Would it be appropriate, in your view, in that situation - and this is particularly pertinent in Bundaberg where you don't have a member of the Australian College as your Director of Surgery, but there are members of the Australian College of Surgeons in local private practice, to invite a local private specialist to participate in the process?-- It would be essential, I believe.

MR FITZPATRICK: And, Dr Young, in answer - following up on the Commissioner's question, in your - when you were running the Rockhampton Hospital as medical superintendent and running a satisfactory credentialing program, did you draw on the assistance from private doctors in Rockhampton to facilitate your credentialing process?-- Yes. Where there was someone available in the town I would use them. If there wasn't, I would often use someone from Brisbane and they would join us on the phone, or via a videolink.

Or via video conferencing?-- Yes.

And, doctor, were you also able to obtain involvement from other colleges satisfactorily in Rockhampton?-- Yes, I had no difficulty getting input from the different colleges.

Did you ever use video conferencing facilities for that

purpose?-- Yes. Again, I gave them the option if they wanted to be involved in the conference - of course I would like them there in person, and I did get some involvement of doctors from Gladstone, which is only an hour's drive away, or I would offer them phone or to put it in writing, or we just started, whilst I was there, using video conferencing.

I see. And that was an initiative of yours?-- Yes.

It was something you thought about doing?-- Yes, although I had the structure of the Queensland Health policy to assist me in how to go about doing it.

Yes. Dr Young, can I ask you in your evidence you gave Commissioner Morris a couple, I think, of examples of some initiatives of yours that have helped with certain aspects of your management of your medical staff. I think one of those was when you were in Rockhampton and you said that you managed, I take it, your junior doctors by arranging for them to come to Brisbane one day a week, is that so?-- No, they were senior consultants.

I see?-- They were people - the specific example I referred to was an American emergency physician and we were very short of emergency physicians, and he came and he wanted to come permanently, so I spoke to him about gaining the Australian fellowship because that's extremely important for a hospital, because if you have doctors with Australian fellowship, then you can get training positions and registrars. So as a hospital you need someone to do the day-to-day service requirements but you also want someone who will be able to train the next generation of doctors, and it is by getting that next generation of doctors in a town that you then get them to come when they are specialists.

I see?-- So in that case I negotiated with Royal Brisbane that he would go down there one day a week so he could be supervised by a fellow of the college and then could do the exam and get Australian fellowship.

I see. And did you yourself regard that as part of your credentialing program?-- That was more part of my recruiting program. Yes, I certainly used that as part of my credentialing, but I didn't do it because I wanted him credentialed, I did it because I wanted him to get the fellowship.

I see?-- I was quite happy with his ability, but I could - certainly if I hadn't have been happy with his ability, could have done that as a means of having his skills upgraded or his competency checked. That wasn't why I did it for that particular individual but it certainly would be a reasonable thing to do.

I see. And was that initiative one which you yourself took or was it something that you needed to obtain zonal or corporate office approval to do?-- I just did it by negotiating with the Director of Medical Services and the Director of the

Department of Emergency Medicine at the Royal Brisbane.

I see. The other initiative was the one that's been taken recently, I think, at your current hospital in relation to provision of parking for VMOs?-- Uh-huh.

Was that something that you and your District Manager arranged, or did that involve input from your zonal management group?-- That was purely a discussion between the executive and the District Manager.

Again, another - an initiative that you have taken?-- The distract manager took.

I see. Yes, thank you, Dr Young. I have nothing further.

COMMISSIONER: Thank you, Mr Fitzpatrick. Mr Mullins?

MR MULLINS: Thank you, Commissioner.

CROSS-EXAMINATION:

MR MULLINS: Dr Young, my name is Mullins. I appear on behalf of the patients of the Bundaberg Hospital. Just a few questions. Firstly, I was interested in your comment that you would go out looking for complaints or asking for complaints. And you're happy to accept them by telephone?-- Yes.

Happy to accept them by an oral interview?-- Yes.

Happy to accept them in writing? That's correct?-- That's right, yes.

Do I understand the situation that in your practice, at least at the Princess Alexandra Hospital, you don't require slavish adherence to forms and the completion of forms?-- No, the person who takes the complaint will fill out the documentation because the complaint, just as such, is of some use but not of the best use. It is better if you can compile them all and work out where you are getting the numbers of complaints about. So the person accepting the complaint would work out what the issues are and enter into a database.

Is that common practice, to your knowledge, among medical administrators throughout Queensland?-- I believe that's certainly the way ahead that Queensland Health is going with the patient safety unit.

So the person receiving the complaint is the person with ultimate responsibility to ensure that the processes are put in place?-- I believe so.

And in your practice and in your experience, that runs right through to the medical Director of Medical Services?-- Yes.

So if you had, for example, two specialists come to see you and report to you a series of facts that were obviously a sentinel event - you are familiar with that term?-- Yes.

That you would make sure that the relevant processes were put in place from the time you received that report to deal with that sentinel event?-- I would.

And you would see that as your responsibility?-- Yes, I would.

And you would think that would be the responsibility of any person who was a Director of Medical Services throughout Queensland?-- Yes, they may pass the complaint if it doesn't directly involve medical staff to the Director of Nursing or Director of Corporate Services but they would pass that on to a place to be dealt with.

The Commission heard some evidence a week before last that it is not the responsibility of the administration staff - and I include the Director of Medical Services in that - to be filling out these forms and making the complaints or recording them. Does that accord with your view?-- I believe that - I can only speak for myself, that as a member of the executive, any complaint that's brought to my attention, I am obliged to make sure that it is resolved. It doesn't matter what that complaint is about.

COMMISSIONER: Mr Mullins, I apologise for interrupting but I want to make sure we're not at cross-purposes here?-- Yes.

Previous witnesses have suggested that they draw a distinction between complaints which are essentially things coming from members of the public, from patients, patients' families, others outside the hospital, and that the term "complaints" isn't used for allegations, if you like, made by one member of the hospital staff against another. In answering Mr Mullins' questions, do I take it you are referring to both categories?-- Yes.

Yes?-- Yes. I mean, I would pass complaints on. I won't deal with every single complaint myself. I mean, PA is a large institution and has - because we encourage a lot of complaints that come in, so we have a patient liaison officer who deals with patient complaints, and so the letter may come to me as Director of Medical Services through a patient, I would pass that to him and he would go and investigate it and involve me as appropriate and let me know the outcome. So we handle complaints in different ways depending on what the complaint is.

MR MULLINS: The sentinel event policy that's currently in operation commenced in about November 2004?-- Yes.

And-----?-- That sounds right.

-----you are familiar with the documentation?-- I am.

A sentinel event includes an unexpected death of a patient?-- Yes.

If you had two specialists come to you and tell you that there has been some surgery involving a particular surgeon and the patient died in that surgery, those particular practitioners didn't believe the patient should have died, would you regard that as a sentinel event?-- Yes, and I would have expected that to be notified to the Coroner.

Is it the case that you would have expected also that the relevant processes, the mandatory requirements set out in the policy and procedure document would then have been undertaken immediately?-- Yes.

Would that be whether there was a sentinel event form filled out or not?-- Yes.

It is the case, isn't it, as far as medical administrators are concerned, it is the practice throughout Queensland that if the facts that would ground either an adverse event or a sentinel event are brought to the attention of the administrator or the Director of Medical Services, that's enough to get the process going?-- Yes.

Now, two of the matters that you raised with - raised in the course of the Commission's questions - and I am only going from my own notes here but I understood that some of the problems that you saw that came from Bundaberg were caused by two factors: (1) was that Dr Patel didn't have adequate peer review?-- I can't really comment - I am sorry if I left you with that impression about Bundaberg. I don't know the facts about Bundaberg. I only know what has been written in The Courier-Mail or reported on the news, so.

COMMISSIONER: I think, Mr Mullins, to be fair to the witness, that she made that very clear that she wasn't speaking specifically about Dr Patel but about situations like Dr Patel and what factors should have prevented that from occurring?-- Thank you, Commissioner.

MR MULLINS: Well, there were two factors as I understand it that you raised. One was the absence of peer review and those types of circumstances is problematic?-- Yes.

Because an overseas-trained doctor who no-one is quite sure about his or her expertise is placed into an area where they don't have a peer review and that can be a problem, can't it?-- Definitely.

You did mention after that that one does have or hospitals do have clinical auditing systems and monitoring systems that are in place that at least give people further up the chain some assistance in determining whether the person is competent or not?-- Yes.

That's correct?-- Yes.

Now, who is ultimately responsible for ensuring those auditing systems are followed?-- The Director of Medical Services or medical superintendent, whatever their title may be, is responsible for the professional standards of medical staff in a hospital.

We heard some evidence yesterday from Dr Anderson that there was a system called Otago database?-- Yes.

That was used for the auditing of the surgical department?-- Uh-huh.

And we heard that that was abandoned by Dr Patel?-- Uh-huh.

Would that be a matter that you would expect the Director of Medical Services to have some responsibility for or knowledge of?-- Yes, I would.

COMMISSIONER: Would you go as far as saying that the abandonment of an audit system, whether it is that one or some other, shouldn't occur without the permission of the Director of Medical Services?-- Yes, and I would even go further, without having some replacement in mind.

Yes.

MR MULLINS: It is really a process that should work - rather than the Director of Surgery simply abandoning it, should be a process where the Director of Surgery might suggest an alternative that's considered by the Director of Medical Services and others?-- I believe so, yes.

And if the new suggested system is better, it might be replaced?-- Yes.

Is that correct?-- Yes.

But one would have thought the simple abandonment of the system might raise alarm bells for the Director of Medical Services?-- I would be concerned.

I am sorry, Director of Medical Surgery?-- Yes.

Nothing further, thank you.

COMMISSIONER: Thank you, Mr Mullins. Mr Allen.

MR ALLEN: Thank you Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Good morning, Dr Young, my name is John Allen and I am appearing for the Queensland Nurses' Union. You mentioned in your evidence this morning that Queensland has the lowest number of doctors per head of any State or territory?-- Yes.

You, at page 3 of your statement in the fourth dot point, provide some statistics in relation to that?-- Yes.

And in paragraph 6 you say that those figures are sourced from the Medical Labour Force 2002 Report by the Australian Institute of Health and Welfare?-- Yes.

And you're aware, given the type of roles that you undertake, that there is a similar publication by the Australian Institute of Health and Welfare which is the Nursing Labour Force?-- Yes.

Report?-- Yes, I am aware of that.

Are you familiar with the contents of the Nursing Labour Force 2002 Report?-- I haven't read them. I am aware of the report. I don't know the contents to the depth that I understand the medical ones.

All right. Well, I am just going to ask you briefly to have a look at one part of one page of that report, if I can put it on the visualiser.

COMMISSIONER: Well, Mr Allen, Dr Young isn't familiar with the report. If it says something that you think is useful, I think just tendering it and putting it in evidence will be much more efficient than getting Dr Young to comment on something that is not known to her.

MR ALLEN: Okay.

COMMISSIONER: Unless, Dr Young, you are keen to speak about that?-- I don't mind if I am asked the question, Commissioner.

MR ALLEN: Are you familiar with the studies to this extent, that the figures in relation to nursing shows a similar picture to that as regards doctors in Queensland?-- I am well aware of those figures yes.

Over the period from 1995 onwards dealt with in the 2002 report, there has been a reduction in the full-time equivalent nurses per 100,000 population in Queensland?-- Yes, I am aware of that.

And that historically, the number of nurses in Queensland has been significantly lower than other states per hundred thousand population?-- Yes.

Except, it seems, that in 2001 Western Australia was slightly worse for the first time ever?-- Right.

Okay. So the problem exists in relation to the availability of both doctors and nurses?-- Yes.

One of the aspects that you referred to in your evidence today in relation to a difficulty facing Queensland Health in recruiting doctors is the comparative pay scales between, say, Queensland and Victoria?-- Yes.

Are you aware that there is a significant discrepancy between the type of pay rates in Queensland Health which apply to registered nurses or enrolled nurses as compared to equivalent positions in other states?-- I'm not aware of that information.

You're not. Okay. Could one of the underlying and inescapable problems be that Queensland, as compared to other states and territories in Australia, has historically spent significantly less per head of population on health than those other states and territories?-- That could be a problem, yes.

Are you familiar with the figures in relation to that?-- I am.

Okay. What type of sources would we go to to gain that type of comparison between what Queensland spends per head of population on health, public health, compared to other states?-- You could probably go to the Australian Institute of Health and Welfare.

Are you familiar with the Report on Government Services 2005 prepared by the Steering Committee for the Review of Government Services Provision?-- No.

A Commonwealth-----?-- No, I'm not aware of that.

Okay. So you're not familiar with the fact that historically and to the current date, Queensland spends significantly less per head of its population on public health than every one of the other states and territories?-- I'm aware Queensland does spend less per head of population than the average spent in the country. I'm not aware of the specifics.

Okay. And that's been the case for some number of years?-- Yes.

That's obviously a significant factor when determining the quality of health, the number of doctors and nurses who can be employed to provide health services?-- It will definitely impact on it, yes.

Thank you, Doctor.

COMMISSIONER: Mr Devlin.

MR DEVLIN: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Ralph Devlin representing the Medical Board, Doctor. Three broad areas I want to take you to. First, one that Mr Mullins raised with you which was the complaints regime, and please tell me if you don't feel qualified from your experience to answer these questions?-- Mmm-hmm.

Are you able to say whether it's fair to say that the - I'm looking here at the external review of complaints as opposed to an attempt to deal with the complaints internally in Queensland Health and I'm looking at it from the Medical Board's point of view and, indeed, from the Health Rights Commission point of view perhaps as the two external agencies. Are you able to agree from your knowledge that historically the practice has been in the main to refer sexual misconduct allegations out of Q Health to the Medical Board of Queensland where it involved medical practitioners but, historically, the tendency was to attempt to deal with unsatisfactory clinical practice within the system? Is that a fair comment or not - it's not meant to be critical. It's meant to be drawing from your experience as to what the past practice has been?-- What I would normally do is examine the complaint and investigate it and come to an outcome. Then once I've come to that outcome, depending what it is, to let the Medical Board know.

If it was appropriate to do so?-- If - yes. Yes, if I had ongoing concerns about that doctor's competency, particularly if they were to resign from the public system.

Yes. So that, you would take it to an assessment situation yourself to determine whether an outside agency was needed to further address some issues?-- Yes.

A classic example of that might be a doctor within the system who develops a drug dependency?-- Yes.

What about suspected unsatisfactory clinical practice however?-- Again, it would be matter of looking into why it was unsatisfactory and when there we could remedy it. So whether we could put in place a training program for that doctor to bring them up to the level that it's required.

Yes?-- In which case, we wouldn't let the Medical Board know because we'd been managing it internally.

Yes?-- We'd make sure the patients were safe and we'd ensure the doctor went through whichever training was required.

Thank you.

COMMISSIONER: I suppose the difficulty is that medical competency isn't black and white?-- Yes.

There's no finite line; you can say someone is above or below the line. So you may have someone who's not the best but still adequate and that's the situation where you wouldn't go off to the Medical Board and say, "Strike this person off"?-- Yes.

You'd try and improve that person's skills?-- Yes.

Is that a fair summary?-- Oh, yes, yes, that's a good summary.

MR DEVLIN: Thank you. The next broad area is dealt with in your statement at paragraphs 8, 9 and 10 and you include attachment 2 being a reporting form produced by the Medical Board, an assessment form for special purpose registrants. Firstly, your attachment 2, do you see it as - do you see the Medical Board form as being adequate for the purposes for which it's intended?-- I believe so, yes. It goes through the key issues that we examine our medical staff against.

You spoke in your evidence however about the position with regional hospitals being less favoured in terms of supervision of IMGs?-- Yes.

And so, does it follow then that there will be some unevenness in the quality of reporting if the quality of coverage is necessarily less in the regional areas?-- Absolutely. If there isn't an appropriate Fellow of the relevant college available to supervise a doctor, it would make filling out one of those forms difficult.

Have you got any thoughts about how one addresses that apart from more peer review?-- I think that's where we need to involve the larger hospitals in supervising, mentoring those doctors.

How would that be done with the tyranny of distance?-- I think there are a lot of ways it can be done. It can be done via telephone and video conferencing link and, also, the doctor can go to that larger hospital.

Very well. You mean on some form of rotation for supervision?-- Yes, yes.

Thank you. Why couldn't we suspect that given the ongoing shortages of medical staff, that there will be a reluctance to make adverse reporting to the Medical Board? What can we do to guard against that?-- It is very difficult. That's why we need to involve people from outside the immediate catchment of that person, because they may be reluctant to say there are some difficulties here because if they lose that person, they know they've lost a significant part of the service.

Thank you. Is it true to say they the rotational idea is not

yet in practice in Queensland?-- It is in some places.

Is it?-- Yes.

So just as the centralisation of the system, where you've got the tertiary hospitals attempting to be of a resource to the regional hospitals, you would say that same resourcing could occur in respect of peer review?-- Yes.

Does it have this effect though, that it leaves the regional hospitals perhaps short of staff or do you see some solution to that?-- It does leave them short because there isn't the capacity for those tertiary hospitals to go and provide those services back in that regional centre.

So we come back to resourcing issues?-- Yes.

All we can do is talk about what should happen in a perfect world in terms of peer review?-- Yes, yes.

Thank you. The last matter I have to address to you is in relation to medical education. I was interested to hear you say in response to the Commissioner that in terms of more medical students, that's already done. What did you have in mind when you said that?-- We already have a significant increase in the numbers of medical students coming through. Whether that's sufficient, I don't know. I think it is a very, very good start. We now have Griffith University on-line, Bond University. And James Cook graduate their first cohort next year.

So the first graduates come out of JCU next year?-- Yes.

Bond is only just starting; correct?-- Yes, they started a five-year undergraduate this year, so five years' time.

And Griffith?-- They started a four-year graduate degree, so four years' time.

So there's a bit of lead time in all of this?-- Yes, yes. If I could just interrupt there. University of Queensland has significantly increased their numbers and, in fact, they took on the Griffith cohort for the year before Griffith started. So there will be increased numbers coming through over the next couple of years. The big numbers won't be for another four or five years.

As chair of AMWAC, are you able to say that the projections necessary to try to deal with this shortfall in medical graduates are the sorts of projections that AMWAC will do in due course?-- Yes, AMWAC's got a project on-line at the moment looking at the numbers that we do need for the future.

Now, of course, we're dealing with shortages of general practitioners locally trained and you've spoken about the difficulties in maintaining them within Queensland as well but we're also dealing with a shortage in specialist staff, particularly in the regional areas?-- Yes, yes.

What role do you see the colleges as playing in due course to address that issue?-- Well, once these increased numbers of medical students come through, they'll need increased training positions to be made available for them. So there will be need to be extensive discussions with the colleges about where those training places should sit and the numbers that are required.

And, again, does AMWAC see itself as having a role in trying to project those issues into the future as well?-- Yes, AMWAC has reviewed most of the speciality work forces and it is just in the middle of completing a review of the general workforce across the country, so AMWAC does that on a regular basis.

So to summarise on this issue of supply of locally grown graduates as it were, we see still some lead time?-- Yes.

We see still some uncertainty about being able to hold our own graduates within Queensland because of market forces presumably?-- Yes.

And we see at this moment anyway some uncertainty about being able to project forward to reassure ourselves that what is being done is enough?-- That work hasn't been completed and there's also some uncertainty as to the number of hours that we're predicting our younger generation of doctors to work. They're still falling. Each year they're working fewer hours but eventually it's going to plateau.

Yes?-- But we're just not sure what level that will be.

And, of course, that alters any projections that one might do in the year 2005 if that falls significantly into the future?-- Yes. And also, as I mentioned earlier, the percentage of women in the workforce will affect the number of hours available.

Thank you.

COMMISSIONER: Thank you, Mr Devlin. Doctor, I'd just like to pick up on two of the very useful points made by Mr Devlin. One relates to this issue of reluctance to make complaints or referrals to the Medical Board. We've already heard the suggestion in evidence so far that, with Dr Patel, people in Bundaberg, and I don't mean anybody in particular, people took the attitude better to have a semicompetent surgeon than none at all. I guess that puts a particular pressure on your opposite number, the medical superintendent or the Director of Medical Services, in a rural hospital where if you lose the doctor you've got, you're not going to have any at all?-- It's a very difficult issue, mmm.

And, therefore, one shouldn't be too critical of a Director of Medical Services who is put in that cleft stick of either hanging on to a doctor who is not as good as one would hope him to be or making complaint and having no doctor at all?-- I would agree, although I also believe that we need to make the

system easier for that medical superintendent so that they don't get put into that position.

Of course?-- Because I don't think anyone believes that it is okay to accept a doctor who isn't competent.

Yes. The other point I wanted to pick up on from Mr Devlin's questions relate to the role of the colleges in specialist training?-- Mmm-hmm.

I guess it's fair to say we've had two different view points expressed in evidence. One viewpoint is that the colleges are just cartels, they look after themselves, they're interested in keeping numbers down and maximising profits. That's putting it in an extreme way?-- Yes.

But that's one point of view. The other point of view that's put forward is that colleges in fact make facilities available for training of specialists in all positions where there are registrarships or traineeships in public hospitals and that it's the public hospitals that have held back the number of specialists rather than the colleges. Do you have any insight as to where the truth lies between those extremes?-- I do. The issue at the moment is there just aren't enough junior doctors to go into training positions. Australia overall currently has 1,752 first-year training positions. We only have been graduating around 1200 medical students. So there is already an enormous gap between the numbers of medical students and the number of training places. Now, if we were to go, and I don't mean to pick on the College of Surgeons but that's certainly been in the media, if we were to go to the College of Surgeons and say, "We need more surgeons in this country", which we do, "Would you please create more training positions", it could only be done at the expense of another college, because we've already got too many training positions and we know that surgery is a very popular area for medical students to choose then to go into as a career. So we'd be short then of psychiatrists, if I could pick on them as another group that isn't as popular an area to go into. And we'd be short of GPs. We'd be short of other areas. So at the moment, I don't believe that the colleges are acting in any way to stop the numbers of doctors going through. I think it's very important that when we do get these increased numbers of medical students coming through, that we then talk at length with the college about where best to put the training positions to meet the community's need.

Well, those statistics would seem to put the lie to any suggestion that the colleges are to blame for the shortages in current trainees in specialists position, whatever may have been the case 50 years ago?-- Yes.

Yes. Thank you. Yes, Mr Diehm.

MR DIEHM: I think it is me.

CROSS-EXAMINATION:

MR DIEHM: Doctor, I'm Geoffrey Diehm, counsel for Dr Keating?-- Mmm-hmm.

I just wanted to ask you, firstly, a question about the credentialing process as you understand it for hospitals of the size of Bundaberg because you've spoken about different sized hospitals?-- Yes.

Now, is it your understanding that the Queensland Health policy with respect to the credentialing process actually requires the participation of the colleges by nominating persons to be involved in the credentialing process?-- My understanding is that the colleges are asked to give input into the process. How they give that input isn't defined.

Yes?-- So that will vary.

COMMISSIONER: And is that a mandatory requirement of Queensland Health policy or is it just the practice?-- No, it's a mandatory - whether, a mandatory - it is a requirement of the current policy.

MR DIEHM: Now, you have spoken about some experience that your hospital has had in terms of occasional delays in getting that participation from the colleges?-- Yes.

Are you aware of there having been throughout 2003 and 2004 some difficulties with the colleges being prepared to nominate people, members of their respective colleges, to participate in those processes?-- I don't use that method at PA. I get college involvement by writing to the college president in Queensland or if the college has told me someone else to use, I use them. And I just write to them and ask for their input into the process and I give them the offer to either turn up in person or to send me a written response.

All right?-- So I don't ask them to nominate someone. I send the request to the person they have told us is to be responsible for credentialing.

Well, that is - that person they have told you is effectively somebody they've nominated then, isn't it?-- Yes.

Or that process?-- Yes.

Is what you're saying is that you have almost like a standing nomination that's been given by a college?-- Yes, yes.

All right. And that's presumably because your hospital's had this system up and running for quite some years?-- We have had it up in place since '93, when the policy was first put in place.

Yes?-- So I took on what had occurred. In Rockhampton, I set

the policy up from scratch.

And when you set it up from scratch in Rockhampton, did that involve obtaining a new nomination from the respective college?-- Yes.

For that process?-- Yes. I understand, though, that most of the colleges in Queensland use the one person to act as providing that information for all the hospitals in Queensland.

But it's been some years since you've had to approach a college and ask for a nomination?-- It's usually a yearly basis. They change over their person each year when they have their elections.

Is part of the reason why you are able to be a little more flexible with respect to how you get that person from the college to participate because within your hospital you have access to senior Fellows of the college who can participate in the credentialing committee anyway?-- Yes, although I still think it's an appropriate way for any hospital to get college involvement.

COMMISSIONER: Just so I understand that, I'm sorry, Mr Diehm, but if - for example, I see Dr Woodruff in the back of the room. If he were on a selection committee for a new surgeon, you wouldn't treat him as the representative of the College of Surgeons without going through the formal channel of getting the college to put him in that position of representative, the fact that he's a member or even an office-bearer of that college, you wouldn't treat him as simply as a substitute for getting a nominee from the college?-- Oh, absolutely not. I mean, I ask the colleges and I want a totally independent person. At times they do appoint a hospital person but it's rare. They would usually get someone from outside the hospital to sit on the committee.

And I think Mr Diehm's questions were along the lines that there was difficulties, perhaps not at the present time but in the last two or three years, in getting that cooperation from colleges?-- Mmm.

Is that right or-----?-- I've not had difficulties getting college representation on selection panels. We don't seem to have any problems with that. I have had some delays in getting the college response when I've sent them a request about credentials.

I suppose it would be fair to say though that you had more clout than the Director of Medical Services in Bundaberg and perhaps where - as you don't have any difficulties, maybe someone in a rural or regional hospital may find it more troublesome to get that assistance?-- They could do, yes.

MR DIEHM: Thank you. Doctor, you mentioned before in your evidence that the credentialing process is one essentially of checking a number of different criteria, one of which was

whether or not the doctor was registered with the relevant - or with the Medical Board; is that the case?-- Yes, that's right.

So you're talking about whether or not they've got registration with the Queensland Medical Board?-- Yes.

Another one you mentioned was checking of references for the doctor. Now, if the doctor had just recently been through a process, a new doctor coming into the hospital just recently been through a process whereby his references had apparently been checked, would that be something whereby the credentialing committee would go and re-check those references or would you just simply check the information originally obtained?-- We'd just take the selection panel's reference check.

Similarly, if the persons who had provided the references weren't completely candid with respect to the information they provided to whichever individual it was from the selection committee or from the credentialing committee checking the references, there isn't any particular process that you have in place to go behind that information they provide, is there?-- If we were concerned, we would ask the individual for additional referees.

There'd have to be something that would trigger your concern though?-- Yes.

Otherwise you would take it at face value and in good faith what the referees tell you?-- We'd look at who the referees are.

Yes?-- And we would assure ourselves that they were appropriate people to ask the reference of.

Now, the third thing as I understand from your evidence is that you have the input of the college and that is simply a process, is it, whereby they review this information about the person's registration and their references, presumably their CV as well, and make observations about that person's credentials to perform work in a particular area in the hospital; is that the case?-- It depends on the qualifications of that person. If they're a Fellow of the college, they would usually just write back and say, "Dr so and so, is a fellow of the college in good standing."

Yes?-- And they leave it at that. If they are not a Fellow of the college, then they would get more involved in the discussion.

And what do they do?-- Usually overseas trained doctors who are coming here to work as specialists go through the AMC process.

Yes?-- So that they would send all their details to the Australian Medical Council, who would then send it on to the relevant college to look at it. So, usually the college has

seen all the information from another source.

Are there occasions, though, when the system doesn't work that way, with - again taking the example of an overseas trained doctor coming to work, say, as a senior medical officer with Queensland Health?-- Yes, they may not go through that college process via the AMC, so a different process would need to occur.

Yes. Sorry, that process would need to occur, do you-----?-- You would have to use - with the credentialing process, you would need to use a different process with the college.

All right. And do you have any practical experience of different processes being used?-- Most of our doctors would go through the AMC process.

Okay. Now, the outcome of that process, is that one whereby the doctor is certified as being suitable to perform particular types of procedures or is it more general than that?-- It depends on the depths that they need to go into. So a Fellow of the college, we assume, would - is able to perform the full range of procedures. If you've got someone coming from overseas, then it is often necessary to go down into greater depth working out what procedures they do have the credentials to perform.

Then as you say, in the privileging process, that then has to be married up with respect to hospitals-----?-- Yes.

-----capabilities?-- Yes.

COMMISSIONER: Mr Diehm, are you moving off from that?

MR DIEHM: I am, Commissioner.

COMMISSIONER: Doctor, dealing specifically with the case of Dr Patel, we don't yet have comprehensive evidence as to how he got the position of Director of Surgery but my understanding from evidence to this point is that he was actually selected by a selection panel merely for the position of a senior house officer and it was shortly after he arrived in Bundaberg that he was then offered the position of Director of Surgery. I guess it's quite unlikely that such a situation would ever arise at the PA, but having had a candidate selected for an SMO or SHO position, should there be another process gone through before that person is then given the position of Director of Surgery?-- Yes. We do that fairly regularly. We'll have someone who will step down as the director of a department, they've done it for a number of years, they want to do different things and then we'll advertise and usually one of the people in the department will apply and we'll appoint that person.

Right?-- We will go through a whole recruitment process for that.

And some sort of accreditation or credentialing process to

satisfy yourself that the person is eligible to be promoted to the position of director?-- Not necessarily, because I expect a staff specialist in a department and the director to have the same clinical competency skills. The director I would expect to do other things, so the management of the department, strategic direction of the department, working with the nursing leader in the department, those sorts of things, and they're not things that we look at in our credentialing process. Our credentialing process is purely about clinical competence.

I guess it's quite different at a hospital the size of the PA, but it seems to me that at least at a regional hospital the size of Bundaberg the Director of Surgery may be the first amongst equals with the other staff surgeons, but nonetheless he is the first, and he is the one that, for example, complaints come to, he's the line manager for junior doctors and so on. I would have guessed that some care would be needed to be taken to ensure that someone who merely satisfied the criteria for a staff surgeon also was good enough to take the position of Director of Surgery?-- And that would be the recruitment and selection process. I would see that as being the key to working out whether that person had the skills to do the Director's job.

D COMMISSIONER VIDER: Can I just ask the clarifying question about that. In relationship to Dr Patel under the Special Purpose Registration, I understood that the title was specific to the nature of his registration. So his registration was as a senior medical officer. So in actual fact he wasn't eligible for appointment as the Director of Surgery, because under the position description of a senior medical officer, he reported to and was supervised by the Director of Surgery?-- Without knowing the specifics, I would have thought that a request would have had to have gone to the Medical Board to alter his position, and we do do that at PA quite regularly.

Yes?-- We want someone to do a different job because we've assessed them, they're competent to do that, so we will apply to the Medical Board for their registration to be changed.

To be changed. And that would be a requirement?-- Yes.

The next step to follow?-- Yes.

COMMISSIONER: Sir Llew?

D COMMISSIONER EDWARDS: No.

COMMISSIONER: You might like to follow up on that if you think appropriate, Mr Diehm.

MR DIEHM: Yes, I don't think it's particularly necessary, Commissioner.

COMMISSIONER: No.

MR DIEHM: Can I just remind the Commission, the evidence is Dr Patel was already in the position of Director of Surgery when Dr Keating-----

COMMISSIONER: I understand that entirely, and it may be that Mr Chowdhury's more interested in that issue than you are.

MR DIEHM: Thank you, Commissioner. Doctor, one thing that I will touch upon because it's been referred to in other evidence, and you have already explained in your evidence this morning that the PA is in the advantageous position of all of the directors of its respective departments being Fellows of

their respective colleges, but in your experience within Queensland Health, is there anything unusual about a senior medical officer being employed as a director of a department?-- No, there's nothing unusual.

One final question I have for you, again because it pertains to other evidence that's been given before the inquiry, you mentioned - and Mr Atkinson raise his name with you this morning - Dr Whitby. He's the head of the Infectious Diseases Unit at the PA Hospital. Is that so?-- That's right.

And is his standing such that he is a nationally renowned expert in that field?-- Yes, he is.

Is he internationally renowned?-- Yes.

Thank you. I have nothing further.

COMMISSIONER: Thank you, Mr Diehm. Mr Chowdhury?

MR CHOWDHURY: I have no questions, thank you.

COMMISSIONER: Mr Chowdhury, I did point out to you yesterday that another witness had given evidence very relevant to your client. Obviously you have the responsibility - I don't have to tell you how to do your job, but I'd be very concerned that we're left in a position where evidence very relevant to your client's position has gone untested.

MR CHOWDHURY: I know what the Commission has said. I don't have any questions, thank you.

COMMISSIONER: Thank you, Mr Chowdhury. Mr Fitzpatrick, any re-examination?

MR FITZPATRICK: No re-examination, thank you.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: No, Commissioner. May Dr Young be excused?

COMMISSIONER: Yes, indeed. Dr Young, you have been a tremendous help. We thank you for your time. We know that you have an extremely busy job and a very hectic schedule, and we're delighted you were able to make your time available to come along and give us the benefit of your input. You are excused from further attendance?-- Thank you very much, Commissioner.

WITNESS EXCUSED

COMMISSIONER: Mr Atkinson, I've received a report that there's an announcement that has recently been made of some significance regarding the administration of Queensland

Health. I don't yet have the full details of that, and it may have some implications - I don't know what - for the course that the inquiry takes in the future. I was therefore inclined to take an early lunch, but Deputy Commissioner Vider mentioned to me that Dr Rashford, I think, is here and is on a short timeframe.

MR ATKINSON: I'm afraid I'd rather underestimated the time the Commission might spend with Dr Young, and he has been here since 10.30 and he has to leave at three. I think that's doable, if you don't mind me saying so, but it will be a little tight, and I was anxious to have his evidence called as soon as possible.

COMMISSIONER: Well, we will, of course, make sure that Dr Rashford gets away on time. Would it be more convenient to have a quick lunch break now and then know how long we've got, or approach it a different way?

MR ATKINSON: It doesn't matter either way. I guess as long as the luncheon break is shortened to something of the order - if I don't incur anyone's ire - of about half an hour.

COMMISSIONER: Will that incur anyone's ire?

MR DEVLIN: We'll just get shorter, Commissioner. We'll be shorter.

COMMISSIONER: And thinner.

MR DEVLIN: Intending to be shorter.

MR DIEHM: Can we stretch it to 40 minutes?

COMMISSIONER: Why don't we resume at quarter past one, and that will make sure we've got, hopefully, sufficient time. We'll adjourn until 1.15.

THE COMMISSION ADJOURNED AT 12.35 P.M. TILL 1.15 P.M.

THE COMMISSION RESUMED AT 1.26 P.M.

COMMISSIONER: Mr Atkinson?

MR ANDREWS: With your permission, I would like to call Stephen James Rashford.

STEPHEN JAMES RASHFORD, SWORN AND EXAMINED:

COMMISSIONER: Dr Rashford, please make yourself comfortable. Do you have any objection to your evidence being video-recorded or photographed?-- No problem.

Thank you.

MR ATKINSON: Witness, is your name Stephen James Rashford?-- That's correct.

Would you have a look at this document? Dr Rashford, is that a statement that you have signed and provided to the Commission?-- That's correct.

And are the contents of that statement true and correct still to the best of your knowledge?-- That's correct.

Perhaps there's one matter that should be addressed - or two matters. The first is that at paragraph 3 of your affidavit you speak of your official title being the Director of Clinical Coordination and Patient Retrieval Services. I understand that in the last couple of weeks that has changed?-- That's correct.

And how has that changed?-- I've left Queensland Health as of July 10, and I'm now the Chief Medical Officer from Mondiale Assistance Australia.

COMMISSIONER: Sorry, Chief Medical Officer from?-- Mondiale Assistance Australia.

MR ATKINSON: And just to make that clear to the Commissioners, is it the case that whereas previously you were involved in patient retrievals across the state and coordinating them, Mondiale coordinates patient retrievals internationally?-- That's correct.

And within the state?-- That's correct.

Commissioner, I seek to tender the statement, but before doing so, one of my learned friends has asked that part of the statement be struck out, and I accept the need to do that, and I can approach it differently.

COMMISSIONER: Yes.

MR ATKINSON: The offending passage is in paragraph 17. The second last line after the words "P26 case", I ask that the words that follow be struck out, "and that I came away" et cetera, et cetera.

COMMISSIONER: Yes, those words will be deleted. Otherwise the statement of Dr Rashford will be Exhibit 210.

ADMITTED AND MARKED "EXHIBIT 210"

MR ATKINSON: Dr Rashford, you were involved in the retrieval for a patient that we call P26?-- Yes.

Your statement deals with that. I'd like to take you through your statement and deal, if you don't mind, with three broad headings?-- Yep.

The first one is how, in your experience, the tertiary hospitals and the regional centres interact?-- Yes.

The second is your involvement in the case of P26?-- Yes.

And the third is how a complaint you raised about P26 and the care he received was addressed. Can I start with the first heading then. You're a Fellow of the Australian College for Emergency Medicine?-- That's correct.

And in 2004 I think you were appointed as a Director of QEMS?-- That's correct.

And QEMS stands for the Queensland Emergency Medical System-----?-- Coordination Centre.

It's a joint creation of the Queensland Ambulance Service and Queensland Health?-- That's correct.

Who is it funded by?-- It's funded in part by both services. The health component - director, staff specialists, and now nursing staff - are funded by Queensland Health. The ambulance staff are funded by the Department of Emergency Services.

So the Department of Health and the Department of Emergency Services fund discrete aspects of the service?-- Yes.

And is it the case that whereas previous to the inception of QEMS each hospital managed its own retrievals-----?-- Yes.

-----now the QCC, if I can call it that, coordinates all retrievals?-- That's correct.

So what you're involved in doing as the director - or you were involved in doing - is making sure that you match up patients, hospitals and aircraft?-- Yes, that's correct. Getting the right patient to the right hospital in the right time.

You mention in paragraph 4 of your statement that the role of the QCC isn't just confined to retrieval services?-- No, I mean, it's a clinical coordination, which means really moving the patients around the state so they access appropriate medical care in a timely fashion. It's also medical advice at times to peripheral hospitals, and to the regional communications centres for the Queensland Ambulance Service, and those problems are very diverse.

Apart from the expensive option of moving patients around-----?-- Yes.

-----a doctor in, say, Cunnamulla or Bamaga could call in and say, "I've got a problem with a diabetic patient" - or with something more traumatic, and you have specialists who can answer the call?-- Yep. Generally, if we cannot provide the emergency medical advice to them, we can liaise and conference call in appropriate specialty areas.

D COMMISSIONER EDWARDS: Within the hospital system?-- Within the hospital system, yes.

MR ATKINSON: Where you do retrievals, doctor, is it the case that the budget - the money for that retrieval doesn't come from the referring hospital?-- No, it's a centrally funded - I believe in the early nineties the funding was split between - split centrally and regionally, but we have a centrally funded model, which means there's no onus of cost that's borne by the referring centre.

There's no penalty for referring someone?-- No, no penalty. In fact it could be advantageous.

Could you tell us then, generally, how well the QCC has worked in terms of working with regional areas?-- Look, I think it's been a very successful program. Before we opened, the clinical coordination of patients was performed by various hospitals, and the standards and consistency were variable. The doctors providing advice could be either registrar or consultant. So we moved to a purely consultant specialist level advice line. It was probably - it's been a very onerous previous 12 months attempting to attract senior staff to provide that service, because it is 24/7, you can't predict when an emergency transport is going to be required. I think we have linked peripheral centres - we've certainly been an advocate for both patients, the regional communications centre for the ambulance, and also the hospitals in gaining access to Brisbane tertiary hospitals. We've also been, I think - I've used the tertiary hospitals in Brisbane quite aggressively in attempting to move patients back to their respective hospitals, making sure that patients are continually turning around between regional and central sites. That way we're efficient. When we first started there were up to 25, 30

patients waiting to go back to places like Bundaberg and Rockhampton in Brisbane hospitals. That's an entire ward. We averaged, once we opened, by aggressively managing and moving those patients back once they were ready to move, down to about five patients waiting at any one time. So we've been very aggressive with that.

COMMISSIONER: Is that merely to make beds available in Brisbane, or is it also for the patient's benefit, being with their family?-- These patients on that list to move have been assessed by the medical officers in the city and they no longer require tertiary level care. It's best to get them back to home. It is to make beds - and it can be quite complicated if we have one aircraft bringing one person down - we have numerous aircraft tasked to transport patients, each taking patients to different sites and each requiring a domino effect to occur so the bed becomes available in the city. It's very tight.

MR ATKINSON: That's why it makes sense, I imagine, that it be coordinated?-- That's correct.

Before individual hospitals managed their own retrievals?-- That's correct, yes.

You perform something of a brokering role then, I imagine. People want to get their patients down here, there aren't ICU beds and you have to ring around to the various hospitals and be a patient's advocate, as you say, and find a bed?-- Generally speaking what we would do is ask the referring physicians to find beds for non-critical or non-life threatening illness, or at least make an attempt to do so. For patients with critical life-threatening illness or injury, we would ask them to make one call. Often we would actually make the first call, because ambulance would notify us of a patient going into these peripheral hospitals, and we would do the rest of the work finding beds, finding services for them to be treated. For the patients with non-life threatening illness, we would ask them to make the referral. If they were bounced around the system, they were finding it hard to find a bed in Brisbane, then we would then step in. There are so many patient referrals that we couldn't take all these calls primarily. It is difficult to access. The hospital system has very tight bed status, both with intensive care and generally, and we have to be an advocate for those referring physicians, and sometimes we have to tell hospitals receiving hospitals the patient was coming, ready or not.

COMMISSIONER: You talk about transfers to Brisbane?-- Yes.

Are you also involved in transfers to, for example, Townsville or Toowoomba or other major provincial hospitals?-- In the first 12 months we covered the southern - two health zones, so central and southern health zone. The northern health zone will come on line in October this year. They are clinically coordinated by medical officers at Townsville at present.

Right. Then I assume part of your judgment is if, for example, there's an acute but not life-threatening situation, shall we say at Charleville, it may be the option of transferring that patient to Dalby or Toowoomba rather than to Brisbane?-- That's right. We attempt to match the patient for the service required, and having a general overview of the system was to provide us with that data so we can match patients. So Toowoomba is a very good option for most patients. If they need something like neurosurgery, burns or the like, then we would come through to Brisbane.

MR ATKINSON: How many people do you actually employ - or does QCC employ?-- Currently or at that point?

Currently?-- Currently the clinical coordination physicians have been outsourced to an external provider. We had a lot of difficulty attracting people to that position. During the first 12 months I did about 80 per cent of the call for the year, which meant about 11 - roughly 11 days in 14, and we had a couple of fellows doing a day every second week. So it was a very onerous position. There's currently a temporary contract being done with added remuneration to attract the correct number of specialists.

To ask a less precise question, what kind of staff do you have available - in what numbers - whether they be employed or contracted?-- Currently we have three FTE nurses, there are about nine or 10 FTE ambulance officers, and the contract service provides a doctor every day. So that's a variable FTE really.

COMMISSIONER: But there's always a doctor in the office?-- Yes, there is. Currently there is someone on site eight till six, and then on call for the following 14 hours.

MR ATKINSON: Doctor, I imagine it's the case that you're one of the very few people in the state who has an eye on medical activity across the state?-- I would guess - certainly - that's correct.

And you can tell if, for instance, in one particular area they're putting a big drain on ICU resources in Brisbane, for instance, because they're doing things that they don't have ICU support for at that particular hospital?-- That's correct.

In that context, did you provide anything of a clinical policing role?-- I think in my record of interview and my statement - we couldn't be - we were never set up to be the clinical police.

COMMISSIONER: Yes?-- Obviously we came across cases such as patient 26 that rose above the background noise. There's always going to be a number of patients transferred from peripheral centres, and it's easy to be the Monday morning quarterback or in retrospect to say, "They should have done this, they should have done that", but they are peripheral centres with less available resources, as we've heard from

Dr Young and the like, but occasionally patients rise above that background noise and say, "We need further investigation." There are a number of cases during my 12 months as the director where I identified - that I felt there were adverse outcomes, and what - my general rule was that I would send an e-mail to the Director of Medical Services, the District Manager, and I would CC that copy centrally to ensure that something was done.

When you say "centrally", to Charlotte Street?-- Usually to the zonal manager, plus or minus the Executive Director of Health Services.

MR ATKINSON: Is it the case, in addition, that in a non-legalistic sense your line manager really is Dr Fitzgerald, the Chief Health Officer, and you would tend to discuss cases above the white noise with him?-- I would discuss - the line management was not quite as clear as it should have been for our centre, because it was really a work in progress, unfortunately. The role of the centre evolved, and we probably took on too much work, if that makes sense, which was an error in hindsight. Fiscally I reported to the Royal Brisbane, but purely for fiscal, to the Director of Medical Services there. Functionally I reported to a combination of people, the zone managers - zonal managers, to Dr Fitzgerald, and to Dr John Scott.

When a doctor is in a regional centre - and it may not even be a hospital, it may be something quite small, and I'm thinking of something like the Bamaga Hospital?-- Sure.

Though they're obviously in the northern zone?-- Yep.

They've got a couple of options, have they? If they wanted advice rather than a retrieval, they could call the QCC, if they've heard of it?-- Yes.

Or alternatively, they might call a tertiary hospital?-- Yes. We try to encourage advice calls to go to their respective drainage hospitals in the first instance, and really keep the higher echelon calls that are requiring transport - obvious transport for us, because we are going to be inundated because of our own number of people working for us. So they would - or they would call tertiary - a lot of the doctors rotated to these small hospitals. Particularly relieving country medical supers come from Brisbane hospitals, so generally they would - for general advice calls they would ring back to their home hospital and get that advice.

COMMISSIONER: And to people they knew?-- As we all do, yes, Commissioner, that's correct.

MR ATKINSON: We have certainly heard evidence of people making calls to people they know, but is there any formal protocol between the small areas like Cunnamulla and the big areas like Brisbane or Cairns in terms of you want to ring up for advice, maybe you don't know people because you're from interstate or overseas? What's the protocol?-- There's

accepted drainage hospitals. For instance, Cunnamulla would - it's in the southern health zones. It drains into Toowoomba, or to the PA Hospital, but the reality is they should be able to ring any major hospital and get any person on the line and get advice if they really want that. I'm not saying it's always easy, but that's what they should be able to do. The QCC was always there as a back-up for that system should it fail, and often we would have people ring us saying, "People are telling me I can't go anywhere, there are no beds. They're not giving me correct advice. I'm not happy", and that's when we would step in, and as a senior clinician we knew how to navigate the system. We knew how to use the authority that we were required to at times, and generally we were able to get resolution of the problem.

Now, it's obviously, as you said, been a work in progress, the QCC?-- Yes.

Do you think that it's adequately resourced now?-- I think-----

Apart from the staffing issues?-- Certainly the resourcing has increased drastically within the last few months. That's correct.

That's the glass is half full, though. But to answer my question, does that mean it's now adequately resourced?-- I think it probably needs some more nursing staff to make it go 24 hours, but essentially I think it's nearing correct resource allocation.

Doctor, there's been a lot of evidence that one of the things that tends to happen is that overseas trained doctors tend to be stationed in regional areas rather than central areas?-- Yes.

Certainly there's a higher proportion of them in regional areas?-- Yes.

Can you say whether or not that fact causes problems for you in terms of coordinating clinical services?-- What I would say is that, firstly, there are some fantastic - I'm not trying to make a speech, Commissioner-----

COMMISSIONER: No, no?-- There are some fantastic overseas trained doctors that do a great service to the community, and places of note that I remember are Emerald and Blackall where the communities probably don't understand how lucky they are to have those people there. They're very, very good. What I find is that overseas trained doctors that go to smaller country sites, even if their what I would describe as clinical skills may be mediocre or average, they are committed to the local community, and generally we don't have too many problems. We can navigate those issues. Unfortunately, as has been evidenced from what I listened to this morning, we do have staff shortages along the east coast, and we find a lot of positions are filled by overseas trained doctors, and it varies from where they come from, but English - being able to

communicate and articulate the clinical problem is very difficult, and when I think back to the issues I've had over the last 12 months, the primary problem I've had has been being able to either understand the person talking to me or - and being able to work out exactly what they're asking me, and I think what happens is I think we really need - I think one of the problems is we need to make sure people can speak English, because that is our language. We need to provide clinical networks for these people. If I go to Bangladesh, I think I've got fairly good medical training, I can work - I might not have the clinical networks, I mightn't speak Bangladeshi, but I've got the training behind me. We've got a lot of people who don't speak English, often have poor medical skills, and don't have the clinical networks, and I think that's a recipe for disaster, and I think we need to get back to basics. That's my personal opinion, and the government - I don't work for the government.

MR ATKINSON: In terms of language, are they problems of accent of vocab?-- Both. I think it's a combination. Accent - that's partly my problem. I have to come to grips with that. That's life. There are individuals who, really, their command of English is so poor, I get off the phone and ask the ambulance officers, "What did they ask of me", and the ambulance officer can't tell me either. So it's not just an individual issue.

Sometimes you're dealing with some pretty sophisticated language describing medical conditions, I imagine?-- I think so. I know so. Yes, that's correct.

D COMMISSIONER EDWARDS: Are these people mainly in the regional areas - in the rural areas rather than the regional areas?-- No, regional areas along the east coast.

On the coast?-- At the larger hospitals. What I'd call the larger community urban hospitals.

D COMMISSIONER VIDER: Given that you have indicated that the service that you provided was across the southern and central zone, and is going to extend to the northern zone, that gives a statewide spread?-- That's correct.

Is that feasible to have - I presume it's going to be based in Brisbane, extending out to the whole of the state, or would you see a decentralised service as being more realistic? I'm thinking of something coming from Townsville and retrieving a patient from Mount Isa is closer than Brisbane would be?-- Commissioner Vider, that's a very good point. What we're going to do is centralise the hardware and the telephony and computing to Brisbane, but the medical coordination will actually still be based from Townsville. So you dial our 1300 number, it would bounce to Brisbane, the person says, "Hello, you're at Bamaga. One moment, I'll connect you to up to Dr Such and such." It could easily be in Brisbane or Townsville. You cannot have someone knowing the entire state, you're correct, but we have to weigh the disadvantages of a decentralised model versus the centralised model, and I think

we've lost some local knowledge, but what we've gained is a far better, efficient system, and been able to highlight some of the cases you're talking about.

COMMISSIONER: Also particularly given your limited resources. There are only so many aircraft available and so on. It's got to be coordinated statewide?-- That's correct. We don't want aircraft overflying each other - and that was the case - and, for instance, Rockhampton used to do their own aircraft, so I now know there's a trauma in Rockhampton, now the Rockhampton aircraft may be committed for another patient, but I may hold the Bundaberg plane on the ground until I get more detail. It's a game of chess, essentially. What we're doing is getting an overview of the whole board rather than just the small part of it.

D COMMISSIONER VIDER: Given that we've got some workforce issues in the next little while, in the foreseeable future, until the number of medical graduates increases to provide greater strength in the workforce, and understanding what you're saying about the need for networking to be available to those clinicians, it would seem that we're going to be reliant on overseas trained doctors in the immediate foreseeable future. Then it follows that it would make sense to have staff of the QCC increased, because they may be a source of that networking?-- I think we need to adequately resource, but also ensure the workload is adjusted so we retain staff within QCC, and certainly the employment of the nurses within the last six months to aid the physicians and the ambulance officers in the processing of the work and coordination has been a great help, and certainly the workload is nowhere near as high per physician now as it was when we first opened. I think you're right.

My question was, you said that the medical service is largely outsourced?-- Yes.

Is there enough medical specialists - I presume of the emergency or intensivist variety to work in the QCC from - I suppose the private sector, if it's outsourced? Are there enough people around if the staff establishment was increased?-- I think essentially it came down to remuneration in the end for participating in the work.

Yes?-- That's what-----

That's that factor?-- Yes.

That might be fixable?-- Yes.

I'm looking at the availability of personnel. Are there people out there who could be contracted in? Are they available?-- Certainly within the outsourced models all shifts have been filled.

MR ATKINSON: Doctor, when you spoke about clinical networking, I understand what you're saying is that doctors in regional centres should have sufficient rapport with doctors

in tertiary centres that they can ring a neurosurgeon in Townsville and say, "I think this person has a closed head injury. What do you think?" That's the kind of networking you'd like to see happen?-- That's correct, yes.

Can I take you then, doctor, to paragraph 5 of your statement. That's when you start dealing with the case of P26 specifically. The initial phone call wasn't taken by you, it was taken by the Deputy Director at the time, Dr Thomas?-- That's correct.

What happened, I understand, is that the phone call comes through on your records, as they show, to say that there's a boy with a bad bleed from his left groin and he's in Woodgate, which is something like 50 kilometres outside Bundaberg?-- That's correct.

You understood, as you say there - sorry, Dr Thomas understood that there were certain indicia that the boy was in a very bad way?-- That's correct.

Tachycardic?-- The patient was grossly shocked and suffered a very major injury to his groin after a motorcycle accident. The helicopter was dispatched not only as a transport platform, but also to take one of the higher echelon, highly trained intensive care paramedics to the scene to provide advanced resuscitation skills on scene. He had very low blood pressure and a very high heart rate, indicative of massive blood loss, life-threatening blood loss.

"Hypotensive" and "tachycardic" are the words respectively for low blood pressure and a high heart beat?-- Yes.

He's moved from Woodgate to Bundaberg?-- Yes.

That makes perfect sense to you in retrospect because it was a very urgent situation?-- He needed urgent general surgical intervention to stop the bleeding. That could be obtained in Bundaberg. That was the closest centre. He would not have survived to fly anywhere else.

That was 23 December?-- That's correct.

So it's clear to you that the right decision was made?-- Yes.

You understand from looking at the records that what happened at Bundaberg is there are three operations done on the 23rd?-- That's correct.

You don't hear any more about the case?-- No.

Is there any protocols in terms of the QCC following it up?-- No, there's not, and we examined this case - I thought this was a sentinel case for us. Ideally we would follow every critical care case that goes into a hospital, and in general we probably do, but in an ad hoc fashion. At that stage there were only about three or four doctors working, and it was very - the workload was quite immense on each individual person.

So to follow up every case was difficult. It was also the political aspect of someone from outside the hospital system ringing in to someone saying, "Look, what have you done there?" There's ways of doing it. You can ring in and find out, "How is he going", but to say, "Why haven't you transferred him" is difficult.

COMMISSIONER: And to be fair to yourself, you've got enough on your plate dealing with the emergency calls that come in without ringing up hospitals and saying, "What have you done with that patient?"?-- Look, Commissioner, I appreciate that. I look back on it as though what could we have done as our group, and I agree we were probably overwhelmed by work at that stage, but we also saw ourselves as providing the entire coordinated care of patients.

Yes?-- We probably - would it have changed if he was transferred out? Probably not, because if the surgeon didn't want to refer him, I can't drag a patient out of a hospital.

MR ATKINSON: He goes in on 23 December?-- Yes.

Nine days pass and then you get another call regarding the same patient on New Year's day of this year?-- Yes.

And your records are coordinated enough that it was very clear to you it was the same patient?-- Yes, that's correct.

I understand that the phone call was a little remarkable in that the call you received was from Dr Ray at the RBH?-- That's correct.

Normally you receive phone calls from the referring hospital?-- That's correct.

Rather than the receiver hospital?-- That's correct.

And I understand that you take from that that it was a serious case. If Dr Ray is calling you from the RBH, that's a bit unusual, and it means that this is something pretty serious?-- Generally speaking, if we receive calls from the referring ICU or the referring medical unit, that indicates that this is a high echelon - this is a high risk case, and certainly Dr Ray was very concerned about the viability of P26's leg - left leg, and so he was very keen to get the patient to Brisbane as soon as we possibly could. On that day it was a very - from memory, it was a very busy day, and when my statement says we had aircraft in all directions, that can happen in a decentralised state such as Queensland, and the closest vehicle - we had one helicopter in Bundaberg, we had another helicopter on the ground in Maroochydore. We tend not to use the helicopter in Bundaberg for interfacility transfers out of Bundaberg because the staffing is such that the paramedics who staff it come off the road. So we prefer to local resource. We tasked the closest available helicopter with a dedicated resource, and that was a Maroochydore paramedic. It was quite evident the patient was very unwell and-----

When you say that doctor, that's because you were in contact with the paramedic?-- But also the referring physician. The way the call came in, Dr Ray contacted me, I then contacted the referring physician as well to ascertain the clinical status of the patient. I needed to make a decision do I wait for a period of time and send a physician - until an aircraft is available to put a physician on the flight, or do I get the closest resource, and it's cost/benefit - risk/benefit, and I felt that the paramedic was very capable of transferring this patient. He needed fluid therapy because he was obviously septic, had septic shock, and was very unwell.

You mentioned that it was a busy day?-- Yes.

But even so, you were able to give priority to this patient?-- Yes.

Is it the case that if you'd been called at any time between the 23rd of December and the 1st of January, that if you were alerted to the fact that it was a young fellow in real need, you could move things around and make sure that he was retrieved the same day?-- That's correct. We clinically prioritise on every case that comes in, and certainly a 15 year old with a non-viable lower limb we're going to prioritise very, very high - highly, sorry.

You said you spoke to the referring physician?-- Yes.

Do you recall who that was?-- Look, I cannot recall his name. I know he was a PHO, which is a principal house officer. That's a non-training surgical registrar.

Does the name David Risson ring a bell?-- I know David from - is it Dalby now?

Yes?-- I know David's name, but all I can remember is the person who referred it had just come back from leave and had found this unfortunate young man on the ward and was - what's the word for it - he was very shocked at his clinical status and wanted him transferred immediately.

You mention at the end of paragraph 7 that you were informed that the young fellow was in a surgical bed rather than an intensive care bed?-- That's correct.

Why is that significant?-- Well, I think we have high dependency areas within the hospital system to deal with critically ill patients. I think this patient's condition had obviously deteriorated to a point where he now was critically ill and may well have been underestimated by the treating staff, and so he was on a surgical ward. He wouldn't - the nursing ratio on a surgical ward as opposed to intensive care - intensive care it is one to one, or one to two nursing. On a surgical ward it is one to four or one to six patients. The ability to perform close observations is different, to comment on the changes in clinical status are different, and this young man needed to be in a high dependency part of the hospital.

Whilst the young fellow was in the air, you spoke to three people, I understand: Dr Widdicombe?-- I believe so, yes.

Dr Ray and also you had regular updates, I understand, from the paramedic?-- Yes, correct, yes.

Is that something you do for all patients or was that-----?-- We do have protocols and we utilise intensive care paramedics as escorts. One of those is the paramedic contacts us from the first patient contact. Now, if I am happy with the patient at that stage, I don't require another call for the completion of the case, because I trust - they are trained very well, but I was very concerned about this young man and I wanted to just update myself during his transit and provide advice on the fluid management to the paramedic.

You spoke earlier, doctor, about the young fellow deteriorating?-- Yes.

And I appreciate that we're about to come to a stage where you saw P26?-- Sure.

You can't know or can't say whether he would have declined rapidly or he could have declined in the last couple of

days?-- Look, I have seen summaries of the medical notes which suggested that he, over a period of at least a couple of days his condition declined to the point where he became - I think he started spiking - on the notes available to me, it appears he started spiking high temperatures from the 27th, but his white cell count, which is a potential indicator of infection, but not always, so started to rise only within the last 36 hours.

Right. If there were other indicia predating the 27th of the mottled foot, coldness in the foot, pain on touching, would that suggest to you that there was a continuous period of problems?-- That would, yes. That would suggest that.

Does that suggest to you that there should have been some discussion with your centre?-- There certainly should have been some discussion - I think there should have been some discussion with a vascular unit, tertiary vascular unit, not particularly with the QCC. We would certainly be involved in terms of the transport, but discussions between units throughout the State peripheral hospitals and inpatient units occur all the time. Not everyone requires transfer. There are a lot of patients managed in their home town or home hospital, and that's important because you don't want to be transferring everyone.

All right. Well, in paragraph 9 you mention that although the QCC is not based physically on the RBH campus, you went across to the hospital when the helicopter arrived from Bundaberg?-- That's correct.

And I won't get you to go - you explain there what you saw and you considered that the young fellow was very, very unwell?-- Yes, I think he was very unwell. I was actually taken aback by a number of things: (1) how tall he was; (2) how swollen the leg was; (3) how purulent the wounds were; and (4) how unwell - generally his clinical status, how unwell he really was.

He was too sick to even smile, he was in such pain?-- Oh, yeah, he was conscious but he was in a lot - a great deal of agony, yes.

Now, you speak in paragraph 10-----

COMMISSIONER: Was he having pain relief?-- Look, I - for the life of me, Commissioner, I cannot remember, but he would have if he needed that inflight, the paramedic would have provided that. They carry morphine.

MR ATKINSON: In paragraph 10 you talk about the case in a bit more overview. I gather, doctor, this is a case that really upset you?-- Look, yes, it is a case that certainly - I think any person who had - I am not trying to pretend I am a saint, but any person who has good values and has ethics in their chosen profession is upset by cases that aren't undertaken to the appropriate level and I thought this case was - this was suboptimal care. That's what it was.

One of the things that struck you, as you have said earlier, is that much earlier than the 1st of January 2005 someone at the Bundaberg Base should have spoken to a vascular specialist in a tertiary hospital?-- Look, reading the notes, I cannot for the life of me understand why someone didn't talk to the vascular specialist on day one. If you take a young man back to theatre three times, and you are not a vascular surgeon doing vascular surgery in a rural hospital, and there is a telephone, pick up the telephone, and calling the person. You know, it is not very difficult.

Right. You are aware from the records that he had the repair to the femoral vein, the fasciotomies, and then the repair to the femoral artery?-- That's correct.

All within 12 hours?-- Yes.

And you say that as a doctor, if you are doing three operations in such a short period-----?-- Yes.

-----that might be a sign to you that you are out of your depth?-- Look, it may well be that I have got a very complicated patient that I managed okay, but I would like to bounce it off someone who it is their subspecialty area. We heard Dr Young saying how subspecialised medicine, and obviously law and various parts of society, in this day and age you go to the best in the profession and find out you are in the right ballpark in what you are doing, at least.

Then you mention that you were struck, as we have discussed, he spent three and a half days on the surgical ward. You also mention that you were concerned by the management of the sepsis and you mention that adage about not letting the sun set-----?-- Look, essentially the management of any purulent collection is to drain it, and the wounds were full of puss. If they are full of puss, then you have to explore, debride, clean the wounds. That's the first principles of surgical management. The actual - you know, surgical management of this patient should really be discussed with a surgeon, but as a non-surgeon doctor, certainly that's my understanding, that if you have wounds of puss, you clean them out, you debride them, that allows the viable tissue then to then receive the antibiotics that are administered. But no use putting - pushing antibiotics when you have still got collections of puss. It is not going to resolve the issue.

Doctor, at paragraph 12 of your statement you explain that you did talk to Dr Ray following the transfer to see what had become of the young fellow?-- Yes.

And you thought that the through knee amputation that he had was quite a good outcome from where he had started when he arrived in Brisbane. Then I understand you did the physician's equivalent of counting to 10; you thought about lodging a complaint but you decided to sleep on it?-- I - yes, I spoke to Mark, to Dr Ray about that and suggested that I felt this was suboptimal management; were the surgical teams

going to do something about it.

Can I stop you there, doctor?-- Yes.

You didn't have any idea at that stage about the surgery itself?-- No, no. Look, the plumbing - the plumbing associated with vascular surgery is for the vascular surgeon. I see Dr Woodruff up here. I can't comment on whether it should have been a prosthetic graft or a native graft. That's for the surgeons to make comment on. But I was upset that the patient hadn't been discussed with a surgical team in Brisbane, at least for advice, and I felt that that should be fed back to the treating team. I had no idea who the treating surgeon was.

You certainly didn't know whether the surgery was good or bad at that stage either?-- No, not really, no. I mean, I did ask Mark what he thought of the surgery and he made some comment about the type of graft and the like, but the principles of management I was upset about.

The postoperative care?-- Yes.

You were concerned about that and you were contemplating lodging a complaint?-- Yes, that's correct.

And what happened?-- I knew the surgeons would follow through because the vascular surgeons are very good. But I decided to also send an email through to the - as is my standard procedure as Director of that unit - was to send it to the respective Director of Medical Services, District Manager with a copy centrally.

So you did that and one finds that exhibited to your statement as SJR1. Can I just take you to that exhibit?-- Sure.

You will see that the email is sent to Mr Bergin, Dr Keating and Mr Leck?-- Yes.

It is headed "sentinel case". I mean, given your concerns, it is a reasonably politely measured sort of email. You would agree?-- Yes.

Doesn't scream out, it just sets out some problems. And you say in the second sentence, "It might be prudent to examine his Bundaberg chart."?-- Yes.

"And management"?-- Yes.

All right?-- I guess I am very cognisant of the fact that people often look at doctors, or hierarchy within Brisbane looking down on their rural cousins, so to speak, and you have to be diplomatic in the way you do that because the reality is you have to form bridges and deal with these people on the longer term, and this may not be the last case that we have to discuss. So I think I thought it my job to highlight this as an issue, it is for the local management to investigate it, and I don't see they should even report back to me. I think

they should investigate it and go through the due process that exists within Queensland Health.

Can you say whether or not you're sometimes involved in the investigation?-- Generally I attempt not to get involved in the investigation, apart from providing data as required.

COMMISSIONER: The mere use of the title "sentinel case" for the email should be enough to tell anyone that you regard this very seriously?-- That's correct.

MR ATKINSON: Now, can I just take you through the exhibits generally? There is one that seems to be missing that I have provided to my learned friend as part of the chain. Would you have a look at this one? It is an email dated 7 January 2005. But you will see following your email there is one from John Scott to Dan Bergin. Now, this is all happening on the 4th of January and then, as one follows through on the bundle, you will see that there is an email from Dr Keating to Mr Leck still dated the 4th of January - sorry, Mr Leck to Dr Keating, asking for a report, and at that stage an external review is being contemplated. Have you found that email?-- Yes, I have got it.

Now, that's on the 4th of January?-- Yes.

Asking for a brief. And then the very next day there is a briefing to the zonal manager. Can you say whether or not you think that the briefing note raises or addresses the issues raised by the case?-- It certainly highlights the issues. In terms of solutions - well, the solution is that it is really related to - I mean, they are talking about improving the working relationship between the vascular surgeons in Brisbane and Bundaberg, but I am not sure that was ever a problem.

Because there hadn't been any contact. If you don't have a relationship you can't have problems?-- That's right. I don't know if this reflects they have had problems in the past but I wasn't aware of any. The vascular surgeons at Royal Brisbane are very good at accepting patients.

COMMISSIONER: But, doctor, going through the briefing note - and I want to make perfectly clear in asking you these questions I am not necessarily making any criticism of Dr Keating as the author of this briefing note, because no doubt he could only go by the information provided to him?-- Yes.

But the briefing note itself provides an extremely rosy and grossly distorted version of what this patient had been through?-- Yes.

You see in the third paragraph - at the end of the third paragraph under "background", it talks about the patient being admitted to ICU after initial operation. We know he was, in fact, in a surgical ward?-- Oh, he did go-----

He was briefly in ICU?-- Yes.

He was left in the surgical ward. It talks in the next paragraph, "Condition improved, stabilised", and a couple of lines down "general condition: left leg continued to gradually improve with respect to size, colour and sensation". That can't be a description of the leg you saw - well, this is talking about up to the 30th of December, two days later?-- No, it certainly wasn't the description of the leg that I saw, no.

MR ATKINSON: It is not entirely consistent, is it, doctor, with a limb observation chart within the file that shows that at least from the 27th of December there was swelling consistently, there was patchy sensation, the colour of the foot was motley, the warmth was cold or cool and there was persistent pain. If there was a decline, it was gradual rather than-----?-- Yes.

-----complete on one day?-- Than sudden, that's correct.

COMMISSIONER: Perhaps the grossest inaccuracy is the last paragraph under the subheading "background" which suggests the patient was transferred because of concern that the leg had failed to improve as quickly as expected". I mean, that hardly, again, describes what you saw on the 1st of January?-- No, no, Commissioner.

MR ATKINSON: Doctor, you will see at the head of the briefing note it says that it has been prepared after consultation with Dr Gaffield and Dr Carter and at the end of the briefing note it says that it has been prepared without recourse to Dr Patel?-- Yes.

Who, of course, was the initial treating surgeon who did all three operations. Would you agree that to make the report really comprehensive it was important that the author speak to Dr Patel?-- If it was possible to speak to Dr Patel.

He was on holidays, sorry, but he was coming back?-- Generally speaking, within the Health Department when they ask for a briefing, they want it ASAP, particularly on a case like this, and I think it is understandable that Dr Keating would have attempted to get a report back on this type of case as quickly as possible.

Well-----?-- But it certainly would be a significant - need significant follow up with Dr Patel.

COMMISSIONER: And Dr Rashford, accepting that that's the case, that Dr Keating was expected to put in a report ASAP and did so, then the very next email we have is a day later where the zone manager, Bergin, is writing to Leck saying, in effect, "I am not sure an external review is warranted.", and that apparently then goes up to Dr Scott at corporate office and Dr Scott says, well, he has seen the briefing note and as far as he is concerned it is all fine. You know, if you take the briefing note as being just the immediate ASAP reaction, then you can't arrive at conclusions like that based simply on

the off-the-cuff briefing note?-- I think that would be a logical interpretation.

MR ATKINSON: Is it also the case that you might expect in the report that followed this incident that there would be some discussion between the author of the briefing paper and somebody in Brisbane who had seen him, you know, from the RBH, such as Dr Ray or Dr Jenkins?-- That would certainly make sense.

And in that category we might put you, too, doctor because you had seen him when he arrived and you could talk about his state and whether it had warranted earlier intervention?-- Sure, I mean, it is not too hard to find me, unfortunately.

My concern, doctor - and you tell me if it is being precious or not - is that there are a number of issues that might have been raised. One was why wasn't a call made earlier, as you have said. Another is what was he doing in the surgical ward for three and a half days. Another is why wasn't there a transfer as soon as he became stable. Another might be if one had reference to the vascular surgeons, why do they call it a femoral repair when it was a femoral vein clip-off; why weren't the fasciotomies as long as they should be; why wasn't the femoral arterial bleed spotted earlier?-- Look, I think in terms of the plumbing, I think that needs to be put to a vascular surgeon, but in terms of the other issues, I would agree. They would be the issues that I would be looking at.

Now, you see in that email of the 7th of January there is reference to a suggestion that more discussions occur about transfers?-- Yes.

And you also see at the bottom of the briefing note the "action taken/required", the recommendation is that "the Bundaberg Hospital institute a policy of transfer to tertiary facilities of patients with emergency and vascular conditions when condition is stable." Do you know whether there was ever any discussion or coordination with you about making such a policy to be documented?-- Not as per a personal phone call or the like. I do remember there was some email crossed my desk from Royal Brisbane along the lines about ensuring that we receive all patients in a timely fashion, but that generally wouldn't come across my desk for permission. My job is to ensure that they move between A and B or have the resources to do it and they are escorted safely.

Now, you mentioned at paragraph 17 of your statement that you went up to Bundaberg on an entirely unrelated matter?-- Yeah.

On the 25th of January-----?-- Yeah.

-----2005. And you raised the issue of P26 with Dr Keating?-- That's correct.

Can you recall what his response was?-- No, look, with my statement - unfortunately, I don't take diary notes. I went to Bundaberg purely to see the ambulance staff and the

helicopter staff about clinical audit and I used the opportunity to meet with Dr Keating and Dr Carter with regards intensive care transfers. The ICU at Bundaberg is often stretched because of the unavailability of intensive care level nurses in the town. It is unlike Brisbane, where they have a floating nursing agency staff that can float between hospitals, they are very limited, and we had to perform quite a significant number of transfers out of Bundaberg, not just for clinical reasons but for resource reasons, and I did mention this case. I did feel that-----

Well-----?-- I can't say what I feel.

Say what you saw or you heard, or what you recollect about - not what you felt, if you don't mind?-- I can't recollect with specifics what the lines were. I did-----

You had an impression?-- I had an impression that - I had a sense that - an impression to me that the case hadn't been fully exhausted in terms of its investigation, yeah.

All right?-- Certainly the outcome wasn't clear to me.

Now, you mention in paragraph 18 that you only met Dr Patel personally on one occasion?-- Actually, two occasions. I remember, now I have seen his face, I remember after the tilt train-----

You flew up, I understand, at the time of the tilt train?-- Yes, the days after, yes.

You were invited to fly up with the Minister?-- That's correct.

And you happened to see Dr Patel, did you?-- In the hallway, yes, that's correct.

The incident in July 2004 left you with an impression, I understand, that Dr Patel was a big-noter, to use your words.

COMMISSIONER: This is the incident in February or March of this year?

MR ATKINSON: Sorry, yes.

COMMISSIONER: Involving the cow-----?-- That's correct, that's correct.

MR ATKINSON: If I can just paraphrase, I understand that you were presented with a man who has had a cow kick a stick through his chest?-- That's correct.

And you're of the view that he needs to be mechanically ventilated?-- That's correct.

And that needs to be done in theatre?-- That's correct.

To extract the stick?-- No, no, leave the stick in situ. It

was to secure his airway for the transfer to Brisbane so the thoracic surgeons could extract the stick. And I suggested to Dr Martin Carter that he do it, being the more experienced anaesthetist, and I would come up and accompany him to the operating room and do it in the operating room, where we have much better facilities than the emergency department. And there was some fellow out to the side - excuse the word - poncing on to a gaggle of student nurses, and nurses, and medical students saying he doesn't understand why they are doing any of this stuff, it is not required, you know, completely misreading the clinical problem in front of us, and I won't say exactly what I said in my mind, but I felt that I couldn't give this guy any respect. I came back, I said, "There is some guy, I don't know who he is, carrying on like this, one of the surgeons."

COMMISSIONER: And it turned out to be Patel?-- It was, yeah.

MR ATKINSON: The thrust of the disparaging comments he was making was to the effect that this was all too much fuss, you can just, what, pull out the stick or-----?-- Get on with it, put him on the plane, get him out of here. You are not understanding that to pass a tube down through the trachea into the lungs, the stick entered the chest just above his sternum, so it was passing very close to his trachea, and as it turned out, the fellow had a very successful outcome, treated at the PA where he lost the top third of his lung, didn't injure any of his great arteries - only by a hair's-breadth, though - and was very fortunate, but the correct thing was to get a special surgeon in that area to remove that stick under direct revision.

Just one last thing, you mention in paragraph 18 that in terms of this noise you spoke about earlier, you had heard of concerns in July 2004 about the levels of surgery coming from Bundaberg?-- That's correct.

When you say levels, do you mean the complexity of the cases?-- That's correct.

But it wasn't within your scope of practice or within your humanly available time, I guess, to do some kind of audit?-- Well, it is very difficult to do the audit because we don't often take the name of the consultant surgeon, or consultant physician or obstetrician involved. We get the referring doctor. So Jayant Patel would never ring me up to transfer a patients, he would get one of his underlings to do it, to make the referral, and so I - as part of my induction as the Director, I met with a lot of the stakeholders and one of the stakeholders was the Director of Medical Services for the RFDS, Royal Flying Doctors Service, and he stated that his nurses had been concerned about a number of transfers they were doing out of Bundaberg, and this is pre-centralised model, and he had visited Bundaberg, and I guess in hindsight he probably spoke to Toni Hoffman because he said he spoke to the senior nurse in the intensive care unit who was concerned about the complexity of surgery and the number of patients requiring transfer. And I said, "Well, look, we will keep an

eye on that." I approached one of the intensive care specialists from the Royal Brisbane and said, "Look, have you had a number of patients being transferred?", and he said, "No", he hadn't noticed it, anything more than the normal number that we needed to move. So because I was so heavily involved in the coordination, it was pretty easy to keep a monitor on it, even ad hoc, and I think probably he didn't perform any oesophagectomies that required transfer because there weren't any other cases further than the spectrum of disease we transported within the next few months, and patient 26 was the first patient out of Bundaberg that put the noise level up that this was something that needed looking at.

You mention in paragraph 19 that it is a case that you discussed to some extent with Dr Fitzgerald?-- That's correct.

Do you remember the extent of those discussions?-- I met with Dr Fitzgerald quite regularly and I would have discussed this particular case, and I was aware that he was going to do an audit of the cases in that area, so I left that to him.

Given that this incident arose for you effectively on New Year's day of this year?-- Yes.

Can you say how soon after you spoke to Dr Fitzgerald?-- It probably was when he returned from hospital - my PDA has the times - I meet with people, sometimes I would meet Dr Fitzgerald in the hallway if I was transiting Charlotte Street or the like. So it is unusual to talk about a case.

COMMISSIONER: This would be late January or early February?-- It would have been when he returned from holidays, yes.

MR ATKINSON: That's the evidence-in-chief, Commissioners.

COMMISSIONER: I will just remind the press and media in Dr Rashford's statement some of the attachments refer to the name of patient P26. I have already made a direction under the Commissions of Inquiry Act that that name isn't to be published or referred to outside these proceedings, for obvious reasons, and I will ask the secretary to ensure that when exhibit 210 is prepared to go on the Commission of Inquiry website, that that name is pseudonymised.

MR ATKINSON: Thank you. Commissioner, might I do this, too: the email of the 7th of January that didn't make its way into the bundle, if it could have a separate exhibit number.

COMMISSIONER: Why don't you just hand it up and I will ask the secretary to add that to the exhibit 210.

MR ATKINSON: Thank you. Commissioner, can I say finally that Dr Rashford has indicated that whilst he did want to get away at 3, it is not for clinical reasons and if he has to stay a little longer, he is certainly prepared to do that.

COMMISSIONER: You shouldn't have admitted to that,

Dr Rashford. Mr Mullins.

MR MULLINS: I have no cross-examination, thank you.

COMMISSIONER: Mr Farr.

MR FARR: No, I have no questions, thank you.

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: Mr Devlin.

MR DEVLIN: Just a couple of matters thank you.

CROSS-EXAMINATION:

MR DEVLIN: Ralph Devlin. I represent the Medical Board of Queensland, Dr Rashford. The patient having had three operations in 12 hours, as was put to you, are you able to offer an opinion with any certainty from your knowledge of the case as to when a transfer should have occurred? Are you able to do that or do you feel that that's better for others to express an opinion?-- I think it would be better for a vascular surgeon or a general surgeon to offer that opinion.

Thank you. Again, from your knowledge of the case, did you have an extended opportunity to examine the charts in this matter or is it more a general knowledge of what occurred?-- I have not seen the Bundaberg chart. I have only seen the zonal manager brief and also a medical brief prepared by Dr Keating. Both of those were emailed to me.

I will just ask these questions. If you don't feel, you know, equipped to answer them, I would rather you didn't?-- Sure.

What do you know about the fitness of P26 to be evacuated within that 12 to 14-hour period? From your experience are you able to offer an opinion on that?-- Oh, certainly he was - once the initial haemostasis, so the stopping of the bleeding, had occurred, there was nothing to preclude him from being transferred at that time. We have certainly transferred far more unstable patients on a daily basis.

On the bigger picture, are you able to offer an opinion with any certainty as to whether an evacuation to Brisbane at that earlier point would have saved his limb or is that more than you can say?-- I think that would be conjecture on my behalf. It should be done by a surgeon.

Thank you. Thank you, that's all I have.

COMMISSIONER: Thank you, Mr Devlin. Mr Diehm.

CROSS-EXAMINATION:

MR DIEHM: Commissioner. Geoff Diehm is my name, Doctor. I am counsel for Dr Keating. You said when you referred to the briefing note Dr Keating had prepared that it identified the solution as something to do with, you said, improving relations or communications between the Bundaberg Hospital doctors and the vascular surgeons. Forgive me if I have misstated that but that's as I understood what you were saying?-- Yes.

Can you tell me which part of the briefing note it is you're referring to there?-- Oh, no, my apologies. I - I'm reading the e-mail that was the, is it, JR4 e-mail?

COMMISSIONER: The e-mail of the 7th of January?-- The 7th of the 1st. I agreed that the action taken was purely to institute a policy of transfer of all vascular patients, my apologies.

MR DIEHM: All right. Now, again, respecting your preference to stay out of issues about the adequacy of the surgery itself, if that policy as described there was implemented, that would answer the concerns that you had about Bundaberg's management of this patient, wouldn't it?-- That - that would on one count, yes, on vascular surgery, that's correct. I think vascular surgery should be performed by specialists in vascular surgery, except in - except in absolutely life-threatening situations, which was the first operation.

Quite so. And your concern is, and in answer to a question from Mr Devlin you declined to be more precise, for good reason-----?-- Mmm.

-----about precisely when-----?-- Yes.

-----the patient could have been stable, precisely when he should have been transferred, but your concern generally is there quite obviously was a time between that first operation and the day on which he ultimately was transferred when he must have been ready and should have been transferred?-- That's correct.

And that policy answers that concern, doesn't it, or those policies?-- That answers the concern in terms of vascular patients, yes, that's correct.

COMMISSIONER: But it answers that concern in this particular case?-- In this particular case, that's right.

But it doesn't answer the underlying problem that there's a surgeon that's doing the wrong thing?-- That's what I was going to say. That's only one part of the answer.

MR DIEHM: Yes?-- You have to address the medical decision-making. That's why I say if I do something wrong in the QCC, I issue a policy the next day and that absolves me from any error in the future.

At this moment in time though, and for the concern that you had raised with all of these other people by your e-mail, what you were concerned about weren't the broader issues about Dr Patel but rather why a patient in these circumstances was kept at Bundaberg for as long as he was?-- That's exactly right. I was concerned about the medical management of that patient by that physician.

Yes?-- Now, whether it was vascular surgery, whether it was any other surgery, it didn't matter. I was concerned about

the decision-making, why someone would decide to do that.

All right. Doctor, you were also asked some questions by Mr Atkinson about whether or not you were provided with any information subsequently that showed that such a policy had been put in place to which your answer was effectively, no, that you hadn't. Would there be any particular reason or need, do you think, given your position for you to be provided with that information subsequently?-- It would - look, you could make an argument that all those policies should come across our desk but there are a lot of different policies from different hospitals. I mean, I think if we're going to start having policies on transfer of patients, I think we need to have a more global approach to it rather than individual hospital to individual hospital. It would have been nice for me to see all these policies so that I can be aware of them but the fact that that didn't occur probably reflected the evolving nature of our centre, that now we're very much on the radar of everyone involved in transfers because we've established ourselves in the system, and I can tell you that in the last half of my tenure, lots of policies along these lines for various reasons would come across our desk, not that I would change them but so I was aware that there were these individual transfer policies. But what I - I'm not trying to be roundabout, it is very difficult. I'm not surprised it did not specifically come across my desk.

Yes. Because, in fact, quite early in your evidence you made the observation that when you raised these kinds of issues through your usual manner of sending an e-mail to the Director of Medical Services and others, that you're not even necessarily expecting to get any response about what is done-----?-- No.

-----in terms of investigation?-- No.

You're simply raising an issue and expecting them to deal with their own processes?-- That's right, there are systems within the health department to deal with that.

Yes.

COMMISSIONER: Doctor, would it be correct, though, to say that the institution of that sort of policy is really a Band-aid solution? You can't have a policy covering every possible situation in which a doctor needs to transfer a patient to a tertiary hospital. The real problem here is having a doctor who has the clinical competence to make that judgment as to whether or not that patient should be transferred to Brisbane?-- That's - that's correct. To use an example, if you have someone who has an abdominal aneurism which ideally should be done by a consultant vascular surgeon but it's a time critical, the longer they - they suddenly bleed, the time it takes to repair it is directly proportional to how - whether they live or die. If they're in a far, remote centre and you have a competent vascular surgeon who makes that, "How long does it take to transfer someone?", do that surgery.

Yes?-- This policy is to stop someone who is obviously exceeding their - they're just making sure someone doesn't exceed their capability. That's what the policy is doing I would think.

But I guess what I'm suggesting to you is that if you've got a doctor who is exceeding his or her capability-----?-- Yes.

-----the solution isn't to put in policies to regulate them; the solution is to find out what the problem is with that doctor, why it is that he or she is doing the wrong thing?-- Look, I would agree. I think, look, everyone - everyone is going to make errors in life, and this may well have been the first error that Dr Patel made, but if it's a constant thing, which we now know there probably was, then this is just another brick in the wall. You know, it really-----

Yes.

MR DIEHM: Doctor, are you aware of when Dr Patel ceased being personally in charge or personally attending to this particular patient?-- According to the notes, after about day 3 or 4.

Yes. So, in fact, not inconsistent with that was the 26th of December when he handed over the patient's care to another surgeon?-- That's correct.

And your concerns, presumably, then are as much about the failure of that other surgeon to cause the patient to be transferred from that day onwards as well?-- Look, I would agree. I would - I would think there's two parts: there's post-operative care and the peri-operative care, and I think they are the concerns of both.

Now, the other - the doctor who took over the care of that patient is a Dr Gaffield?-- Yes.

Do you - you were familiar with Dr Gaffield, aren't you?-- I am now, yes, because I've spoken to him a number of times.

He is a surgeon who you hold in quite high regard?-- Look, in the dealing - in the cases I've had dealings with him, I think he's acted in an exemplary manner, including one time I thought I was talking to a junior medical officer who obviously - he escorted a patient, a ruptured triple A, a ruptured aneurism, and we made the decision to get the patient to hospital as quickly as possible, and I was talking to this American - he is the American surgeon. I was talking to this American, I didn't know he was the surgeon, I thought he was a senior medical officer in the emergency department, and he said, "Look, I won't put that junior doctor on it. I'll do it myself", and I thought, "Isn't that great. He's going to go with him. This is the best way to get the patient to hospital." Again went to the PA. Had a successful outcome. And, in fact, it was the surgeon. So he was a fellow who would go outside the rounds. And on the same day we had a

very severe tragedy in which a fellow died from a motor vehicle accident and he pulled out all stops to try and save his life. So, they're my two occasions of service that I knew particularly with him and on both occasions I thought that he acted well above what he needed to do.

One of the problems for Bundaberg Hospital of course at this time was that it did not have a vascular surgeon-----?-- Yes.

-----in its employ. So in the case of there being a need for emergency vascular surgery, as was the case with P26, that was always going to fall to a general surgeon-----?-- That's correct.

-----to perform that work. Now, a general surgeon would not, having a patient who is having surgery that was of an ordinary kind for a general surgeon to perform, need necessarily to have a policy in place in their hospital that says that, "When you perform some conventional general surgery, as soon as the patient is stable and safe, you should transfer them out"?-- No.

They don't need they sort of policy, do they?-- No.

It would be silly?-- I would agree.

However, if they have to deal with something that's outside of their ordinary experience such as vascular surgery, they get the patient to the point of being stable, life and limb saved and it would be wise to then have a policy to then say, "Okay. You've made them safe but they're outside of your area of specialisation. They should be transferred out"?-- Look, I think that that is a fair policy to make but in this case, no-one can prove to me that that limb was safe at the end of that third operation.

No, and, indeed, what the briefing note acknowledges is that there was something that went wrong because the patient wasn't transferred after being - becoming stable?-- Sure.

And so, therefore, we must change our system by introducing a policy that says that if the patient's had emergency vascular surgery, once they're stable they should be transferred out?-- Look, I would agree, but there should be a policy in neurosurgery and all different types of subspeciality if we're going to do that. I don't think it is an unreasonable decision to make to have that policy. The policy in itself is not a problem, I think it is very appropriate, but we need - but - so I'm not arguing with you. I think that's-----

Thank you. Doctor, you've given some evidence about speaking to Dr Fitzgerald in late January, early February?-- Yes.

When you mentioned this case to him. Was he aware of the case before you mentioned it?-- I cannot remember. I couldn't honestly answer that question, I'm sorry.

Did he indicate to you that he was going to be carrying out

some investigation into clinical issues-----?-- Yes.

-----concerning Bundaberg Hospital?-- Yes.

And he indicated to you that he'd be looking at this case as part of that review, did he?-- I cannot remember the specific comments about this particular case. I certainly made him aware of my concerns.

Yes. All right. I have nothing further, thank you.

COMMISSIONER: Thank you, Mr Diehm. Mr Chowdhury.

MR CHOWDHURY: Just a couple of questions.

CROSS-EXAMINATION:

MR CHOWDHURY: Doctor, an e-mail which is attached to your statement, SJR1?-- Yes.

Is an e-mail which you sent to Dan Bergin, Dr Keating and Peter Leck. I should say my name is Craig Chowdhury. I act for Mr Leck, all right. As you make clear in your statement, you were simply trying to make sure that it got to the right levels of people to consider the issues you raised; that's so?-- That's correct.

And you even went so far as to CCing or copy that e-mail to Dr Scott?-- That's correct.

And Dr Peter Thompson?-- That's correct.

I want to make this perfectly clear though: the medical treatment of P26, whether he should have been transferred, the decision to do so is clearly a medical decision to be made, wasn't it?-- Oh, yes.

There is no question of that?-- No.

Thank you. Can I just take you to the last document, it's actually the last document attached to your statement in my brief. It's SJR3. It's a copy of an e-mail from Peter Leck to John Scott. You make reference to that at paragraph 16 of your statement?-- That's correct.

Can you just help me as to why that's part of your statement? Had you received a copy of that or was that just simply shown to you?-- It was just shown to me.

It wasn't anything to do with you; you were just shown it by whoever I presume took the statement?-- Yes, that's correct.

Nothing further.

MR DIEHM: May I briefly cover one matter-----

COMMISSIONER: Yes, of course, Mr Devlin.

FURTHER CROSS-EXAMINATION:

MR DEVLIN: Thank you. Going back to the helicopter evacuation, I think you were quite definite in your evidence, the way I heard it, that you were of the view that he would not have survived a transfer to Brisbane at that point?-- Very definite, no.

And that - is that about excessive blood loss at that point?-- That's correct.

So he needed to be repaired anyway before we could think about the future?-- Yes.

Thank you.

COMMISSIONER: But I think the question raised with you by Mr Diehm was whether the patient had to be safe in life and limb before he was brought to Brisbane and I think that the answer you gave to Mr Diehm was to the effect, "Well, this patient was never safe in limb. He should have come to Brisbane as soon he was stable"?-- I've seen no evidence to suggest to me that the limb was safe at the completion of the third operation.

Yes?-- And so, on that basis, if that's the case, if there's any doubt at all then I think that it should have been referred to a consultant vascular surgeon for opinion.

Nothing arising out of that, Mr Devlin?

MR DEVLIN: No, thank you.

COMMISSIONER: Mr Diehm?

MR DIEHM: No, Commissioner.

COMMISSIONER: Any re-examination?

MR ATKINSON: Just one issue.

RE-EXAMINATION:

MR ATKINSON: Dr Rashford, can I take you back to that e-mail on the 7th of January 2005. You were asked questions by my learned friends Mr Diehm and Mr Devlin and there was some

discussion about a policy. There's talk in the e-mail about a timely transfer. Is it your view that different people could differ on what a timely transfer is?-- That's correct.

And people could differ on which areas are specialities which require a transfer? You mentioned neurosurgery for instance?-- Yes - that's right. I mean, a general surgeon may well have undertaken a period of training in an area of surgery but without gaining the subspeciality recognition. For instance, vascular surgery has a second, as in a post-surgical fellowship specialist training and exam, and they may consider themselves capable of performing minor vascular procedures rather than the major ones, so.

My question-----?-- There are-----

Sorry. My question is this: if there was to be a policy covering transfers for different speciality areas?-- Yes.

It would require some working up?-- Oh, yes, it is not something you could just put in overnight. You'd have to consult and-----

Again by reference to this e-mail, you haven't been told whether that proposed policy was ever created or whether, indeed, those discussions happened between Bundaberg and the RBH?-- I have a very vague recollection of seeing some sort of e-mail from the Royal Brisbane stating that - about timely transfers around this period of time but I can't remember if it related to this particular case or was just a general rev to everyone to make sure that they accepted patients correctly.

You-----

COMMISSIONER: I must say, I'm a bit bemused by all this talk about policies. It sounds like an attempt to over-police. You shouldn't need to tell a surgeon the obvious?-- No. Well, one would hope so, Commissioner.

I mean, it is like saying that Coles should have a policy that you don't let the customer take the goods until they've paid for them. There are some things that are so fundamental to the job that you should know them without having to document a policy, and this strikes me as being one of them?-- I think what you're alluding to is ensuring the right people in the right job.

Yes.

D COMMISSIONER EDWARDS: And make the right judgment?-- That's correct.

MR ATKINSON: Nothing further, Commissioner.

COMMISSIONER: Thank you. Doctor, thank you so much for coming in and giving us your time. You will make your 3 o'clock appointment after all?-- I know. Thank you very

very, Commissioner.

Thank you. You're excused from further attendance.

WITNESS EXCUSED.

COMMISSIONER: Mr Atkinson.

MR ATKINSON: Commissioner, it is proposed to call Dr Nankivell, Dr Charles Nankivell next. He is coming in but he hasn't arrived yet. I was wondering if you could take the afternoon break now.

COMMISSIONER: Yes, I think we will take afternoon break. There was one thing I should do before we do take the break. On the 21st of July we received a letter dated the 18th of January from Dr Buckland addressed to myself personally and I replied to that yesterday, the 25th of July. I don't like - well, everyone knows my view about transparency and openness and all that. I therefore want to put that correspondence on the public record, so I will ask the Secretary to mark as Exhibit 211 Dr Buckland's letter to me, as I say, dated the 18th of July received on the 21st and my reply dated the 25th of July. That will be Exhibit 211.

MR ATKINSON: I think initially you said the letter from Dr Buckland was 18 January but it is 18 July.

COMMISSIONER: It is 18 July, yes.

ADMITTED AND MARKED "EXHIBIT 211"

COMMISSIONER: We will adjourn for 15 minutes but, Mr Atkinson, let us know if Dr Nankivell hasn't arrived.

MR ATKINSON: Yes, he may well take a little longer than that. He is coming in from Logan and he has already started and I'm not sure how long he will take.

COMMISSIONER: We will come down at 10 past 3 unless we have heard from you in the meantime.

MR ATKINSON: Thank you, Commissioner.

THE COMMISSION ADJOURNED AT 2.49 P.M.

THE COMMISSION RESUMED AT 3.20 P.M.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: If I may, I propose to call Dr Charles Nankivell.

COMMISSIONER: Yes, certainly.

EDWIN CHARLES NANKIVELL, SWORN AND EXAMINED:

COMMISSIONER: Please be seated, doctor, and make yourself as comfortable as possible. Do you have any objection to your evidence being filmed or photographed?-- No, that's okay.

Thank you.

MR ATKINSON: Is your name Edwin Charles Nankivell?-- Correct.

And do people normally call you Charles?-- Correct.

And you're a surgeon, Dr Nankivell?-- Correct.

Doctor, you provided a statement to the Commission?-- Mmm hmm.

Could I show you this document?

COMMISSIONER: Just not to the Commissioners. Can we have copies?

MR ATKINSON: Dr Nankivell, is that the statement that you prepared?-- Correct, it is.

And are the contents of that statement true and correct to the best of your knowledge?-- They are.

Commissioner, I tender that statement.

COMMISSIONER: Yes, the statement of Dr Nankivell will be Exhibit 211.

ADMITTED AND MARKED "EXHIBIT 211"

MR ATKINSON: Doctor, did you also send the Commission a letter dated 18 July 2005?-- Yes, I did, in response to discussion paper 6.

Can I show you this letter? Is that a copy of the letter you sent the Commission?-- It is.

Doctor, if you don't mind, I might work back to front. The letter you sent in draws on your experience, I understand, and addresses discussion paper 6?-- Correct.

And there are discussions in that paper about whether it might be the case that VMOs are often a cheaper and better option than staff doctors, and your concern, I understand by the correspondence, is that if that suggests VMOs are better than staff specialists, that's not the case?-- Correct. Whether you're a full-time staff specialist or a part-time staff specialist or whether you're a visiting medical officer is purely a choice of the contract that you choose. It has nothing to do with experience or qualifications.

Staff specialists and VMOs should both be Fellows of their respective colleges?-- Correct. Same exam, same requirements for fellowship. No difference. It's purely a contractual matter between the doctor and his or her employer.

I understand in terms of efficiency, your view is that staff specialists are very efficient because they're on campus all the time?-- Well, that's correct. Under the award, when a visiting medical officer is on call, their actual on-call duties don't officially start until 6 p.m. because they're often out of the hospital. You've got to distinguish clearly between rural and city VMOs and staff specialist. There is quite a difference. See, in Bundaberg, for example - from Bundaberg Base Hospital to Mater Hospital is, sort of, one minute, to the Friendly Society Hospital is two minutes, whereas I'm currently working at Logan Hospital. Now, if the VMO happens to be at the Mater in town or, say, the Mater Redlands or Greenslopes, they can be a substantial distance away in time factor et cetera. So, for example, if there was a post-op problem, a catastrophe for example, or even a car accident, or a junior staff had a problem dealing with an unexpected adverse outcome, it's the staff specialists who are there on site, they're the people who do that sort of work because they're there.

All right. For similar reasons you make clear in your letter that your view is that staff specialists provide at least an equally high standard of health care?-- Oh, absolutely, and I'm certainly not running down VMOs, but the fact is if you're a patient of mine - whether it be in Bundaberg or at Logan - you see me at 8 o'clock in the morning and you see me at half past four in the afternoon, because I'm there every day. You might even see me at lunchtime if I'm concerned about something, because I'm there. You will find if a patient is in ICU, the sickest of all patients, the intensive care doctors prefer to have the staff specialist surgeons involved in their management, simply because they're there all the time. A visiting doctor may only be in the hospital one day a week or one and a half days a week. Now, again in Bundaberg, or in rural centres, the distance between the private hospital

and the public hospital - even in some city places - is so close it doesn't matter. But again, in some parts of the city the private doctor could be actually an hour away. So you do have to have a mixture. The emphasis has to be on a mixture. I couldn't survive without VMOs. I could not survive because of the on call roster. As I can easily make clear in my submission, in Bundaberg we had two full-time staff specialists, and that's a completely disastrous policy. It's a complete disaster, because you then have a one-in-two roster. Now, if you add up sick leave, conference leave, holidays, the usual stuff - there's only two of you - you're taking out three months of the year. There's one of you for what - when I was there, for 78,000 people. Now, one surgeon for 78,000 people - remembering in a country town you do everything. Now, if I'm at Logan Hospital, if a two year old child comes in, off to the Mater Children's. Head injury comes in, off to PA. Chest injury comes in, off to Prince Charles Hospital, et cetera, et cetera, et cetera.

The point you make is-----?-- You do everything, and you're busy.

In Bundaberg you really need to supplement or augment specialists and VMO?-- Absolutely. You'd go mad. If we had four VMOs, that's when the roster becomes acceptable.

There's certainly a place for VMOs, you say?-- Absolutely. You see, I've been reading that Bundaberg's an Area of Need. That is total nonsense. Bundaberg has two private hospitals. Now, my understanding is that private hospitals, if they don't make money, close. So you've got a town with two fully working private hospitals full of VMOs, and it's called an Area of Need. Something is wrong in the logic there, isn't there.

COMMISSIONER: Doctor, if I can interrupt, firstly, I'd like to say thank you for your response to the discussion paper. The whole point of putting them out there is to get feedback, and we're particularly grateful to get your feedback. The passage that you refer to was, of course, taken from the evidence we heard from Dr Molloy, and whilst it's not my function to defend Dr Molloy, I think to put it in context, Dr Molloy was referring quite specifically to the situation in country areas where staff specialists may not necessarily be of the highest standard, and when we look at the principal focus of this inquiry in Bundaberg, it does seem in retrospect - not even in retrospect - in prospect it must have seemed disappointing that with private specialists in town of the calibre of some of those who are available in Bundaberg-----?-- Yes.

-----that the hospital didn't have the advantage of their input?-- Correct.

And I think it's in that context, that when a staff specialist like Dr Patel is compared with people like Dr Thiele and Dr Anderson, for example, there is a lot of force in the proposition that they're more experienced, better qualified,

make more efficient use of the resources and so on?-- Yes. You've got to distinguish the staff specialist who is Australian qualified-----

Yes?-- -----and someone whose qualifications have not been recognised as being equivalent or - et cetera.

I think from our viewpoint what it comes back to is this: everyone tells us - and I'm sure you wouldn't disagree - that there is an overall shortage of doctors in Queensland, in Australia, and indeed worldwide?-- Huge, yes.

In rural areas and regional areas there's going to be a difficulty attracting the very highest calibre of medical practitioners. In that sort of situation, one of the solutions to the problem is to make maximum use of VMOs where they're available?-- I totally agree. I trained in New South Wales, which is a VMO system, and it worked perfectly fine.

Yes?-- I did about a year of my training in fact in Wagga Wagga in New South Wales, and it's fantastic, the VMOs.

I was in fact just commenting yesterday when Dr Anderson was giving his evidence, that what does seem extraordinary about this is that Bundaberg - as you say, it's almost laughable to call it an Area of Need when they do have an extraordinarily high quality of private specialists available in the town, and yet the base hospital was making little or no use of them?-- Yes, well, that's in my submission.

Yes?-- There was a feeling that VMOs were not wanted, and that was asked at one of the meetings with one of the head people in Queensland Health, and they denied that there was a policy of discriminating against VMOs, but all the VMOs felt that they were unwanted.

And I think when you look at our discussion paper, really the conclusion is expressed in paragraph 14.2, which is precisely the one that you'd make, that the quality of medical services can be improved by making greater use of Australian trained VMOs rather than overseas trained staff doctors?-- That is totally true. It was purely paragraph 11 that I disagreed with.

Yes?-- The rest I totally agree with, and we could have made wonderful use of VMOs in Bundaberg. For example, most of my time there we had ear, nose and throat surgeons at the private hospital. Now, in theory they could have done half a day a fortnight rather than having to send children to Brisbane who needed their tonsils out or their little grommets put in their ears or things like that. We could have had an ENT service. Potentially we could have had a limited ophthalmological service. All those options were available, and they can be controlled. For example, when I worked in the UK, you wouldn't just appoint a doctor and say, "Here you are. Open slather. Do what you like." You might appoint an orthopaedic surgeon and say - I'm making it up a little bit, but, "You can could 20 knee joints to year, 10 hip joints." So you can

control the budget if you just select what you do, and if - you know, of course you may want to see - the bigger things or the more expensive things will have to go to Brisbane, but you can control what VMOs do in elective surgery. If you had, for example, an ear, nose and throat surgeon and you said, "You can only do these three operations" because they're quick, in-and-out, complications very low et cetera, et cetera, you can define what you do. There are possibilities.

Yes.

MR ATKINSON: Can I take you to the Bundaberg experience?-- Yep.

And take you to your statement. We might just walk through that, if you don't mind?-- Thank you.

Your primary degree is from the University of New South Wales?-- Correct.

You're a Fellow of the Royal Australian College of Surgeons?-- Yes.

And also the equivalents in England and Scotland?-- Correct.

You worked at Bundaberg Hospital from 1995 to 2002?-- Yes, I did.

That would mean, I understand, that when you started, the superintendent would have been Dr Brian Thiele?-- That's right. He was the superintendent. Dr Anderson was the Director of Surgery.

And Dr Strahan the Director of Medicine?-- Correct, and it was a positive hospital.

When you finished it would have been Dr Keating was the Medical Superintendent-----?-- No, no, Dr Keating came after I left. Mr Peter Leck was the District Manager-----

-----Dr Wakefield was the Medical Super?-- No, he'd left by that stage. We'd had a lot of trouble after Dr Thiele left in getting a superintendent. We had -Dr John Wakefield did the job for about 18 months. Dr Kees Nydam did it for a while. What - we didn't have a fully qualified person - John Wakefield at that stage was still in training. I think this was his first major superintendent job.

He'd come across from England, I think, in 1999?-- He'd come to Gin Gin before that, and he was the super at Gin Gin, which is a small GP hospital, and then he moved to Bundaberg.

Okay. The time when Dr Anderson - you were working there with Dr Anderson as your director, Dr Strahan is there, and Dr Thiele?-- Yes.

Did things work differently to how they worked later when Dr Thiele had left?-- Yes, they did, but it was a gradual

downhill slide. It would be wrong to just blame it on one thing or one individual.

I'm not interested in personalities, but how did they work when they worked well?-- It was a positive hospital. We genuinely believed things were going to get better and better and better. By the time I left, moral was destroyed. Everybody was distraught, basically. There was anger and bitterness. It was a destroyed hospital by the time I left.

Can you compare and contrast - in the good times, tell me about how the hospital operated. What was so good?-- Just felt you were working with people who were go-ahead type people. It's very hard to say. Dr Thiele was such a positive personality, a fantastic surgeon. He wanted to do big things. He wanted to get the hospital moving. He wanted to increase funding. He wanted to improve things.

And in terms of models for Director of Medical Services, he seemed to have a bit of a player/coach model. He did some surgery as well as-----?-- That's right. He was the last clinician to take that role.

And he was doing vascular surgery?-- He was doing vascular surgery, which was a once in a lifetime opportunity for Bundaberg that will probably never happen again.

In that period of his term, which was from about '94 to '99, there were two surgeons, yourself and-----?-- Dr Anderson.

And you were a recognised training facility?-- Yes, yes. Can I just crush one thing straight away. This idea that surgeons are trying to stop other people from becoming surgeons is just nonsense. It's extremely offensive. It is totally untrue. We wanted - this is true. We wanted to get new people in, Dr Anderson and Dr Thiele put in the submission to the College, we got it done. Since I've been to Logan, we put in a submission, we got a trainee for Logan. Put in another submission, we've now got two trainees for Logan. We've now got an orthopaedic surgeon in training. The College is-----

You have to go slowly for the stenographer. She's copying down what-----

COMMISSIONER: In any event, I think you're preaching to the converted. We heard evidence this morning from Dr Young from Queensland Health who confirmed unequivocally that the colleges provide training for every registrar and traineeship position that exists, and the difficulty is the training positions, not the willingness of the colleges to support the training?-- That's true. You see, our campus is the public hospital system, and I'm the old school. Because I trained in the public hospital system, I'm still loyal to it. That has to be acknowledged. Our campus is the public hospital system, and we should be grateful for that, and we need support from the public hospital system to continue doing it. The average age of general surgeons is in fact 54. That's in the current edition of the Australian Medical Journal. So we're a very

ageing group of people, general surgeons.

MR ATKINSON: That's partly, I imagine, because people are becoming surgeons for the first time much later?-- Yes, much later. One of the disasters of modern medicine - now I'm sort of preaching here, but the universities have gone down the wrong track. We have a very huge workforce problem, and we're training our doctors far too late. Someone invented this idea that you should do an unnecessary degree before you go into medical school, based on what I consider to be bogus research. So I did my final consultant exams at age 30. I got my ticket when I was 31, which was normal in my time. Now I'm teaching people who are 31 how to stitch up skin. They're doing an unnecessary degree first and they're coming out old. Now, the research is bogus, because what they've done is compared the new and the old interns. I was a 23 year old intern. You compare me to, say, a 28 year old intern. These ones are much more mature and have got more communication skills, but I think that's a bogus comparison. They should be comparing a 28 year old intern with an old style 28 year old person who is already taking out appendixes, doing on-call, got maturity in them. I don't think we have the luxury to have post-graduate medical education. I think the universities should change to undergraduate medical education, but they must have an interview, because we don't want to get the wrong people in. You can't just be chosen on the basis of good marks and a Higher School Certificate.

Then they'd come out the other end younger?-- And then they have more time in the workforce. We've made a huge mistake.

COMMISSIONER: It's been suggested to us that these problems are exacerbated by a number of things. One is that the current generation of graduates just aren't interested in working the long hours that you probably had to when you went through?-- That's true.

And secondly, the increasing feminisation of the medical graduates means that there is a proportion that aren't going to remain full-time career doctors?-- That's well published, yes. It's a huge problem.

You're getting value for money by giving this evidence because, as you know, Sir Llew is also Chancellor of the University?-- I wasn't aware of that, but I can say, Sir Llew, it's a huge mistake, that we don't have the luxury to have our graduates so old. Perhaps Newcastle University might be a good example. They have both undergraduate and graduate entry. They have a mixture to get a balance of people, but it's just - but you're right. My generation is the end of the baby boomers, the boy scout generation. We worked the long hours, and it's just that people have different attitudes these days. That's going to be a huge problem right across Australia, not just Queensland Health.

D COMMISSIONER EDWARDS: My only defence is that I graduated at an older age because I was made to become a tradesman first.

MR ATKINSON: It's a useful degree. Can I take you back to the specifics of Bundaberg before we get into the big picture. As I say, you worked - there were two surgeons on staff. There was you and Pitre Anderson?-- Yes.

And you had a registrar at the time-----?-- We had a registrar and a PHO who was trying to get on to the training program. So one senior, one junior.

And I guess having the registrar there helped in terms of giving you time off?-- What registrars can do - you see, our emergency department was a shambles basically because - I'm not trying to be rude to people. Most of the time it was staffed by junior doctors. In fact sometimes at night the surgical registrar on would be an intern, an unregistered doctor. So when you get an unregistered doctor being on the phone, has no experience at all, trying to describe what's coming in the door, you have no idea whether the information they're giving you is valid or not. So you've got to come in and see them yourself. When you've got a trainee registrar on the phone, they can tell you - ring you up and say, "Sir, this is it" bang, bang, bang. It's nicely explained. You know that they've made a proper assessment. You know it's intelligent. You can make a judgment based on that.

You know whether you have to come in?-- Absolutely. You don't with a non-trainee.

We've heard evidence from an American doctor, actually working at Rockhampton Base, that if your emergency department operates well it has flow-on effects for the rest of the hospital?-- Absolutely. Absolutely.

And as you say, if you have a good play maker, the registrar, they can work out how things are allocated much better?-- Exactly. The emergency department affects everything. I can remember being in Bundaberg casualty at midnight, and obviously tired, seeing a patient who has been there since 6 o'clock in the evening, understaffed, under-resourced, doctors who don't know what they're doing, finally I get a call at midnight, when I should have been phoned at half past six. It wrecks your lifestyle, and that's what makes you leave.

Just concentrating again on what was good in that period that people seemed to speak fondly about under Dr Thiele, what else was good? Was the responsiveness of management different to how it was subsequently? Why was it so good?-- I think because Dr Thiele was the end of the old style manager. I mean, if the light bulb was broken, Brian would say, "Fix it", whereas now you have to go through a committee to fix the light bulb. It's broken. That may sound a joke, but that puts it - that was it. I went to so many committee meetings for seven years. It ruined my life. It wouldn't have mattered a jot if I didn't go to any of them, because nothing happens. The meeting culture gradually came in. You've got to have meetings and meetings and meetings that go nowhere. The targets came in, which was a huge disaster, and the

business model came in. Brian Thiele did say once you lower your standards by calling patients clients, you've lost the plot. Whenever patients are referred to as clients, all the nurses and doctors basically vomit, metaphorically, because we don't want to treat people - it's not a business. Okay? Once you treat people as a number and with targets and utilisation and graphs that have got to be right, and all these things, and you're not resourced to do it - it was just the whole system went bad, basically.

Well, so the corporatisation was a problem?-- Huge problem, because the people in Brisbane - and this is not being rude, this is simple fact. If you've never lived or worked in the country, you have no idea. That's just fact. It won't be just for medicine. It would apply for just about every profession. It is quite different. The people that we were talking to had no idea basically, and one of the problems was whenever Queensland Health came up to visit Bundaberg, on the rare times they spoke to clinicians, we were talking to a bureaucrat, and I don't think they were ever - they can't have been on the same wavelength. The whole model was wrong. It just doesn't work. I can talk to a bureaucrat about things that concern me and we're on different wavelengths.

When you spoke to Dr Thiele you were speaking to him?-- Same Wavelength.

Because he was a clinician or a Bundaberg boy?-- Both. See Brian was batting for Bundaberg and that was the problem. You see, Brian believed that Bundaberg should get better and better and better, and Brisbane didn't, and that was the issue. And that was, you know, one of Brian's big fallings out with management. Brian is a Bundaberg boy. He wanted what was best for Bundaberg. Management are not employed by Bundaberg people. Bundaberg management are the servants of Brisbane, okay. Brisbane says do this, they do that.

And they glean with Dr Thiele that what he would do is do whatever was needed, was necessary for the community and square it away with Charlotte Street later?-- He would try to but he didn't get away with it all the time. There is a classic story that's mentioned in Dr Theile's testimony. I think it is worth going through because this explains the foolishness of Brisbane.

You know about this story firsthand?-- Absolutely because I rang - I spoke to Dr Michael Delaney on the phone. He was a registrar about to do his final exams the following year, and he rang us up - and I spoke to him and said, "Oh, Michael, come and work for us." He said, "Oh, do you think there will be a job for us?" I said, "Yes, go and speak to Brian Thiele." Now, Michael is just about to graduate. He would be in his early 30s, he is an orthopaedic surgeon, which is as rare as hen's teeth. Our current orthopaedic surgeon, from memory, was about 60 years of age, okay, so you have got a 60 year old orthopaedic surgeon and you have got a guy who is 30 saying, "I want to work in Bundaberg for the rest of my life." And Brian took this and said, "Yes, let's get Michael in.", and he got squashed. So Michael came up to Bundaberg, no job. So he just went into private practice. Dr Thiele, you know, did what he tried to do, got a bit of money and scrimped and scraped, and gave him a part-time VMO job. But that's just a golden opportunity. There needed to be someone who had some sort of common sense in Brisbane who could say, "This is a town where all the orthopods are about to retire." We know - when you are 18 months in advance, he was about to graduate, but this wasn't some sort of, you know, sudden decision. And Dr Thiele had planned it. There is going to be a job for Michael, he is going to work here for 30 years. We lost him.

If you don't get them quickly, I understand they are likely to establish themselves in the private sector and be less receptive to the public sector?-- I think for the first three weeks Michael was a bit bored, and then three months later he was sort of turning patients away.

And it was very hard to get him back?-- Well, he worked as a VMO but only because he was a boy scout personality who wanted to be in the public system, but that is the ludicrous behaviour that was happening from Brisbane. It was just ludicrous.

Doctor, in your submissions you talk about - or your statement you talk about why you left Bundaberg and you say under that heading in paragraph 1 that there was a lack of resources?-- Yes, there was.

Can you elaborate upon that? What resources were missing?-- Everything, basically. Our funding was based on what I call an historical funding model, and Dr Thiele was always going on about this. He used to go to Brisbane and talk to people there and he used to come back livid. Historical funding model, which basically means you have been dudded in the past, you are going to be dudded next year. Your budget was just no good.

You might have to break that down for me. Dudded in the past?-- You didn't get enough money last year. We were a busy growing area, we needed more money and it was just so obvious. And I would like to go through the 19 attachments to try to prove this. I want to prove this is true; I am not making this up.

We will come to that?-- We were so badly under resourced that people died. I am going to try and prove that to you. Now, we - Brian Thiele was very livid about that and he fought very hard to get money but he just - just hit his head against a brick wall, you know.

I think Queensland Health called you the most efficient hospital in Queensland?-- Is that true? I used to say this is not true. I used to say we were the worst funded hospital in the entire Commonwealth of Australia and I based that on my straw poll. When I used to go to College of Surgeons meetings, we used to go around the cities and I used to say to my mates, "What's the waiting times at your hospital? What's happening at your hospital?", and I never found a hospital that was worse. Now - worse resourced. So they're saying we're the most efficient and that's pure yes Minister stuff.

COMMISSIONER: Doctor, you mentioned the problem with this historical funding model that you put, in terms of if you are dudded in the past you are going to be dudded again?-- Yeah.

It has been suggested the other problem with that model is that if you do have a bit of money left over in the current year, then there is this mad rush to go and buy new cutlery or China or something?-- That's true.

To fill out the budget?-- I mean, come June you have got problems in the operating theatre, you would run out of things, like the little white tapes people put across wounds, because they wouldn't buy them, you know, because, "We can't go over budget." So by the end of June you are running out of little things. Suddenly on the 29th of June you have got $50,000 and you have got two minutes to put in a submission how we can get rid of this money. I mean, this is the sort of things that were going on.

MR ATKINSON: And the problem then to your mind, is this right, is that clinical decisions were being decided for lumpy budgetary reasons?-- Yeah. I mean, the evidence is so obvious we needed more help. You know, I have always thought if a manager goes over budget, that might mean that the budget was wrong in the first place. But unfortunately it is a key performance indicator, I understand, for managers that you stay on budget. If your budget is wrong, you know, it is the patients who suffer.

COMMISSIONER: I have this perverse view that the main performance indicator in hospitals should be whether you save lives rather than whether you save money?-- But that doesn't get measured. That should be what quality assurance is; do the patients get better or not. I used to get these quality assurance data that used to infuriate me because it used to be length of stay, which is a financial indicator, and I used to get this thing with highlights. It would say this time period, my average patient for this stayed 4.3 days, when the stay average is only 3.1 days, you know, and this somehow made me feel bad, that my patient stayed 1.6 days longer than the State average. I mean, that's not quality. I want to know if my patients get better.

MR ATKINSON: Right. If I can just focus on the lack of resources, one of the main shortfalls in resources, I understand, was staffing, in that, as you said at the outset, there is two staff specialists?-- Yes.

That meant it was really a one-in-two deal?-- One in two. We used to get one of - Howard Kingston, one of the VMOs, to work Monday night. That came in '99 for a while. He couldn't take care of the patients the next day. The one in two is a lot worse than it sounds. Let's pretend I am on tonight. The terminology says I am on tonight, which, of course, is not true. I am on until 8 o'clock the next day. Of course, patients come in overnight, and so even though Wednesday could be my day free from on-call, it is not, I have got new patients to see in the morning and no allocated time to see them because you have got a full day. So it really is terrible. And if you ever wanted to go on holidays, it gets worse, because normally if you wanted to take holiday you do 19 days straight, because you would do two weekends in a row. So, you know, five-two, five-two, five, comes up to 19 days straight. Then you go on holidays for three weeks and the other poor fellow would just work straight through. When you came back from holidays feeling fresh, the other poor fellow was exhausted, so then you would do 19 days straight.

Just fishtailing?-- It was just awful. I sort of felt you never had a holiday for seven years.

And that problem could have been addressed quite squarely by better use of the VMO population?-- Yes, it could have, but it needed an input of funding to get more VMOs. It is as simple as that. It all comes down to funding.

Right. Now-----?-- There was a - there was a funding

application put in to get more surgeons but that was obviously rejected. I will come to that later.

That's in your attachments, I notice?-- Absolutely.

I am just working my way through. You spoke about funding and resource allocation. You have spoken about staffing?-- Well, the funding and resource allocation needs to have a bit more depth on it because I - it wasn't just we were badly funded, it was funding within the State of Queensland maldistributed. In other words, different hospitals don't all suffer the same dire problems. And I can give you a copy of a newsletter sent out by the Director of Medical Services at Bundaberg Base Hospital in December 2000 telling the GPs to send patients to Hervey Bay or advising they can go to Hervey Bay, which is about an hour and a half away, because there was no waiting list down there for surgery - see a doctor or for surgery. So here you have got one town, Hervey Bay, with no waiting list, and then you have got Bundaberg with this huge waiting list. Well, one has got to ask why.

And you think the answer is a political one, I gather?-- It is either incompetence or politics. I mean, you know.

COMMISSIONER: But it wouldn't take too much common sense for someone in Charlotte Street to say, "Possibly we have got an oversupply of surgeons in one town and an undersupply in another. If we make a surgeon in Hervey Bay available in Bundaberg for two or three days a week, that will redress the balance?-- It is so easy, Mr Commissioner, but that was not done. It is primary school logic. For example, in one of my attachments I speak about a 12 to 14 month wait to get a colonoscopy at the Bundaberg Base Hospital, okay, 12 to 14 months' wait. The day after I resigned and I went to Logan Hospital, I said, "What's the wait here for colonoscopy?" "Six weeks." Someone in Charlotte Street's got to say, "Hang on, what is going on?"

MR ATKINSON: That should be one of the benefits of a centralised system, that there is some coordination?-- You need a general at the top who can shift troops around to where the flanks are weak. It is common sense and it is not difficult, despite what they say.

COMMISSIONER: As I observed with other witnesses who mentioned this fact, colonoscopies, like endoscopies and some of the other diagnostic procedures, are the worst example because the whole purpose is prophylactic?-- Correct.

If you don't detect the problem, the polyp or the bowel cancer, whatever it is, at an early stage you are going to have a very sick patient-----?-- Correct. You have got-----

-----or a dead patient?-- You have got to distinguish between, say, mammography and colonoscopy because the two cancer screening tests are totally different. A mammogram aims to diagnose a cancer early-----

Yes?-- -----when the prognosis is favourable. Colonoscopy aims not to diagnose cancer, the aim is to diagnose a polyp at a stage where it can be burnt out and cancer prevented. So it is quite a different thing. So, you know, colonoscopies are incredibly important. Now, if you go through - do you want to talk about colonoscopies now?

MR ATKINSON: No.

COMMISSIONER: I was simply going to lead from that to the point that again we have heard the suggestion many times that waiting list figures are routinely misrepresented in Queensland because there is a waiting list for the waiting list, and diagnostic procedures like colonoscopies have been put forward as an example of that. If you are waiting 18 months to get a colonoscopy, then you go on to another waiting list after that for the ultimate surgery?-- Yes, you do. Colonoscopies - there is a problem with colonoscopies. It is more than the fact that there is a waiting list, it is the fact that with the stroke of a pen someone has crossed it off surgical waiting lists, okay.

Yes?-- So when you see the published data for surgical waiting lists, the endoscopic procedures don't appear. That's just a stroke of pen. It is a little computer thing. I put them on, I put them off. They don't appear. And the effect of that is two-fold: because they don't appear. Apart from fudging the figures, there is no incentive to fix the problem because they don't account as targets and when you have got a system that's focussed on targets and you have - now, colonoscopy represents 10 per cent of my work. It did in Bundaberg, it did in Logan. Dr Anderson, represented 20 per cent of his work. When we first discussed this with someone from Queensland Health, they didn't even know surgeons did colonoscopies and gastrotomies. They didn't even know that. That's when we started sort of having this fight with them, so it is not a targeted thing.

MR ATKINSON: But it is the subject of a waited separation?-- Yeah, but you don't get incentive money. See, if you go back to my 11th attachment, which is the letter from Dr John Wakefield to, I believe, Dr Pitre Anderson, he makes the point. And that's a very important letter. That's the one dated 22nd of May 2000. Now, if you read the second paragraph, he says - he talks about the current budget, doesn't allow additional medical and nursing staff, and he makes the point that endoscopies are not recognised as elective surgical activity. Once they are not recognised as elective surgical activity, there is no imperative on the hospital to do it because you don't get incentive money, it doesn't help your targets. It has been crossed off the important list.

D COMMISSIONER EDWARDS: But it could save lives?-- Not could, does. Does. And, of course, the reverse is true, Sir Llew. You miss your colonoscopy, you can lose your life.

MR ATKINSON: And the polyps turn into cancer?-- Absolutely.

And they become metastable?-- Absolutely.

COMMISSIONER: Even if you are a bean-counter and you don't care about the lives, it also saves money because removing the polyp now is going to be a lot cheaper than dealing with the bowel cancer in 12 months' time?-- Correct. If you go back to my attachments, attachment number 1 talks about a patient - this was on Dr Anderson's list - who waited longer than she should have, by which time her polyp had turned malignant. Attachment number 3, dated 25th of May 1999, the lady was now dying, so I reported this to the Director of Medical Services because it had been documented in a complaint she had waited too long. I am now documenting to the health service that this lady is now dying and that we believe that this was because the colonoscopy was delayed. My attachment number 2 refers to a patient with stomach cancer who waited six months to get her diagnosis of stomach cancer, which, of course, is awful. These, of course, are only samples. I haven't got most of the stuff. I can still remember a chap who waited seven months to have his cancer of the oesophagus diagnosed on the waiting list. That man chose to have no treatment; he chose to go home and wait to die. I still remember that. I still feel - I have this guilt about this, that it somehow is my fault. It is not my fault, but if you are the doctor - and I used to suffer stress at the endoscopy list, "What am I going to find today?" I would pick up the chart, "This patient has waited a year. What if it is cancer again."

MR ATKINSON: Eventually what they did was sent up gastroenterologists from Brisbane?-- Which was a flawed response. I am glad they are coming. These are great guys, I am glad they are coming, but the cost to fly up a doctor from Royal Brisbane - you know, taxi to the airport, whatever, plane up, they get there at 10 o'clock in the morning, they do a list, see some patients. They have got to finish about 3.30 to catch the 4 o'clock flight back, back they come. That costs a fortune. Now, numerous times, Derek Macgregor, who was one of the surgeons in town and a recognised skilful endoscopist, had offered to do lists to help us out. In fact, after Dr Anderson resigned, he did do a list for a while. When I went to Royal Brisbane in about April 2001 I spoke - it was either the Director of Medicine or the Director of Gastroenterology, and I said to him, "Why are you flying up a gastroenterologist when we have a VMO?" He wasn't aware. The problem at that time locally - Derek Macgregor has since left the town, but at that time there was a local solution. In fact, you will see that in, again, one of my attachments - that's the attachment - I am going to be - this is attachment number 9, letter from Dr Pitre Anderson dated 20th of April 2000. He talks about a patient who was on the waiting list at the Base Hospital who eventually gave up waiting, went privately to see Dr Macgregor and had their cancer of the oesophagus diagnosed. And Dr Anderson makes the comment "is one further patient who has come to grief while on the endoscopy waiting list." Then it goes on to say that Dr Macgregor offered to do an endoscopy list - this is the only time I have got it in writing, but I know this

conversation. Bundaberg was a small enough place. From time to time Dr Macgregor would say, "Yeah, I will do a list." Occasionally, even if I am on holidays five weeks of a year, he could have come and done this for five weeks. He was a busy man but the offer had been there. Now, I don't know the budgetary figures of flying up someone from Brisbane to Bundaberg - I think I saw it once, but I won't quote it - but it is enormously more expensive.

I guess the problem is worse in that doing gastrotomy work isn't just the purview of surgeons; there are physicians like Dr Martin Strahan?-- Correct.

Who did gastrotomies week-in week-out?-- Dr Strahan, in fact, was a VMO, and he did scope from time to time. He left. I did write in my attachment number 18 - I did write to the former Director-General, Dr Robert Stable and pointed out that whole issue of the endoscopy list to him, saying that with all this extra money we've gone from having three lists a week to now having three lists a week. Dr Strahan, he dropped out at that stage. I am not sure if it was the department - you will have to talk to Dr Strahan about that - but these are great guys, they are very talented. I am glad they fly up. Please don't misinterpret this, but it was done badly. It was done wrongly. And they started coming, I think, in 2001. Now, if you go back to my attachment number 1, I think the first letter I have about delayed diagnosis is 1997. My attachment 2 is 1998 where I said this is a repetitive problem, where I am talking about delayed diagnosis for cancer being a repetitive problem in 1998. And it just goes on. If you read all my attachments, a lot of it is about all the patients who came to grief on the waiting lists and nothing was done about it. You know, I mean-----

Doesn't seem to matter whether it was Dr Thiele as the medical super or Dr Wakefield?-- Correct. Now, can I state this very clearly, because I am out of step with some of the others: I have no personal problem with Mr Peter Leck or Dr John Wakefield and I make no criticism of them. They were polite, kind, helpful, friendly to me at all times. They had no money. Money comes from corporate office. So I do not blame the local management for these problems. These problems were discussed at higher levels.

You say - that first memorandum you took us to, it is from Dr Wakefield to Pitre Anderson, it is exhibit 200, of course?-- What's the date of that, please?

22 May 2000?-- Yes, I have got it.

And, of course, Dr Wakefield there candidly acknowledges the problem, and in the last paragraph talks about developing a brief report with a view to attracting more funds?-- Dr John Wakefield worked very, very hard. His office is 10 yards away from where mine was. John probably got sick of me saying how bad things were. He tried very, very hard. He makes it clear in this letter he has put in the business case to get more staff.

What was the problem? I mean, it seems so clear, you know, even to non-doctors that you needed endoscopies, gastrotomies generally. If you didn't have them, you had a bad consequence and you have senior doctors recording they are urgently needed and there are these terrible consequences?-- Correct.

It is championed, if you like, by the DMS of the hospital. Do you know where the hurdle was?-- To this day I am stumped, because we've documented and I have spoken about it to people, you know, higher up than Bundaberg people. So I am not blaming them at all. We had unsafe working hours, as I am going to come to later. We were in breach of the legislation. I have got that from the Medical Board. We have got unacceptable delays in diagnostic procedures, documented patient deaths. Queensland Health publishes guidelines for how long patients should wait on an outpatients clinic to be seen. We were way over their guidelines. We couldn't see category 1 patients - by the time I left it was about 90 days to see a category 1 patient. Category 2 patients, which should be seen in three months, I forget, about 11 months or seven months. Category 3 patients I called the limbo list.

Yes?-- The trouble with that is unfortunately on the limbo list are a couple of cancers lying around, because, as everybody knows, we've all heard - even a non-doctor knows of people, they are really well, they went to their GP one week, "I feel a bit off." Three weeks later they have got cancer everywhere. So you get a letter from the GP saying, "This patient is a little bit off, nothing important." There is no alarm ringing on that. If you have a long waiting list, simple probability says somebody on that list must have unknown cancer. That's obvious. Breast screen's a classic example. You get 1,000 women on a bus, do mammograms, somebody would have cancer nobody knew about. Waiting lists have to be addressed. We were outside the government guidelines - sorry, the Queensland Health guidelines. The guidelines read beautifully. They come in beautiful manuals, client focussed, all that sort of stuff. I wrote to them and said, "What happens if you don't fill the guidelines?" So we can't fill the guidelines, we've asked for more surgeons, and we get turned down.

The problem, I understand, doctor, is that the clinical requirements weren't determining the budget, but rather the other way around. That's the problem you saw?-- Absolutely.

And I understand from the attachments that the other problem you saw in the system was this: that people were classified category 1, 2 or 3 by their general practitioner, but almost-----?-- No, we had to do that, which was something I actually refused to do. I work now at Logan and I refuse to code people.

Sorry?-- I refuse to do it. I let somebody else do it because the coding system is dynamite. How can I code a patient I have never seen? I will make mistakes and I feel it on my conscience. So I say to my director, "No, it is your

job, you code", because if you called someone a category 3 and they wait a year to get in and they have got a cancer, I feel really bad about that. It is not my fault but I feel bad about it, so I just say - if it is a private referral to me, I will code them. I will have nothing to do with the coding list.

Sorry, I thought I read in your attachments that a problem you saw in the system were that people were referred by their general practitioners?-- Yes.

But those people, by definition, if you like, didn't have the expertise to deal with the problem and maybe also to classify it?-- Yes, I did say that. Bundaberg, I used to do the classifications for some of the people and I hated it because, of course, you make mistakes. Because you're basing a judgment on a, perhaps, two-lined letter on a patient you have never seen. That's always going to be the case. But at least if waiting lists are reasonable, maybe it won't matter so much. I even wrote in one of my attachments that because category 2s have to wait 11 months, I am now frightened to call people category 2, so I am calling more people than I need to category 1 just in case, which then blows out the category 1 time, and the whole system falls apart. This is not just my opinion. You will see in my attachments a letter to Dr Barry O'Loughlin, who at that stage had an official position in Queensland Division of the Royal Australasian College of Surgeons, Dr O'Loughlin put a little ad in the three-monthly bulletin and said, "Look, we have got coding problems. We have got a problem. Write into me." So I wrote into Dr Barry O'Loughlin. I think that's in 1999.

COMMISSIONER: 10 August 2000, I think?-- 10 August 2000. And I have spoken to Dr O'Loughlin on the phone. This is a problem right across the State. How do you code patients when you don't know what's wrong with them?

And also the coding system is almost self defeating, because if you define a code 2 as someone who is going to survive for six months without treatment, but it is in fact taking 18 months for the category 2 patient to be seen, then they are not category 2, they have to be category 1 and it sort of swallows its own tail?-- It does. I don't know what the answer is at the moment. The ultimate answer is to have good waiting times to be seen at a clinic.

MR ATKINSON: Not just blitzes, but a regular infusion of funds?-- Yes.

And staff?-- Yeah. You know, that's the answer because there will always be coding problems.

COMMISSIONER: Yes?-- But if everyone is going to be seen in a reasonable time-frame, it perhaps doesn't matter.

Doctor, dealing with this question of waiting lists, I mean, without putting too fine a point on it, the suggestion that we've repeatedly heard is that the waiting list statistics put

out by Queensland Health are simply fraudulent, to say that there is a waiting list of X months is a distortion of the truth, when the waiting list is X months, plus Y months, Y months being the length of time it takes to see the surgeon in outpatients, and possibly add on Z months questions the length of time it takes then to have the diagnostic procedure before you progress to the waiting list for the substantive operation. Is that consistent with your experience?-- Look, every single person in the entire State knows that's true. All the patients know it's true because they have been on the waiting list before the waiting list, and all the doctors know it is true. So we may as well all say yes, it is true. The waiting list to see the outpatients shouldn't be called, necessarily, the waiting list to be on the waiting list. It is the waiting list to see your doctor, who will then decide if you need to be on the waiting list, but there is this hidden waiting list. We should just open it up and say what it is. Because until we open it up and say what it is, we can't deal with it.

MR ATKINSON: When you say waiting list, you should add the two lists together?-- You need to publish the two figures separately because then you can start to deal with it, because if you can say, "This hospital has a huge waiting list, this hospital's not so bad", you can now - GPs start referring to this hospital rather than that, resources can be shifted around. If we open it up, I think we can deal with it.

If it's transparent?-- If it's transparent. Whilst it's hidden, it's not going to be dealt with because it's going to be difficult to deal with, and I know that and I'm sympathetic to anyone who has to deal with it. There is no easy answer-----

COMMISSIONER: But, Doctor, the suggestion we have got is it is actually even more sinister than that and more deceitful because there are specialists available in the major tertiary hospitals to see patients but the patients aren't being given appointments because the administration knows that when that patient sees that specialist, the patient will then go on a waiting list?-- Yes.

And the statistics will look bad. So you've got specialists sitting in their cubicles at the RBH or the PA not seeing patients and the reason they're not seeing patients is to make the waiting lists look better than they really are. Is that consistent with your experience?-- I've heard first-hand of it happening at one particular hospital which I can name if you like.

There's no need to?-- But - and in my own hospital, that's been refused. My Director of Surgery has refused to do any form of manipulation. But it is - I know what you're saying, yes.

MR ATKINSON: And if you could-----

COMMISSIONER: When you say your Director of Surgery has refused, that sounds as if he's been asked or she's been asked?-- Yes, it was suggested that one of our doctors whose waiting list was too long - sorry, surgical waiting list. I've got be clear on my list. There's the operating waiting list, was too long and that he should cut back seeing the number of patients, okay. We know there's thousands of patients being - waiting to be seen and if he saw less in the outpatient clinic - I'm not saying that the motive was necessarily wrong; what I was told was the logic was it was unfair to put people in a list if they weren't going to get an operation. But either way he was suggested, shall we say, that he shouldn't be seeing so many patients because they would then be transferred from the outpatient list to the operating list.

MR ATKINSON: So there were-----?-- He refused and the director of my department has refused point blank. So it's not happening at my hospital.

And won't-----

COMMISSIONER: I'm sorry, Mr Atkinson.

MR ATKINSON: No, I'll stop.

COMMISSIONER: I'm going to steal some of your thunder for a moment. Doctor, you've told us a lot about problems. I hope at some stage we're going to come to addressing solutions and one of the things - bearing in mind your response to our discussion paper 6, I don't know whether that means you've looked at the other five and you agree with them or you have no comments on them?-- I have looked at most of them and I agree with basically everything I've read.

One of the issues that strikes me as tremendously important is autonomy within regional hospital administration. You've made the point and I think made it very well that people like Mr Leck and Dr Keating can't be blamed for operating within a system that starves them of resources?-- Correct.

But, on the other hand, if there were an autonomous administration responsible to the local community, they'd be kicking and screaming to get more money for their hospital or to re-allocate the resources so that, for example, Dr McGregor, was it-----?-- Yes.

-----is used to provide the endoscopies rather than flying someone from Brisbane?-- Yes.

There would be a sensitivity to local needs?-- Yes, I agree with that. I think there should be more autonomy locally but, at the end of the day, who do you screen to - do you know what I mean? The money will still be granted or your budget will still be granted from Charlotte Street.

MR ATKINSON: And it's done on an historical basis in terms of whether or not you have reached your elective surgery targets rather than what your needs are likely to be in the future?-- Well, the elective surgery targets get you incentive money and I'm not the expert to talk on that. There is, of course, general money for general running of the hospital. So it's not just obviously target money. But I - you know, the way they went about working out budgets was clearly quite wrong.

You don't know how they worked it out. You don't know where if there was a - as they do with the departments in the government, where each department makes a submission to the cabinet about receiving money. However they did it, which you don't understand how they did it, however they did it, it had a bad result?-- It had a bad result.

Okay.

COMMISSIONER: Mr Atkinson, it's obvious that we're not going to finish Dr Nankivell's evidence this afternoon and I think it's tremendously valuable evidence and I don't want to shorten the time but can I ask whether arrangements have been made with Dr Nankivell for him to come back tomorrow or at

some other time?

MR ATKINSON: We have been talking to Dr Nankivell about which option he would prefer, whether it was to work late or to come back tomorrow. I understand the doctor has a list starting at 1 o'clock tomorrow?-- That's right. I'm available in the morning. In the afternoon, I can cancel the list, obviously, but-----

COMMISSIONER: No, no, the last thing we want to do is to add to the problem. No, we certainly wouldn't want you to do that?-- I could be here from, say, 10 to half past 11, or 12 at the most, for a 1 o'clock list.

COMMISSIONER: Would a 9.30 or 9 o'clock start-----?-- Yes, I will be here, yes.

Because I also wanted to fix up some housekeeping things while I think of it. Dr Nankivell's statement includes a number of exhibits which refer to individual patients. I'm not sure what the situation is with these individuals but my inclination is to make a general direction that those patient names not be disclosed or published outside of these proceedings.

MR ATKINSON: That will be appreciated. No arrangements have been made with any of those patients.

COMMISSIONER: All right. Well, I make such a direction and I will again ask Secretary to ensure that those names are appropriately covered up when the statement goes on-line.

Also, I think I got the exhibit numbers wrong a little earlier. Just so we're all referring to the same numbers, Exhibit 212, 2-1-2, will be Dr Nankivell's statement.

ADMITTED AND MARKED "EXHIBIT 212"

COMMISSIONER: I will give a separate number 213 to Dr Nankivell's letter of the 18th of July 2005.

ADMITTED AND MARKED "EXHIBIT 213"

MR ATKINSON: Thank you.

COMMISSIONER: Can I also take the opportunity, by way of housekeeping, to mention to counsel and solicitors present we were planning to continue working a nine-day fortnight, to go through to Friday this week and then Monday next week, with Tuesday, Wednesday, Thursday in Townsville. I've been told

that this courtroom is required on Monday morning for the swearing-in of a new Magistrate, so we will have a delayed start on Monday morning at 10 o'clock or as soon as possible after that. Otherwise we'll continue sitting at 9.30 as usual.

MR ATKINSON: That's only a little concerning because Dr Strahan's being flown down from Bundaberg and I promised him - I understand we can't do anything about it, but if we could start as soon as possible after 10 because-----

COMMISSIONER: Well, I'll ask Mr Groth to inquire into the possibility of using a different courtroom so we can start on time. That would be the only other option I suspect.

MR ATKINSON: Thank you. Ms Gallagher acts for Dr Strahan but it would be greatly appreciated if he wasn't too inconvenienced.

COMMISSIONER: I think everyone here knows my view that doctors are important people and shouldn't be kept waiting if that's humanly possible.

MS GALLAGHER: Thank you.

COMMISSIONER: And that's not to put them in a different category to nurses and other health care professionals but we certainly don't want to keep Dr Strahan or anyone else waiting longer than necessary. Anyway, I will have Mr Groth make those inquiries and see what can be done.

MR ATKINSON: Thank you.

COMMISSIONER: Anyway.

MR ATKINSON: What do you propose to do this afternoon?

COMMISSIONER: Well, let's go through to quarter to 5 and then resume at - would 9 o'clock suit?-- Yes, yes.

MR ATKINSON: Doctor, you mentioned in passing working long hours?-- Yes.

What kind of hours were you working in Bundaberg generally or by reference to particular years?-- It's - the problem with rostered hours versus on-call hours, and this is something which you have to understand, you are rostered to work Monday to Friday between - you know, to do your 40 hours some time between 8 a.m. to 6 p.m. That's the award, okay. Out of hours is potluck, which is why Queensland Health can get away with saying, "We don't roster doctors on horrendous shifts." That's just a little, you know, trick basically in payroll. So if you're back at midnight, you're not rostered to be there at midnight but you happen to be there, my body doesn't know whether it's rostered hours, unrostered hours, time and a half or double time. If I'm there at midnight, I'm tired. And we have a very lousy award, so we still have to be back at 8 o'clock in the morning. What people don't understand is

that our time sheets bear no relationship to what we actually do. Let me give you an example. I get rung at 10 o'clock at night by the junior doctor. The doctor has a patient in casualty who is very ill, who needs to go to the operating room soon. I say, "Good. What time can we do it?" "Can't do it now, there's an emergency Caesarean section on." I say, "That's fine, ring me back." You get rung back at midnight: "We can't do it now." You get rung back at 1 o'clock: "Come in." So you come in and it's now half past 1. You do the operation and by now the adrenaline's running. You go home - say you're in for one hour, you go home at half past 2 or maybe 3 o'clock, if it's a long operation. What do you do at 3 o'clock in the morning? You don't go to bed I can tell you, and other doctors will tell you this. You have a bit of toast, you have a drink. You put the tele on. You watch TV marketing or something ridiculous to wind down. You get to sleep about 4 o'clock in the morning. If you're lucky you'll get three hours sleep and you're back at 8 o'clock in the morning. Now - but the time sheet will only record the hour and a half hours that you were in, even though you only got three hours sleep, talking to the Registrar arranging theatre. That sort of thing happens a lot. Now, say - take a simple weekend in Bundaberg. You're in at half past 8 or 8 o'clock in the morning to do a ward round of all the patients. You go home. 11 o'clock you see someone who has an appendicitis. They're not in the operating room till 2 o'clock, so you go home - you're in hospital for half an hour only; you go home for three hours. You go back at 2 o'clock. You take the appendix out. It takes you half an hour. You go back home. Remember, in Bundaberg everyone lives five to 10 minutes from the hospital. You then get called at 5 o'clock. You go in, see someone; "Yeah, needs an operation." You go back in at 9 o'clock and do it because you can't do operations until people have been fasting for six hours. So you may be in at 9 o'clock, you're back home at 10 o'clock. Now, the whole day's gone but the time sheet will - may record two and a half, three hours, if you're lucky. So a bureaucrat might say, "Oh, well, three hours' work. Wasn't much." The entire day goes. Remember, we don't have junior staff who can do the surgery for you. See, at Logan Hospital the junior doctor - sorry, the Registrar on the training scheme will ring me up and say, "Sir, we've got the appendicitis." I can say, "Fine. Do it. If you need me, give me a ring", because I can trust them, they're qualified to do that, whereas in Bundaberg you've got to do it yourself. So you're working around the clock. The same thing goes on Sunday. You get home about 10 o'clock Sunday night; back in Monday morning. You got to operate at half past 8 but now you've got a stack of new people to see, people that are sick, and it just goes on and on and on. Now, it might say we're off on Monday. No, you're not off on Monday at all. You're still working your normal hours. You've still got your operating list. You've still got your outpatient clinic and you've got to do operations that have come in over Sunday night which are yours. And then you've got the emergencies. For example, one of the crazy things Queensland Health did when they put the renal unit in Bundaberg, they forgot about the surgery. We've heard so much about surgical disasters in the renal unit. Now, to a

non-surgeon, establishing a renal unit in a town, you think that's a medical unit. They go to the medical ward, they have the dialysis, but every single one of those patients needs an operation. So as the renal unit came into Bundaberg, which was a fantastic thing, our surgical workload went up because they're sick patients, they're the sickest patients in the hospital and they're the patients that can't wait. So if Dr Miach rings you and says, "I need to dialyse someone", and they need one of those plastic tubes that Dr Patel got into trouble putting in, you got to do it. Now, when I was there, say with Dr Baker, I was the one who was doing - Dr Thiele and I used to do that. So, you're never free. You are never ever, ever free from new problems, urgent problems, and you had to work 12 days on to get two days off. And because I was the boy scout era, I worked for seven years free of charge every single Saturday morning to see my own patients. The only times I ever charged was when I had to actually operate. I did a free round to do the right thing for the patient. So you can say I've worked 13 days out of 14 but, okay, the 13th was my decision to do the right thing for the patients.

It is going to be very hard, if we've got a non-boy scout generation, to attract people to work similar hours at the expense of family and friends and-----?-- Well, they won't do it. You see, I was lucky; I went through university for free so I graduated with zero debt. I had about five cents in the bank but zero debt. Now they've got 40,000-dollar loans. I mean, that's nothing. Someone with a 40,000-dollar loan who's now 28 years of age, because I was 23, you just - we were little boy soldiers, we just did what we're told. If you've got a 40,000-dollar mortgage, you're not going to do a minute of overtime for free of charge.

So the call of the private sector is much louder?-- The call is much louder but one of the problems with Queensland Health is it's full of wounded soldiers. Dr Anderson is a very wounded man, so am I, and as I - whenever you talk to people at meetings, and I include nurses, Commissioner Vider, in this, everybody's got their bad story to tell. Everybody at some point's been done in by the system or feels that way. Whether it's a perception or whether it's truth, I'll leave that to other people to judge. One of the problems I have was with - I did hear some of Dr Jeanette Young's testimony. I've worked with Jeanette for a year. She's a particularly good person. I believe what she says 110 per cent. When she says, "Complaints are welcomed, we welcome complaints", she does. I have no doubt about that. But I don't believe the system does welcome complaints. I mean, how many - what more was I supposed to do? What more was I supposed to do? We complained, we complained, we complained. We went to my Director of Surgery - as I say in my thing, we went to the Director of Surgery, we went to the district - the Superintendent, the District Manager, the Zonal Manager, the Director-General, the - something we will probably talk about tomorrow was the mass meeting with the local member of parliament. This hospital was so dire that we all figured - you see, in Queensland Health, all our understanding is if you talk outside the system you get sacked, and all of

us were prepared to sacrifice our careers and we went en masse to see Nita Cunningham, the local member for Bundaberg, to complain about resources. We did not mention patient issues, I have to be clear on that. And I'm 99.99 per cent certain I didn't mention people were dying.

Do you remember what year it was?-- I believe it was about the year 2000. Mrs Cunningham will have the records and we'll talk about that meeting later. But we went outside the system. We went outside the system. I mean, the newspapers have made a big thing, and I don't mean that rudely, but a great thing about Toni Hoffman going to the parliamentarian and there has been a suggestion that the doctors perhaps covered up the mess in Bundaberg. That's not true. Five years prior to Toni Hoffman we had put our careers, put our necks on the line. We went outside the system, we broke the codes of misconduct and we saw our local member of parliament.

And that happened I think also in-----?-- And where else do you complain to? The only person we didn't complain to was the Queen, you know.

COMMISSIONER: It's an interesting point you raise, Doctor, and I have voiced my concern about this number of times. The more I think about it though, the more it strikes me that Queensland Health's so-called code of conduct is actually a contempt of parliament because it is, as you say in your statement, attempting to deprive people of their democratic right to spike to their local member?-- Absolutely. The people in Queensland Health are terrified of the code of conduct, particularly the nurses, because the nurses are much more vulnerable. Doctors, if they get sacked, can always go to the private sector. Nurses are - because they're a more vulnerable group, are terrified. But everyone's terrified. I mean, you'd be terrified. If anyone - if you understand that if you break ranks - we'd gone through the system. So when Jeanette Young says complaints are welcome, if she was - you know, I've got to say, "Sorry, I complained and nobody listened." What - I mean, please tell me what more I could have done. The only thing I could have done, which would have got me really into trouble, was talk to Lucy Ardern. Lucy Ardern was the editor of News Mail. Always knew something fishy was going on. She used to ask me for information. I can quite honestly say I never gave her anything but I probably should have.

MR ATKINSON: And I think-----?-- Because if we'd told her years ago how bad it was and it had come into the press, maybe the problem would have been solved.

COMMISSIONER: Dr Young, on the other side of the coin, admitted to us this morning that significant changes in recruitment practices and so on have taken place as a result of the Dr Patel issue?-- Yes.

And that's the tragedy of it. That you need something that dramatic, you need the whistleblower, you need a Toni Hoffman, you need a Mr Messenger to raise it. You need the Bundaberg

newspaper and the Courier Mail to talk about it before something gets done?-- You do. And can I refer you, Mr Commissioner, you will find very interesting - I can give you my copy - an article in the Medical Journal of Australia, 5th of July 2004. I'm very happy to give you my thing. This is written by a lawyer from ANU Canberra and Dr Steven Bolsin. Now, Dr Steven Bolsin was the world's most famous whistleblower. He was the chap who blew the whistle on the Bristol Royal Infirmary with the paediatric cardiac surgical deaths. What he's done is analyse - they've analysed three whistleblower sagas in Australia, the Camden one in New South Wales, the neurosurgery department in Canberra and the King Edward, I think, Memorial Hospital in Perth, and he states absolutely clearly that all these hospitals had ACHS accreditation and quality assurance stuff but only when people went outside the system did anything happen. Now, the problem with the code of conduct, it suppresses our democratic rights and it hides the truth. You see, there's a problem with it. If I tell the truth to the media, I get sacked but if people in administration spin doctor the media, they get promoted. Do you know what I mean? It seems to be wrong somewhere.

Doctor, what I'll ask you to do is to make that available to Mr Atkinson and we'll get it photocopied so you don't have to lose your copy?-- Thank you.

MR ATKINSON: Doctor, you were talking about the extent to which doctors within the hospital agitated this issue. I understand in December 2001 Dr Strahan, through the local medical association, published an article in I think it was the AMAQ newsletter about hospital problems and low morale. Do you have a recollection of being involved in that?-- I wasn't involved in that. I seem to recall that but I honestly, without reading it again-----

Right?-- I don't remember the context.

And you don't recall shortly after that the then Minister Wendy Edmond coming to Bundaberg?-- That was the country Cabinet. That's - that's a long story.

Do you have any first-hand involvement in that story or can you only repeat what other people told you?-- Rob Stable, that's Robert Stable, came to Bundaberg-----

That's right?-- -----about that time. And he had a meeting with the doctors.

But not you?-- Astonishingly - this was absolutely astonishing. What had happened was there had been a crisis in the paper. I'd quit and there was big headlines "Surgeon Quits". Then Dr Sam Baker resigned because he wasn't going to carry the can and do a one-in-one because when Dr Anderson left in 2000, about August 2000, I was just dropped in it like you wouldn't believe. I just had to do - work solely, basically, for most of three months with very little help, and I can talk about that later. So Dr Stable came up to Bundaberg. There was this crisis. Now Dr Baker was in the

paper. There was now officially no surgeons. I'd resigned - you've got to give three months' notice. I'd resigned, Dr Baker resigned, so there was nobody left. So Dr Stable flew up and he had this meeting with us at which he said, "Does anyone object to Dr Anderson being re-appointed?" And we said - no, there was no objections. So he said, "Okay. Dr Anderson's now re-appointed as a VMO", and he did comment at that time that he had 100 per cent faith in the District Manager. And I personally introduced myself to Dr Stable. I personally handed him my submission number 18 and I never got a reply and I thought, "Why didn't he talk to Dr Baker and myself?" At that time Dr Baker got what I call physiologically intimidated. Dr Baker was threatened, because he'd broken ranks, that he'd never ever be able to work in any Queensland hospital - sorry, public hospital ever again. I heard that both from Dr Baker and Mr Peter Leck. Sam was white, he was ashen. Sam was a big and bold fellow. I don't know if Dr Baker's put in a submission, but he was intimidated. And I call it physiologically because he was ashen, you know. And so, this - and yet, here's a doctor being intimidated. Why didn't Dr Stable speak to me and say, "Hey, you're leaving, I'm sorry about that"? It had been in the paper, there'd been - the patients had been up in arms, there was a petition, I know, went to the Health Minister in Canberra saying, "Get this doctor back." Nobody in Canberra rang me up, nobody in head office rang me up. Maybe I was arrogant but I really thought someone would just ring me and say, "Oh, we hear you're leaving. We're sad about that. Would you like to talk to us?"

COMMISSIONER: Is this about the time when Dr Anderson wrote a letter to the local paper pointing out what a tragedy it was that you were leaving and for his troubles got seriously slandered in parliament?-- Yes, that was the time. I can't remember the exact chronology but that was the time, when - yep.

You mentioned something about the country Cabinet. How was that connected with the incident you just described?-- Bad publicity.

MR ATKINSON: Your recollection is that you met - that Dr Wendy Edmond came to Bundaberg?-- I didn't see her.

No?-- But I understand that Sam's - Dr Baker's resignation was just before the country Cabinet, so it was a bad time politically to have a kerfuffle in the newspaper.

There were some discussions when the country cabinet came up and shortly afterwards Dr Anderson was reappointed?-- Dr Stable came up and re-appointed Dr Anderson as a visiting medical officer.

Is that a convenient time, Commissioner?

COMMISSIONER: I think that is. Does that suit you to adjourn now and come back tomorrow morning?-- Yes, yes.

Is 9 o'clock convenient for everyone else? I'm bearing in mind what Dr Nankivell said about the risk of burn-out if we work too long. I think we can manage 9 o'clock.

THE COMMISSION ADJOURNED AT 4.41 P.M. TILL 9.00 A.M. THE FOLLOWING DAY