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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 28/07/200

..DAY 29

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THE COMMISSION RESUMED AT 9.34 A.M.

COMMISSIONER: I apologise we're not as punctual as usual. There were administrative matters I had to deal with relating to the inquiry. Mr Perry, what a pleasure to see you here.

MR PERRY: Good morning, Commissioner. I seek leave to appear on behalf of Dr Sangeeva Kariyawasam who is to be called to give evidence today.

COMMISSIONER: Certainly. Such leave is granted. Mr Atkinson. Oh, sorry.

MR FARRELL: Your Honour, I take the opportunity to announce my appearance on behalf of Linda Mulligan. Farrell, F-A-R-R-E-L-L, initial S, is my name.

COMMISSIONER: Thank you.

MR ATKINSON: Commissioner, in terms of the order of events today, it is proposed, of course, to call Dr Kariyawasam as the first witness, Dr Peter Cook as the second witness and Dr Fitzgerald as the third witness.

Can I say this, Commissioner, a draft statement was prepared for Dr Kariyawasam from the CMC records. Of course, Mr Perry has added much value by sitting down in conference with Dr Kariyawasam and preparing a fuller statement. That only came to the Commission last night at 10.30 and the parties only got it this morning, so there may be some delay in people's readiness to cross-examine but I'm hoping that we can get through that. I say that particularly for this reason, Commissioner, because Dr Kariyawasam works at the Nambour Hospital and he has made himself available for today's events.

COMMISSIONER: Thank you. Obviously we give particular priority to the convenience of medical practitioners but that can't prevail over people's rights of natural justice. So that, if any of the representatives at the Bar table feel a need for some short extra time to review the revised statement, I'm sure we can juggle the witnesses so that the doctor is not excessively inconvenienced but everybody's rights are respected.

MR ATKINSON: Thank you.

COMMISSIONER: I take it that's suitable.

MR PERRY: He will attend at the Commission's convenience. We can arrange a suitable time by reason of his new posting.

COMMISSIONER: Thank you.

MR ATKINSON: I call Sangeeva Kariyawasam, K-A-R-I-Y-A-W-A-S-A-M.

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MR PERRY: Dr Kariyawasam has asked that there be not video pointing at him but audio is of no problem.

COMMISSIONER: All right. Yes, I will ask that - does the doctor have no objection to being photographed whilst giving evidence?

MR PERRY: I think we have been photographed fairly extensively outside and so, in that sense, that has probably already been achieved. But simply in the course of giving his evidence, audio is no problem but otherwise he would prefer not to be photographed in the particular precincts.

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COMMISSIONER: Yes. I will direct that Dr Kariyawasam not be photographed/video recorded whilst giving his evidence.

SANGEEVA KARIYAWASAM, SWORN AND EXAMINED:

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MR ATKINSON: Good morning, witness. Would you tell the Commission your full name?-- Sangeeva Kariyawasam.

Doctor Kariyawasam, you're a medical practitioner working at the Nambour Hospital?-- That's right.

You're working in surgery there with a special interest in urology?-- That's right.

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But you're not a qualified surgeon at this time?-- No.

Doctor, I understand that you graduated from the University of Queensland in 1998?-- Yeah, that's right.

Sorry, Doctor, perhaps I should start by doing this. Do you have a copy of your statement with you?-- Yes, I do.

Is that a sworn copy?-- That's correct.

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That's a statement that you have prepared with your solicitor and your barrister?-- That's right.

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

What's the date of that statement?-- It's dated the 28th of the 7th 2005.

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Commissioner, I tender that statement.

COMMISSIONER: Yes. The statement of Dr Kariyawasam will be Exhibit 221.

ADMITTED AND MARKED "EXHIBIT 221"

MR ATKINSON: Thank you, Commissioner.

COMMISSIONER: We can leave the doctor's copy with him at the moment because we all have copies.

MR ATKINSON: Doctor, you graduated from the St Lucia campus in 1998. You worked at the RBH from 1999 to November 2002?-- That's right.

You were respectively an intern, a junior house officer and then a resident medical officer?-- Yeah, that's right.

Over that period?-- Yep.

From November 2002 to April 2003 you worked in the United Kingdom?-- Mmm.

Doing, effectively, a working holiday?-- That's right.

You came back to the RBH in April 2003 and continued to work there, eventually as a PHO?-- As a resident medical officer again.

But then, I understand in the first half of 2004-----?-- That's right.

-----you became a PHO?-- Yes, that's right.

And you were a night reliever?-- Yeah, that's correct.

That means that you're there at night-time, not doing surgery as such but checking that the surgical patients are properly looked after?-- That's correct, yes.

COMMISSIONER: Doctor, you've been blessed with a very pleasant voice but not a particularly loud one. I wonder if you can possibly keep it up-----?-- Oh, sorry.

-----so that everyone in the room can hear you.

MR ATKINSON: It's the case, is this right, Doctor, that from July 2004 to January 2005 you were seconded from the RBH to the Bundaberg Base Hospital?-- Yeah, that's right.

And that's a common pattern I understand, that RBH RMOs or PHOs get sent to the Bundaberg base?-- Yes, that's correct, yes.

For a short, limited term?-- Yeah, that's right.

Now, when you went up to Bundaberg Base, you were involved in the non-training surgical program?-- That's right. I was on basic surgical training.

So you weren't part of a formalised surgical training

program-----?-- No.

-----to become a surgeon?-- No, that's right.

Can I ask you this, when you went up there, I see from your statement that you worked predominantly with Dr Patel?-- Yeah.

And that was about 80 to 85 per cent of your time?-- That's correct.

The rest of the time was with various other doctors?-- Mmm-hmm.

Is it the case that about 10 to 15 per cent of your time was with Dr Anderson?-- Yeah, that's right.

And that was with a special interest in urology?-- Urology, yeah.

So, maybe, nearly of all of your - 80 to 85 per cent of your time with Dr Patel, most of the balance with Dr Anderson and a small bit extra with various other doctors?-- That's correct.

Such as Dr Gaffield?-- Yes.

When you went up there and you're working with Dr Patel, all the work you were doing, is this right, was what doctors call general surgery?-- That's right.

Can you explain what general surgery encompasses?-- It mostly deals with abdominal related conditions, hernias, appendices, gall bladders, bowel related sort of cancer related surgery, skin lesions. There's a wide variety of surgical procedures but predominantly abdominal related.

Now, when you worked at the RBH, you rotated between the RBH and the Rbh Children's?-- Yeah, that's right.

Then you did the night relieving work?-- Yep.

How much of that time between 1999 and 2004 was general surgery?-- As an intern I did six weeks of general surgery. There was very little other general surgical experience that I have. Most of my - my sort of resident years was with various other units such as plastic surgery, ENT surgery, there was paediatric surgery, orthopaedic surgery.

And some vascular surgery I think?-- Some vascular surgery, yes.

When you went up to Bundaberg then, is it the case that there were many operations that you were doing for the first time?-- Yes, that's right.

Now, can you explain your duties, if you would, at Bundaberg. If I can take you to paragraph 8 of your statement.

COMMISSIONER: Perhaps paragraph 9.

MR ATKINSON: Perhaps paragraph 9, thank you, Commissioner. You explain there your role during a typical day. Is it the case then that much of what you did was administrative work?-- Yeah, that's correct. A certain proportion was administrative work and that would involve things such as organising outpatient appointments, follow-up appointments but it did involve clinical work such as reviewing patients and admitting patients through the emergency department and also assisting Dr Patel with surgery.

When you were involved in surgery you were the PHO in Bundaberg?-- That's right, yep.

And your role would include tying things off?-- Mmm-hmm.

Putting in the sutures?-- Yeah, just very simple sort of basic sort of skills that I'd sort of acquired through basic training.

And using the retractors?-- Yeah, mainly to - yeah, that was a lot of what I was doing, retracting, as well - and I'd be involved in simple surgical procedures as well.

Just to clarify, the retractors, they're an instrument that helps the surgeon get access to the abdomen?-- Yes. Yes, it's, yeah, basically exposing the operative area for the surgeon to operate.

And often a junior doctor does that to make sure that none of the organs are cut?-- You have to be careful that your retractors don't inadvertently damage other organs, but you place them in positions that expose the operative area where the surgeon is working and do it as carefully as you can. So it's just a measure to sort of give exposure, really.

Sure?-- That's what retracting does.

Can you say, Doctor, when you were working with Dr Patel, whether he would involve you or seek your advice as to whether or not the patient was somebody who should have surgery or some less intrusive form of therapy?-- No, he wouldn't ask me for advice, it was - it was the other way around. I would certainly ask him, as a consultant senior surgeon, for advice. I would have no decisions on surgical decision making, whether a patient needed surgery or not. All I would do is present the case and the history and findings to Dr Patel and he would make an assessment whether the patient needed an operation.

I understand that he was a much more senior doctor?-- Yes, that's right.

But, nevertheless, did he not consult with you at all about decisions?-- Not with regards to whether he needed an operation or not. He would ultimately make the decision, as the head of the unit. I would discuss what I felt - if I felt that the patient needed an operation, I would say, if he had

an obvious hernia, for example, and was causing pain and symptoms, based on my reading and knowledge, I would say, "I think this patient needs an operation", and Dr Patel would assess the patient and he would make - you know, I will just give my opinion but, certainly, I wouldn't certainly book a patient for an operation had the consultant not seen the patient, assessed the patient.

Did you have a role in deciding whether or not patients might be transferred?-- Again, it was only ever through the - with permission from the consultant. I couldn't transfer a patient without letting the consultant know.

When you had an operation?-- Yes.

Would you sit down with Dr Patel before the operation started and go through the plan for the operation?-- Not usually, no. Dr Patel would occasionally discuss patients in the outpatient setting. If, say, a patient had a hernia that was interesting, he would - he would bring me in and there might be a simple discussion about it, the procedure, but as a general rule, there wasn't a formal session before the surgery to discuss what we were doing that day.

Effectively, you would be there and then do as you're told?-- Yes, that's right.

Throughout the course of the operation?-- I wouldn't have much input as to what was on the surgery list for that day. Dr Patel would organise that list through the people in the operation bookings and he would organisation the list, organise what patients are on there. So I had very little input into that sort of side of the surgery. I would do the ward round in the morning with Dr Patel and then front up to theatre and have a look at the theatre list and-----

But you front up to theatre and find out on the day what surgery was on?-- And assist Dr Patel with the surgery.

Now, when you arrived in July 2004 can you say whether or not you were involved in an induction course at the hospital?-- Not a formal induction course. I was briefly introduced to the ward on my arrival and the brief set-up of the ward but no formal showing round of the wards or where things were. I think I received some basic paperwork about the layout of the hospital.

Can you say whether or not you were involved in a credentialing or a privileging process?-- No.

You weren't?-- No.

Had you been subject to such a process at the RBH?-- What do you mean a credentialing, sorry?

Well, a process where a committee works out exactly what your qualifications are and what you might be permitted to do within the hospital?-- No, there wasn't - there wasn't that

formal credentialing prior to me arriving. I was seconded from the Royal Brisbane and relevant paperwork would have been sent to Bundaberg Base Hospital----- 1

D COMMISSIONER VIDER: Doctor, did you have a position description?-- I was a principal house officer.

And you had that position description?-- Yeah, that's correct.

Outlining what your responsibilities were?-- Yes, that's----- 10

Can I just ask you one other thing. In paragraph 10?-- Mmm-hmm.

You have got a statement that says "a basic surgical trainee"?-- Yeah.

You don't mean there as a surgical trainee seeking qualifications with the College of Surgeons?-- No, I've been accepted as a basic surgical trainee with the College of Surgeons, so I was in my second year of basic surgical training while I was sort of working at Bundaberg Hospital as a PHO. 20

COMMISSIONER: But when you were at Bundaberg, as I understand it, it wasn't an approved traineeship for the College of Surgeons?-- No. As a basic surgical trainee you do various rotations with consultants. The hospital doesn't have a formal advanced training position but basic trainees go to various hospitals with consultants and get - and they get assessed by consultants at the end of their term. 30

So your time at Bundaberg would have counted as part of your basic training?-- That's correct, yes.

For the college?-- That's right.

MR ATKINSON: Doctor, when you arrived at the hospital were can you informed about whether or not there were any limitations on the kind of surgery that might be done there?-- No. 40

Now, you were there for six months. Is this a fair summary: you certainly didn't see anything glaringly wrong with Dr Patel's general practises as a surgeon?-- Not glaring. I certainly - I didn't feel that there was any obvious concerns with his operative technique. I did note that he was and could be quite aggressive in his manner and occasionally had a rude manner towards other nursing staff and other staff but nothing of great concern. 50

But, on the other hand, I understand you'd concede that you're not qualified to assess a surgeon at this stage of your career?-- That's right. It is my basic training that I'm on, as I have no other general surgeons to compare him to - I've worked with other various orthopaedic, vascular, plastic surgeons but in terms of the operations and the type of surgery, I really had nothing to compare his technique to.

Doctor, we'll come later to a letter that you wrote with Dr Athanasiov-----?-- Mmm.

-----giving some support to Dr Patel?-- Yes.

I understand that he had some good qualities. Can you tell us some of those qualities that you found useful and helpful and supportive to you?-- I think towards me he was quite pleasant. I feel we had a good working relationship and certainly in my experience on-call, I found that he was very available. If I was - had concerns or had questions that I needed to ask Dr Patel, he would be freely available. I could call him at any time. So in that regard I think, as, you know, a basic trainee, when you're out of your depth, it's important to have a consultant who isn't someone - or who is someone who is willing to help at all times. So that was quite - that was quite helpful.

I understand he was quite a strong leader?-- Yeah.

Very confident?-- Yeah, he was very confident, yes.

Tell you what to do and when to do it?-- Yeah, and he was very knowledgeable as well.

Happy to teach people?-- Yeah, he was always keen to teach the medical students and the junior staff, yes.

And generous when people went out socially?-- Yes, that's right.

COMMISSIONER: Doctor, I note from your statement at the top of page 3 you say that you'd had no prior experience with operations like oesophagectomies, anterior resections and colectomies, or total colectomies. I don't wish to force you into a position about giving an answer that you don't feel comfortable about giving but did you feel at that stage you were sufficiently experienced to form an impression as to whether operations at that level of complexity were appropriate to be done at Bundaberg?-- I felt that that level of - I mean, this is based on my experience, that certainly the bowel procedures that Dr Patel did, possibly the anterior resections and the colectomies, certainly were able to be done at Bundaberg. With regards to oesophagectomies, I feel that that may have been something that should have been done down in Brisbane.

And again, please tell me if you don't feel-----?-- Yes.

-----comfortable in responding to this but were your concerns, for example in relation to oesophagectomies, related to Dr Patel's own competence or related to the facilities at the hospital such as the available ICU facilities and so on, or related to the availability of other specialists as necessary, vascular surgeons and whatever you might need?-- I felt - this is all in hindsight and looking back on things. At the time there wasn't any concerns raised by me and Dr Patel came

across as someone who was very competent and confident to do the surgery. I hadn't considered the fact that had something gone wrong, I think maybe Bundaberg may not have been an appropriate setting to manage complications in these high level operations.

Yes. Thank you for that.

MR ATKINSON: Is that a function of the level of support you could expect from the Intensive Care Unit?-- Yes.

If the operation went swimmingly, that would be fine, but if there were-----?-- That's right.

-----any complications, you've only got two ventilated beds?-- That's right, and there were a lot of people coming through the emergency department, a lot of traumas. Certainly if someone was - had a complication from the a surgery, they would have stretched the resources.

And can you say whether or not it's been your experience at the bigger hospitals, the tertiary hospitals like the RBH and the Gold Coast Hospital I guess, that when you have a complicated case, you might have doctors from different disciplines-----?-- Yes, yes.

-----on the case?-- That's correct.

D COMMISSIONER VIDER: Doctor, did you understand that the Intensive Care Unit was classified as a level 1 unit, so there was an expectation, if you like a ceiling put on that hospital as to what its level of service would be?-- No, I wasn't aware of that, the level classification.

So you weren't aware that there were limitations by definition-----?-- No.

-----on ventilated patients, how long to keep them there, et cetera?-- No.

MR ATKINSON: Doctor, you mentioned that you can see some problems in hindsight. Is it the case that when you were there it wasn't something you really stepped back from and looked at critically?-- Sorry, can you repeat that?

You mentioned in hindsight you could see some scope for criticism about particularly whether complicated operations were done by Dr Patel?-- Yeah.

And my question really was this: whether at the time it wasn't something that you could really - you really did step back from and look at in a critical analytical sense?-- I think in terms of what I say in that statement, the bigger picture, I am sure - the trends that were occurring at Bundaberg Hospital over a period of two years, certainly I think there were issues relating to infections that was brought to my attention and those - in that scenario that would have probably been something that certainly people would have been there for, you know, two years, whether it be nursing staff, ICU staff, or admin, may have been able to sort of noted.

When you worked with Dr Patel, was it the case that you worked more or less in isolation? You weren't-----?-- Not necessarily in isolation. We worked with other staff and with ICU and theatre staff and with the ward staff.

I am sorry to cut and paste but can I take you to paragraph 25 of your statement?-- Yes.

You talk there about surgical audit meetings?-- Yep.

And there would be these monthly M&M meetings?-- Mmm.

But if I take you to paragraph 27, you make the point that there was little general discussion and little critical analysis. Can you explain that any further?-- I didn't feel that there was an adequate forum of discussion for - relating to adverse outcomes and how they could be best avoided in the future. My role there was to gather the data for the patients that had complications and present them in the presence of the other consultants and the junior doctors. Once I'd finished presenting that case, Dr Patel would take over and start the discussion. I didn't feel that he - it was an education session. It was more that he would state what had happened and there would be no discussion of how things could be adverted.

So it was more a case of Dr Patel explaining what he had been doing?-- That's right, yeah.

And not a case of him inviting other people-----?-- That's right.

-----to say how they would have talked about it?-- Yeah.

And people didn't, is that the case? They didn't say, "I would have handled that differently, I would have transferred

that patient."?-- No, no-one said that. 1

COMMISSIONER: I assume you have attended similar audit meetings or M&M meetings at hospitals like the Royal Brisbane Hospital. Are you able to make a comparison between the way Dr Patel conducted such meetings and how they are conducted in your experience in other hospitals?-- In my experience there would be various audits that were quite similar to Dr Patel, but as a general audit, probably more scope for discussion about complications, other consultants that would have more input and ask questions. In my experience, very few junior doctors raise their hand and made - and asked questions, it was more the consultant level at these audits that there would be a discussion about what happened and what went wrong. 10

Would you put the difference then at Bundaberg down to the fact that really there was Dr Patel as Director of Surgery and then a number of junior doctors but no-one much in between to be offering commentary?-- That's correct.

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MR ATKINSON: In the other hospitals, is this the case, doctor: that at the audit meetings, hospitals you have worked with have encouraged a no-blame, transparent, freely-speaking sort of environment?-- Yeah.

Whether it be with the senior doctors or the junior doctors?-- That's right. I don't feel at Bundaberg there was a blame policy. I don't think - it was just a forum where there was no frank discussion. Certainly I think maybe Dr Patel took over those audit meetings and expressed his views but no real questions were asked. 30

You mentioned earlier that Dr Patel could be aggressive sometimes. I understand that was particularly, in your experience, with nurse unit managers?-- I must say, I haven't really experienced a lot - saw a lot of events in which Dr Patel was aggressive. I do recall a conversation which I heard while I was down the corridor and Dr Patel was at the other end of the corridor. I think he was having an argument with a nurse, nurse manager. I can't say what they were talking about, but I did. 40

Generally you found him quite polite with his own staff?-- With the surgical staff certainly.

And quite polite with the patients?-- That's correct.

D COMMISSIONER EDWARDS: And would he be very willing to give you time to explain procedures and give you-----?-- Certainly. 50

-----the proper programmes for your training program?-- That's correct. There was a formal presentation or formal timetable for us to give presentations as junior doctors. He would also take medical students through tutorials. Occasionally if he was doing certain procedures he would - there would be a whiteboard adjacent to the theatre and he would draw out sort of what he was going to do.

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And that's common practice with a lot of surgeons?-- That's right.

So you didn't really feel his programs and activities were very different from any of the other surgeons where you have worked?-- Quite similar.

D COMMISSIONER VIDER: Doctor, you indicated that the PHOs at the M&M meetings didn't really raise issues in discussion or disagree with Dr Patel?-- It really wasn't any sort of questions raised by PHOs, junior doctors. Occasionally Dr Patel would, when I was in theatre with him, discuss certain procedures and complications.

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My question then is when he was in discussion with other members of the clinical team - for example, nurses - you said you didn't always hear what he was saying but sometimes would they be challenging what he might have been outlining as the clinical pathway for that patient and they might have had a different view?-- I can't recall any instances where he was challenged by the nursing staff. I felt, during that time he was there, he had a lot of authority, and I think there was probably a degree where maybe there was - I am not sure if I'd use the word fear, but, you know, because he could get aggressive and maybe people held back to a degree and didn't question or raise issues.

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Did you have a good working relationship with the nursing staff?-- Yeah.

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In terms of the working together-----?-- That's right, yeah.

-----for the clinical benefit of the patient.

MR ATKINSON: What you found, I understand, doctor, but tell me if I am wrong, is he was quite dogmatic. If he chose a path and someone sought to defer him from that path, he became belligerent?-- Yeah, that would be-----

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They are my words?-- That would be a fair comment.

That's a fair comment?-- Yeah.

But if you sailed the same course as him, things could be okay?-- Yeah. I would, based on my experience, ask questions and he would explain his reasoning. He was very knowledgeable and there was nothing to suggest he was - I didn't find any instances where he was going against what I really thought should have been done. I felt his management, based on my experience, was appropriate.

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D COMMISSIONER EDWARDS: And he was always accessible when he was on call?-- That's correct, yeah.

MR ATKINSON: You found out, is this right, doctor, soon after you came there that Dr Patel and Dr Miach weren't comfortable with each other?-- I didn't directly see any arguments or

confrontation. All I recall is that Dr Patel saying to me that he and Dr Miach didn't get on well. That's it.

And you were aware that Dr Miach sent his patients to Dr Gaffield, not Dr Patel?-- That's correct, yeah. I think Dr Patel mentioned that as well.

D COMMISSIONER VIDER: Doctor, we have received evidence that there is an opinion that some of Dr Patel's knowledge was a bit old fashioned, certainly in the management of patients requiring inotropes in the intensive care unit. Did you make any such observation?-- No. Dr Patel, if there was a patient in ICU, would often - we would start a ward round at about 7.30, and Dr Patel, as a general rule, would see the patients and discuss management with ICU prior to the 7.30 ward round. So by the time we turned up, the ICU patients had been managed or planned, set in place. So I didn't really see a lot of that.

Yes.

MR ATKINSON: On a related topic, if you did have a criticism of the doctor, it might be that he wasn't as ready to prescribe antibiotics as other doctors?-- I can't really say that as a general statement. I think Dr Patel would consider the use of antibiotics. In situations, there may not be an indication for antibiotics. If I did have concerns that a patient needed antibiotics, I would discuss it with him and he would explain his reasoning for not using antibiotics, which in most cases were - was appropriate. Occasionally if I felt there was something that needed antibiotics, I would press the issue, he would agree.

But you agree with the proposition that he was more reticent than other surgeons to use antibiotics?-- Maybe to a slight degree.

COMMISSIONER: And you wouldn't necessarily regard that as a criticism; just a difference?-- Yeah, just a - I mean, a lot of the surgery I hadn't had experience with, and so in terms of experience with patients getting complications, I am sure Dr Patel would have done a lot of surgeries and found out there was a high risk of infection, whereas based on my knowledge I really sort of - I was more likely to give antibiotics, but that's my inexperience, I would think.

MR ATKINSON: Doctor, can I take you to the issue of transfers? You deal with that to some extent at paragraphs 23 and 24 of your statement. Is it the case that sometimes you were between a rock and a hard place, in that nurses would come to you and say, "This patient should be transferred" and you would then take that to Dr Patel?-- I do recall maybe one or two situations when nursing staff in ICU had concerns with ventilated patients and suggested a transfer and what I would do is discuss that with Dr Patel.

Did he have a readiness to transfer or a reluctance?-- As a general rule I felt he was more reluctant to transfer

patients. I think he felt that he could manage them. Unfortunately, that would stretch the resources of Bundaberg ICU but he would prefer to keep them in Bundaberg.

Right.

COMMISSIONER: Did he ever offer any explanation for that or did he simply announce the decision?-- He wouldn't give a reason - well, he - I - what I gathered was that he felt he could manage it.

Yes.

MR ATKINSON: And the mechanics of transferring was easy. In your time there were lots of orthopaedic patients being transferred?-- That's right. In my experience on call, I would speak to the orthopaedic doctors and if they felt it couldn't be managed in Bundaberg, all the medical team were called to the clinical coordinator and the process was started, and a few hours later they were transferred.

In retrospect, I understand there are some patients that you would have liked to have seen transferred earlier?-- Yeah.

One of them is the man Mr Kempst?-- That's right.

And we will come to that later in more detail. Another you spoke about elsewhere is a man who came in for a toe amputation?-- That's right. He - he had a gangrenous toe that I felt should have been managed or should have been investigated, sent down to Brisbane. Unfortunately, the patient started to become unwell, started to get temperatures and fevers so Dr Patel made the decision to remove the gangrenous toe in Bundaberg, which subsequently failed to heal requiring an above-knee amputation. His - that patient's main issues were related to his heart, cardiac issues and the medical team was involved. I guess in hindsight it may have been more appropriate to manage that patient in Brisbane.

The patient died?-- That's correct.

And he was in Bundaberg for about four to six weeks?-- That's right.

And you don't know whether transferring him to Brisbane would have saved his life?-- That's correct. Certainly - I am not sure whether - what course would have taken, I can only speculate, but at the time he became unwell and it was felt that he needed an operation sooner rather than later.

COMMISSIONER: Mr Atkinson, do we have a patient number for that patient?

MR ATKINSON: I know his name but I don't have the patient code with me and I am not sure if he has been given a number.

COMMISSIONER: Don't waste time now. That can be sorted out.

MR ATKINSON: I think my friend Mr Harper might be able to identify the name. Doctor - it is P43, my learned friend informs me, thank you. 1

COMMISSIONER: Perhaps we just might ask the doctor to confirm that. The name is the subject of a suppression order, so it shouldn't be mentioned outside these proceedings, but was that a patient by the name of P43?-- I think so, yes.

MR ATKINSON: P43 ?-- Yeah. 10

Now, in paragraph 28 of your statement you speak about the catheter group. You have spoken already, of course, Dr Kariyawasam, about the frostiness between Dr Patel and Dr Miach. Can you tell us anything more about the catheters and your understanding of the catheter event, or is that all just hearsay?-- It is hearsay. I didn't or wasn't involved in any catheters.

In paragraph 29 and 30 you speak about this letter of support. You mention in the last sentence of paragraph 30 that the letter wasn't intended to be a critique or a support for Dr Patel's particular skills?-- Mmm. 20

Nor a criticism?-- No. We felt that as junior doctors he was very good to us, and the fact that he was on call when we were on call and he was readily available, was reassuring, specially when you have certain situations where you might be out of your depth or you may have a question. So in that regard, all that letter was stating was something to that effect, that he was quite good to his junior staff. 30

In paragraphs 31 to 37 you speak about wound infection and wound dehiscence. If I can just summarise what you say on wound dehiscence, it is the case that when you arrived there was a lot of talk about wound dehiscence?-- That's right.

And you understood it was a live issue in July 2004?-- Yeah.

But you personally didn't see a lot of wound dehiscence yourself?-- No, I only saw one and that was related to an infection. 40

You've worked now, doctor, in the RBH, the Gold Coast Hospital, some time in Britain and now a couple of weeks at Nambour. How common is wound dehiscence in your experience?-- It is very rare. Prior to that I hadn't seen any. I have heard of a few cases but, yeah, I would imagine it is very rare.

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In terms of wound infection-----

COMMISSIONER: I am sorry, Mr Atkinson, at the top of page 8 of your statement, if you can turn that up, you say that you "recall nursing staff describing instances of minor superficial/skin parting as wound dehiscence whereas it is my understanding that wound dehiscence refers to a situation where the deep tissue of the wound separates." Now, it is

that second category, if you like, that you describe as extremely rare?-- That's correct. I think that was a concern of Dr Patel, was the classification of the wound dehiscence. I wasn't directly involved in any of this but I do remember a conversation with Dr Patel and the CNC on the ward about the nature of wound dehiscence and how to classify it. That was sort of - I was doing something else at the time but that's sort of what I gathered they were trying to define.

The other category, if I can put it that way, that nursing staff were identifying, the minor/superficial or skin parting, that would not be entirely uncommon in your experience?-- Yeah, that would be more common. Sometimes it is not unusual to get a partial separation of the wound, and again that can be associated with infection and things. But that would be a lot more common than a deep wound infection - dehiscence.

We've already heard some evidence - and, doctor, you will have to understand I have got no medical background myself, so I can only ask these questions from what I have heard in evidence. But there has been some discussion about different techniques of suturing or stitching, one involving stitching each layer separately from the internal muscle or right through to the outer surface of the skin, and the alternative being simply to stitch up the entire separation in one go. We've heard that Dr Patel regularly used the latter, he simply stitched up the entire wound. Is that correct?-- Yeah.

The other practice that I have referred to, is that still a common practice or is that something that's a bit old fashioned and has gone out of fashion?-- In my experience it is the latter procedure that I have used or been taught to use.

Yes?-- Yeah. It may have been - the former procedure may have been used in the past but from my experience it is one layer deep fascia closure.

D COMMISSIONER VIDER: Can I just clarify that what are you saying now is the usual experience?-- The deep fascias closing in one layer and then the superficial skin is closed.

So it is a layer-by-layer closure?-- Yeah.

MR ATKINSON: Doctor, in paragraph 31 you speak about skin versus fascia dehiscence, superficial and deep dehiscence. If I can just confine you to the superficial dehiscence, how often have you seen that?-- It is not an uncommon thing. I can't tell you exactly how many times I have seen it but numerous times, and that can occur with anywhere on the body. A skin lesion can get a wound skin dehiscence so it is not an uncommon thing but I am not able to give you statistics about how common it is.

Okay. Now, you speak also about wound infection and you make the point that in your time at the Bundaberg Base there did seem to be an uncommon amount of wound infection in the surgical department?-- I did notice there was a high rate and

there were steps taken to try and investigate that - I think the CNC was auditing wound infections, both post-operative and there was a form to fill in in the outpatients if the patient had-----

That's not the CNC, that's the CNC?-- CNC.

N for November?-- Yes.

You make the point there were some changes, for instance, in the gear that was worn in surgery?-- That's right, that was towards the end of my term there.

COMMISSIONER: Doctor, did you yourself observe anything that could account for the apparent increased incidents of wound infection, anything for example relating to the way that Dr Patel or other staff scrubbed for surgery or any other features that struck you as being unusual or inappropriate?-- No, not unusual or inappropriate. I couldn't - there wasn't anything obvious that Dr Patel did that I felt was compromising sterility. I think part of the factor might have been the fact that he was doing a lot of bowel related surgery.

Yes?-- And certainly faecal contamination, there is a high risk. It is a different operation to doing - cutting out a skin lesion because you have a high rate of infection in those procedures. The other thing it possibly is, a lot of these patients would present quite late or with advanced stage cancers that required longer surgery or bigger surgeries and they may have contributed to a high rate of infection. I didn't see any instance where Dr Patel obviously compromised sterility in his technique.

We have heard suggestions, for example, that when he was doing wards rounds he might inspect a patient's wound - when I say the word "inspect", obviously do more than look at it, physically palpate the wound, and then move on to another patient without having washed his hands between patients. Did you observe anything of that nature?-- He may have done that. I can't directly recall any instance of that. Yeah, I do know he had a latex allergy to the rubber gloves that were on the ward, so I don't think he liked using them and was trying to get latex-free gloves on the ward and that might have been an issue that he may not have used gloves.

D COMMISSIONER VIDER: We didn't hear any evidence, though, he had a soap allergy. He didn't seem to be able to wash his hands either?-- No.

MR ATKINSON: To be fair, at paragraph 36 of your statement you make the point that you did observe of his hand scrubbing technique?-- Yeah.

For the most part - well, you didn't see a problem with it?-- No.

But I gather from your answer to the Commissioners' questions

about latex that you didn't study him-----?-- No.

It wasn't part of your job to watch his hands?-- No.

Okay. Doctor, with bowel surgery, I understand that the infection rate can be as high - the expected infection rate can be as high as something like 4 per cent?-- It can be.

And for other surgery maybe only one or two per cent?-- Depends on the nature of the surgery and how you classify the risk of infection. Skin lesion excise would be classified as a clean procedure, wheres a bowel operation would be considered a clean/contaminated or contaminated procedure because of the presence of bowel contents.

To be fair to Dr Patel, if he was here what he might say is, "One of the reasons I might have got more infections is because I was doing more surgery than anyone else."?-- Possibly, yes.

Was that the case? I mean, you have got these two big surgeons, Gaffield and Patel. How much of the work - how much of the surgical theatre time was taken up by Dr Patel? Just roughly?-- Well, they would share on call. They would each have various theatre sessions and all I could say is they probably operated equally in terms of the amount of theatre hours but the types of surgery would have been a little bit different.

And Dr Patel is this - well, was a real workhorse. He would do five in the list. If he was running late he wouldn't postpone the patient, he would work longer hours?-- I felt that he was - not keen to cancel patients and I think that he did have the patients' interests in that regard, he didn't like a patient to be placed into surgery and then be told they had to be cancelled because they ran out of theatre time, so he would push himself and theatre staff to get the case done, and if that meant running over, finishing theatre late, that's what he did.

And took some pride, I understand, in the fact that he could do a gallbladder operation in one hour?-- Not necessarily a gallbladder. I do recall him saying - talking about a bowel related procedure, that he was, I guess, proud that he could - I'm not sure if "proud" is the right word, but he could do it in three hours, whereas - with his technique, whereas with someone else it might take an hour or two longer.

He said to you, I understand, doctor, that he was well regarded by the administration because he was putting a dent in the elective surgery waiting list?-- That's what he told me.

But your evidence nevertheless is that he wasn't doing any more surgery than Dr Gaffield?-- I really can't comment on how much operating Dr Gaffield was doing. I wasn't attached to his unit. All I can say is that Dr Patel did four or five cases on his list, so he was working very hard.

Can I jump ahead again to the case of P21. That's a patient that we - there is no suppression order, doctor, so you are allowed to mention his name, Mr Kemps. That's a case - is this right - that you found quite traumatic?-- That's correct.

It stayed with you for many weeks afterwards?-- Yes.

The operation was, I think, the 20th or the 21st of December 2004?-- Mmm hmm.

Doctors must see bad things all the time. What made this one a little bit more traumatic?-- With regards to the second operation and being in a situation where it was difficult to control the bleeding. I'd never been in that situation before.

It was a bit special, I guess, in that the doctor knows the patient's bleeding, he knows that if he continues to bleed the patient must die?-- Mmm.

And to be fair, you've indicated in your statement and elsewhere that Dr Patel went for two hours to try and find the source of the bleeding, but there came a time when he just gave up?-- He - yeah, I got the impression that he exhausted ways or techniques to stop the bleeding, and decided that he couldn't do anything more for the patient.

Was that the bit that you found traumatic? That you hadn't seen that happen before?-- I think the whole - it was more the trying to - the procedure in trying to find the cause of bleeding and trying to stop it was - it was a very adrenaline-rushed charge sort of time in theatre.

Just to go through that in a bit more of the sequence, Mr Kemps came in - you weren't involved in his care or any clinical decisions until the day of surgery?-- Yeah, that's right. I'd briefly seen Mr Kemps for about two minutes just on a quick ward round with Dr Patel the day before, but I

hadn't assessed the patient or had laid eyes on the patient prior to that brief visit.

And you'd never been involved in an oesophagectomy before?-- No, that's right.

You hadn't even studied it at university?-- No.

It's a fairly rare operation. You can call yourself a doctor without talking about being trained-----?-- I hadn't sort of learnt about the actual operative technique, but I knew a little bit about the oesophagectomy, basic knowledge about it.

D COMMISSIONER EDWARDS: You would have been aware that it was a very major procedure both operatively and post-operatively?-- That's correct.

As would everybody in that-----?-- That's right.

MR ATKINSON: In the operation first of all they do a laparotomy?-- Yes.

You're there - Dr Patel's the lead surgeon, you were the PHO, so that was the second in charge, effectively, and Dr Athanasiov was the third?-- That's right.

And from time to time - I think in the second operation Dr Risson was there?-- Yeah, he was in attendance. I think Dr Athanasiov was scrubbed in as well.

COMMISSIONER: Do you recall if there was an anaesthetist present as well?-- Yes, Dr Berens, I think it was.

Right.

MR ATKINSON: They do - I'm sorry to use lawyers' language, but they do a laparotomy where they resect the stomach?-- They-----

Or lift it up?-- They mobilise the lower oesophagus where the tumour is located.

And they do a thoracotomy where they get to the oesophagus as well as the stomach?-- Mobilise the upper end of - through the chest mobilise the tumour from that-----

And that part of the operation with Mr Kemps went quite well?-- That's right.

And then when you turned him on his side, I think, the bellovac drains started to fill?-- That's right.

You say in your statement at paragraph 49 that you observed that the level of discharge reduced?-- Mmm.

But it didn't stop?-- It was slowing. I brought Dr Patel in to specifically look at that, and he and I observed it for 20 minutes, and it was decided that the bleeding was slowing.

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And this is happening in theatre?-- Whilst he's being transferred to the ICU bed. He's still in theatre at the time, but the operation is finished and he's being transferred to the ICU bed and on his way towards the ICU.

So drains are working and they're filling, but it's slower?-- That's correct.

He goes to ICU. In the meantime - is this right - yourself and Dr Patel go to perform another operation?-- There was another case on that theatre list, so we proceeded to do the next patient.

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And that operation took a little longer than expected because there were complications?-- That's right.

In the end I think it might have taken as long as four hours?-- I can't recall how long, unfortunately.

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And is it the case that in the meantime Dr Athanasiov is updating you on what's happening in ICU?-- That's correct.

Doctor, he was getting infusions of blood in ICU and you knew that?-- I think the discussions were made with Dr Patel. I think Dr Athanasiov and Dr - the ICU doctors were talking to Dr Patel and letting him know. I was just secondary to that.

Doctor, you were aware - is this right - that even though the blood levels - sorry, even though he was receiving very substantial transfusions of blood, his haemoglobin levels weren't rising?-- Yes, and that indicated a surgical cause for that, requiring a relook, or operation-----

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Can you explain how is it that you know from the fact that the haemoglobin levels aren't rising that the problem is a surgically related cause?-- The haemoglobin should rise if there's no bleeding. If there's ongoing bleeding it suggests that - if the haemoglobin is not rising, giving - it should rise by about 10 each unit of blood you give, and the fact that it wasn't rising despite giving blood product suggests that there was a source of bleeding.

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You go back into surgery with Dr Patel the second time?-- That's right.

And at that stage I understand that you were giving some advice, some help, some ideas to Dr Patel about what the source of bleeding might be?-- I, based on what I observed, made suggestions to Dr Patel as to what the possible cause of the bleeding could be. I wasn't sure myself. He was looking for the cause of bleeding. If I saw something, I said - I would suggest, "Could this be the cause of the bleeding, Dr Patel", and he'd look at it and make a judgment whether it was or not. I was only offering suggestions.

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COMMISSIONER: Doctor, I recall from Monday that Dr Risson used the word "frantic" in describing attempts - you don't

come across to me as someone who does anything too frantic, but would Dr Risson be correct in describing it was a fairly frantic situation in any event, where a fairly desperate attempt was being made to locate the source of this bleeding?-- Certainly the longer the procedure took the greater the urgency was. I think the use of the word "frantic" is inappropriate. Certainly I wouldn't have been shouting. I would have in a calm, collected manner suggested to Dr Patel, but certainly there was a great urgency in trying to find the cause of bleeding.

And in a sense that urgency is reflected in the fact that you, as a relatively junior doctor who had never performed or seen one of these operations performed before, were doing your best to try and assist Dr Patel to find the source of the bleed?-- Yes.

MR ATKINSON: You deal with that to some extent in paragraph 52 of your statement, and as the Commissioner says, you don't accept the suggestion that you were frantic, but certainly, as you said earlier, it was an adrenaline-charged environment?-- Certainly. It was an urgency to try and stem the bleeding as soon as was possible.

Now, there have been suggestions from other witnesses that Dr Patel was saying in the course of the operation, "This wasn't caused by my surgery. This wasn't caused by my surgery."?-- Unfortunately I can't recall that. He may have said it, but I can't recall him saying that.

Do you have much recollection of what other staff members - the nurses or Dr Berens or other people were saying?-- No, I was focused on the job at hand, and everyone has a role in theatre to do, and my role was to assist Dr Patel. So a lot of the communication outside, I wasn't - or didn't register.

Really, as you say, you take your lead off Dr Patel and you're listening to him-----?-- That's right.

-----and trying to cut out some white noise?-- That's right.

Doctor, you understood that the bleed was coming from the aorta?-- The oesophageal vessels coming off the aorta.

You thought there may have been - most likely possibility was there was a perforation or a cut to those oesophageal vessels?-- During the procedure those vessels were likely to have been lacerated or damaged, yes.

You knew the source of the bleeding, but you didn't really know the cause of the bleeding?-- The cause of the bleeding were those oesophageal vessels. The problem was accessing - or being able to access that and stem the bleeding.

D COMMISSIONER VIDER: Doctor, we've had evidence that Dr Patel's surgical technique may be described sometimes as rough, and he didn't always get access to the best surgical field. Perhaps with the benefit of hindsight and the further

experience that you've had since this time, how would you assess Dr Patel's ability to assess a surgical field? And where I'm coming from is if you are repeatedly unable to find the source of the bleeding, that's indicating to me, as an absolute outsider, that what was the technique that was used to establish a good vision of the surgical field?-- Initially it was very difficult to get an idea because there was blood in the abdomen. Once this was drained, the procedure would then be to systematically look for causes of bleeding. It's not something that was very obvious at the start, so that's where the difficulty lay. After a period of time trying to exclude other possible causes, the bleeding was narrowed down to that segment of the aorta. My role was to get as much exposure for the surgeon as possible, and also to use a suction device to remove any bleeding so that he could operate, basically, or so that he could see what he was doing.

Was there any time during this procedure, to your recollection, that Dr Patel requested that an attempt be made to find another surgeon?-- No.

MR ATKINSON: I think Dr Risson was called in at one stage?-- Mmm.

But he's a relatively junior doctor?-- That's right.

Is that right?-- That was to assist in the - assist Dr Patel with the surgery.

But I guess, of course, he's not a surgeon, Dr Risson?-- No, that's right.

D COMMISSIONER VIDER: And my question really was directed at going outside the hospital-----?-- No, not to see another specialist.

-----to see who might have been able?-- No, there wasn't any mention of that.

COMMISSIONER: Doctor, just going back to Deputy Commissioner Vider's earlier question, perhaps not specifically relating to Mr Kemps, but dealing generally with surgery performed by Dr Patel, are you able to comment on the suggestions we've heard about a certain roughness or brusqueness in the way in which he carried out surgery?-- I really don't have much to compare him to in terms of general surgery. I didn't feel that he was overly rough or his technique was poor. It would be difficult for me to make a comment on that.

Certainly. And similarly, if you feel it inappropriate to comment, please say so, but are you able to offer any comment on the suggestion that he generally exhibited a poor surgical technique in terms of getting a clear field of vision of the organ that he was working on?-- I didn't feel that that was - based on what I saw - an issue.

MR ATKINSON: Doctor, Mr Kemps died. That wasn't an outcome that you had been briefed on as likely - a likely possibility

at the commencement of the surgery?-- All operations have risks of death. Certainly he was undergoing a big operation. That was worse case scenario.

Any operation that involves general anaesthetic involves the possibility of death?-- That's right, and every patient, no matter how low the risk, should be informed.

It was a possibility, but-----?-- That's right.

-----did you consider that it was reasonably likely at the outset?-- It was a very unlikely scenario, but a possibility.

So the patient bled to death, and your understanding was that the bleed was surgically caused?-- That's right.

What discussions - or what did you do afterwards about whether that needed to be referred to the coroner?-- He told us that because we knew the cause of bleeding it didn't need to go to the coroner.

Because you knew that the blood leaks were coming from the aorta, Dr Patel told you that meant it didn't need to be referred to the coroner?-- That's right.

COMMISSIONER: Doctor, is it part of your training to be advised as to the circumstances in which a death should be reported to the coroner's office?-- Yep.

And would it be part of your understanding with that background, that if a death occurs during medical treatment which was not the expected outcome of the treatment, that should be reported?-- What Dr Patel's reasoning was that bleeding was an expected outcome - or a possible outcome, and because we knew the cause of the bleeding, then that was his reasoning for not taking it to the coroner.

COMMISSIONER: If a healthy 18 year old goes into hospital for - shall we say to have their appendix removed, we all know there's a chance - whether it's a one in 100,000 chance or whatever - that that patient will die because of the general anaesthetic, but you wouldn't describe that as an expected outcome of the procedure?-- No. The oesophagectomy had a lot higher chance of complications such as bleeding or leak, or even death. That would be a very unlikely scenario if it was an appendix.

I am genuinely concerned - and please understand this isn't directed at you, or indeed at Dr Athanasiov who signed the death certificate, but it does concern me that from the evidence we've heard, Dr Patel performed this operation on the footing that there was no initial expectation that Mr Kemps had more than the usual statistical chance of dying as a result of the operation, and yet after Mr Kemps did die there was a bit of sort of backfilling and saying, "Well, patients do bleed to death and that's one of the possible outcomes, therefore we needn't report it to the coroner's office." With the benefit of hindsight, do you agree that it's

troublesome?-- With the benefit of hindsight, yeah, it probably should have gone to the coroner's. That death certificate was left to Dr Athanasiov, but I guess thinking about it, possibly.

I also have to say, doctor, that I find it very disturbing that a surgeon who performed the operation delegates to a very, very junior doctor the responsibility for signing the death certificate. Would you agree that that's an unfair - unfairly onerous responsibility to put on someone who was merely assisting?-- Based on my experience, it's usually the junior doctors that would fill in the death certificate, and certainly Anthony was very competent. Should there be any problems, he would either sort of speak to me or Dr Patel, but when I was a resident in his situation, I would be the one filling in the death certificates.

For the future, do you think that should be changed? Do you think the-----?-- I think certainly that could be improved. The surgeon responsible possibly should write the death certificate himself, if that was an outcome.

D COMMISSIONER VIDER: Doctor, on reflection, could you see that Dr Patel's reasoning may be taken - perhaps given a different interpretation? He said to you that bleeding is an expected complication of surgery, and that part we can accept, but this was bleeding that was knowingly unresolved, which - another term for that, perhaps, is exsanguination, because our understanding of the description we've had of this procedure earlier is that the patient was closed at the third operation, knowing that that bleeding had been unresolved and that it was extensive?-- At the time Dr Patel felt that he couldn't do anything for the patient. He asked for the family to be called in and to tell them of - to discuss with them the problem, and so he - yeah - essentially closed him up with unresolved bleeding.

And I appreciate that you found this extremely stressful?-- That's right.

COMMISSIONER: And, doctor, let me assure you again that none of our comments are in any way intended as criticism of your role, or indeed the role of Dr Athanasiov. That should be clearly understood?-- Yep.

MR ATKINSON: Doctor, you made clear - this is unequivocal, I understand - that it is the usual practice that the very junior doctors fill out the death certificates?-- That's right.

The problem, do you agree, in this case - you weren't part of the planning or the clinical decision making about doing an oesophagectomy. You had no experience with it?-- That's right.

And even more so Dr Athanasiov. He was much more junior than you?-- That's right.

And both of you effectively, particularly Dr Athanasiov, turned up on the day and did as you were directed?-- That's right.

So you weren't in a very good position, either of you, to make diagnoses about the cause of death or whether it was an expected outcome?-- Well, that's right. Certainly it wasn't discussed - his situation and his scenario - or his presentation wasn't formally discussed with us. I do remember Dr Patel showing us the CT scan and saying, "This is where the tumour is and this is what I'm going to do", but that was at an unrelated - I think that might have been a week or so earlier. I again hadn't seen the patient, just saw a CT scan. So certainly we really had very little input and very little knowledge of the patient and the decision-making process.

And that's, would you agree, a good reason why it's hard for junior doctors to, in any meaningful way, complete a death certificate?-- I can see that there would be issues, especially with regards to expected outcomes, that filling in a death certificate - junior doctors may not realise whether - or be able to assess the risk of these complications or, I guess, the chances of these outcomes happening.

Dr Patel having told you that it didn't need to be referred to the coroner, that wasn't something that you considered independently of him?-- No, no, he stated that.

And to be fair to you, doctor, is this right: you were aware that Dr Berens and Dr Carter had gone to see Dr Keating?-- Yes, that's right.

So as far as you were concerned, more important people than you were looking at the matter?-- Yes.

COMMISSIONER: Or more senior people anyway.

MR ATKINSON: Sorry. Sorry.

D COMMISSIONER EDWARDS: Doctor, could I just refresh my memory about the signing of death certificates. As I understand, the system still is that the house officer or the resident medical officer on duty in the particular ward is responsible, perhaps with consultation with the consultant, to sign death certificates?-- If there is - in most situations the diagnosis and the cause is straightforward. Speaking from experience, if I did have concerns or had difficulty writing the death certificate, I would firstly speak to the next senior doctor, and the consultant if need be.

But it would be the junior doctor who technically will sign the death certificate?-- That's right, yes.

COMMISSIONER: Doctor, in this particular - or this type of case, distinguishing it from a case where a patient comes in in an emergency situation - for example, an internal bleed and you know the patient is going to die within a number of hours unless the situation is rectified, but in a case like

Mr Kemps, it's almost a cleft stick or a dilemma. If death was an expected outcome, then the operation should never have been undertaken. If death wasn't an expected outcome then the matter should have been reported to the coroner. In that sense Dr Patel can't have it both ways?-- I think death wasn't an expected outcome. It was a possible outcome, and this would have been discussed with the patient prior to that, so I'm not sure of the exact statistics as to how likely the risk of death from the oesophagectomy is.

MR ATKINSON: The questions, doctor, are really addressed at the criteria in the Coroner's Act about when something should be referred to the coroner, but that wasn't something that you had refreshed yourself on?-- No, no.

COMMISSIONER: Mr Atkinson, if you're moving off Mr Kemps, perhaps that's a convenient time to take the morning break.

MR ATKINSON: I had two documents I was going to show shortly and then I'm done on the Kemps matter, Commissioner.

COMMISSIONER: Thank you.

MR ATKINSON: Could you have a look at this document? You have a screen in front of you. It should light up. Is it lit? Is it illuminated? This is a histopathology report. You will see, Dr Kariyawasam, that it's addressed to you?-- Mmm hmm.

The comment that intrigues me - two things intrigue me that I'd ask you for your comments on. The first is it's dated the 20th of December 2004. Did you see this before the operation?-- Sorry, did I-----

See the histopathology report prior to the operation?-- No.

The other thing is down in the "Comment" section. You will see that it says that, "The findings favour origin in the stomach with extension into the oesophagus." I guess if you had seen this, and if Dr Patel discussed it, if the cancer was starting from the lungs or the stomach, it makes the operation, in a cost benefit, way less attractive?-- I can't comment sort of - and I don't have enough experience to comment whether the - if it was coming from the stomach would mean that it was less likely to be resected.

Sorry, this is the point I meant to make: if the primary tumour is in the stomach and the secondary tumour is in the oesophagus, unless you're somebody - a really, really, really good surgeon, you're not going to get rid of a secondary tumour and-----?-- That's right. I do note that there's metastases to lymph nodes. So it had spread outside the origin of where the tumour first started.

Your recollection is that you didn't see this before the operation even though it's addressed to you?-- I would have signed the pathology form. Is this on the date of the procedure? This is the actual pathology from the procedure. So once the-----

I see?-- Once the tumour is - or the operation is done-----

I see.

COMMISSIONER: I think there's some confusion. It says "collected 20 December".

MR ATKINSON: Yes.

COMMISSIONER: I assume that's the date of collection of the sample?-- That's right.

Then the report itself is dated the 22nd.

MR ATKINSON: So this would have been collected in the course of the operation perhaps?-- In the theatre, yes.

There's just one other document-----

COMMISSIONER: I suppose we can make these a single exhibit because they're both histopathology reports.

MR ATKINSON: Yes, Commissioner. Actually, I'll leave that one. There was one other one that I wanted to show you. Doctor, this is some pathology of the 10th of December 2004. It talks about various lymph nodes and problems in the lungs. It's dated the 10th, as I say. Do you know whether you saw that prior to the operation?-- I didn't see the report, no.

That is a convenient time for me.

D COMMISSIONER EDWARDS: Could I ask that that be shifted down to see - what is this report?

D COMMISSIONER VIDER: It's the CT report. It's the scan report.

MR ATKINSON: Maybe if you could scroll down, if you don't mind.

D COMMISSIONER EDWARDS: I've got it now. Thank you very much.

COMMISSIONER: The CT report dated 10 December and histopathology report dated 22 December 2004, both relating to Mr Kemps, will together form Exhibit 222.

ADMITTED AND MARKED "EXHIBIT 222"

MR ATKINSON: Thank you, Commissioner.

COMMISSIONER: We'll now take a 15 minute break.

THE COMMISSION ADJOURNED AT 11.01 A.M.

THE COMMISSION RESUMED AT 11.30 A.M. 1

SANGEEVA KARIYAWASAM, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Atkinson.

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MR ATKINSON: Thank you, Commissioner. Dr Kariyawasam, can I take you to paragraphs 62 through to 74. You deal with a patient who we have described as P26. You make clear that you're aware from the charts that he had three operations on 23 December 2004 but you had no involvement whatsoever in any of those operations?-- No.

And you're not in a position to have an opinion on whether they were done badly or well?-- No.

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The first time you saw P26 is on 28 December 2004; is that right?-- Yes.

By that stage Dr Patel had gone on holidays?-- That's right.

He left on Boxing Day?-- Yes.

There had been a handover to Dr Gaffield?-- Mmm-hmm.

And you were working at that time, were you, with Dr Gaffield?-- That's right. 30

In paragraph 65?-- Mmm-hmm.

You mention that Dr Patel wrote that patient P26 may lose some foot tissue?-- That's right.

So it was contemplated at the time of the handover that there might be a minor amputation?-- It wasn't handed over to me but on reading the notes, I made that - or that was the plan that was in place. It was a possibility. It wasn't saying that he would but I think there was a small chance that that might happen. 40

Was there any discussion from the 28th, when you became involved, to the 1st about transfers to Brisbane?-- No.

You mention, Doctor, that the patient was improving?-- That's right.

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Is that something you've been told or something you observed?-- That's what I observed. During the time I was there, I noted that the leg swelling was reducing and the mottling was reducing as well in the foot.

And then you make that point actually - in paragraph 69, but throughout the time that you were there, certainly the foot was still mottled?-- That's right. When I was first

introduced to the wound on the 28th, it was mottled then. On the subsequent days, I felt that that was slowly improving.

Right. Doctor, can I ask you to look at this document on the screen. Maybe if you could scroll down to the top of the document so we can see what - the heading. You can almost see that's a "Limb Observation Chart"?-- Mmm-hmm.

If you can look at the various categories there. It starts, of course, on the 27th of December 2004. I have, in a rudimentary way, de-identified the document but it is about P26, if you would take my word for it. If you look at the various categories - if you scroll down a little bit. And further. In those categories, I mean, at least on the 27th - that's the day before you start, wasn't it?-- Mmm.

On the 27th, certainly you see across the board that the warmth was cold, the movement is absent, there's swelling, there is patchy sensation and there's pain. Could I ask you to scroll down.

COMMISSIONER: We might also raise the focus a bit so we can see right across the page if that's possible.

MR ATKINSON: Reduce the document in other words.

COMMISSIONER: Yes, thank you.

MR ATKINSON: Just to cut to the case, Doctor, I'm asking you to look at this document because, on the face of it, to a non-doctor, it looks like there wasn't any steady improvement?-- The swelling, when I saw it each day, I thought was improving and the mottling colour was slowly improving. It was still classified as mottled but I felt that during the time I was looking after it, that that had improved.

COMMISSIONER: Was there a pulse in the foot?-- That's right, yes.

MR ATKINSON: That's dealt with in the second column, if you like, that talks about the pulse. I think the wording says "at the ankle"?-- Yes.

Can I ask you to turn over then. Now, can I ask you to look, Doctor, at the 30th of December?-- Mmm-hmm.

It talks there about, under the heading "Pulse", the first line seems to say "ankle only".

COMMISSIONER: What does that mean? Does that mean that's the only place you tested for a pulse or that's the only place a pulse can be found?-- I'm assuming that that was - that's where they looked or I can't say whether they had a look at the pulse on the back of the foot.

MR ATKINSON: The main development, Doctor, I understand is that in terms of warmth, he seems to be a little bit warmer

around the ankle?-- Yeah, the foot was always warm around the ankle because of the mottling of the - of the foot, the front of the foot appeared to be cool compared to the ankle. 1

Are these notes that you made or one of the nursing staff?-- No, they were nursing observations.

But they accord with your recollections?-- Yes.

COMMISSIONER: Under the "Pulse" column, about five items down it's got "TP" tick and "DP" cross. Can you interpret those abbreviations?-- The DP is a dorsalis pedis pulse. 10

Right?-- Which is on the back of the foot. And the other pulse should be PT, not TP, which is posterior tibial, which is behind the ankle.

Is that sort of at the Achilles tendon?-- Yes.

D COMMISSIONER EDWARDS: Could I ask, it was 1600 - sorry, the capillary return was obviously very extended rather than the three seconds - the 73 seconds, am I reading that correctly-----?-- Three seconds, greater than three seconds. 20

A massive change at that stage.

COMMISSIONER: No, I think, Sir Llew, it's badly written but it's like a greater sign than sign, like an arrow head, so greater than three seconds.

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D COMMISSIONER EDWARDS: Thank you.

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MR ATKINSON: Doctor, just to take you to the end of your evidence at paragraph 74, you were aware that on New Year's day P26 was transferred to Brisbane?-- That's correct.

Your observations were that there was no substantial decline in the last two or three days?-- That's right. Whilst I was there I assessed the wound twice daily and my feeling was that that was improving. I felt that on that - on the 31st there were signs of infection and what we did was look for causes of infection. I didn't think that the left leg was the main issue. Source of infection was found in the left groin and he was appropriately given or continued with the antibiotics but we also did look for other sources of infection. At the time I wasn't concerned about infection in the leg itself. The next day he still had further temperatures and a raised white cell count which caused concern and I had asked Dr Gaffield to come in and have a look at the patient.

Do you know - can you say why he was transferred on New Year's day as opposed to an earlier time?-- I think - yeah, what I think - just hearing from the doctors in - hearing what the doctors in Brisbane have suggested, it was a gas gangrene. My understanding of gas gangrene, it is a rapid infection that occurs over hours and I think that is possibly what may have happened, that this was an acute rapid infection that when I saw it on the morning of the 31st certainly wasn't evident.

Right. You can't comment on the vascular surgery and the extent to which that had a role in his condition?-- No, I can't. All I can say is there wasn't any blistering or obvious infection in that foot. I was concerned about the infection in the groin and his temperature sufficiently enough to ask Dr Gaffield to come in and review the patient.

Did you have any discussions with Dr Risson about the patient?-- Dr Risson was on that afternoon, so he, I think, came in and saw the patient. Reading from the notes I think he saw the patient actually on the 1st, on the next day, but Dr Gaffield reviewed the patient that afternoon.

D COMMISSIONER VIDER: Doctor, had you seen compartment syndrome previously?-- Yeah, I haven't had much experience with it but I have seen it.

Were you surprised that P26 was transferred to Brisbane or were you of the opinion that P26 could have remained in Bundaberg?-- Looking back, I think he probably should have been sent to Brisbane straight away, immediately after his first surgery, once damage control was achieved. When I arrived I was told that there wasn't a plan to transfer, he was improving and everything was - he had come out of ICU and that his leg was improving and the plan at that stage was to monitor his improvement and skin graft the fasciotomy sites.

There was evidence that when he arrived in Brisbane one of the words used to describe his wounds was purulent. You had no-----?-- The groin wound was the most likely source of that and that was a concern that I had with the patient on the

morning of the 31st to request Dr Gaffield to come and have a look at it. 1

There was also evidence that his general condition was such that the sepsis was so advanced that that was a concern for his general condition?-- When I saw him on that morning he certainly wasn't septic. We had done blood cultures the night before and they were negative. I think he had severe infection. What I think happened is that he developed this gas gangrene rapidly over the course of maybe the afternoon of the 31st and that's why he presented so unwell to Brisbane. 10

MR ATKINSON: Doctor, in retrospect you say that after the very first operation on the 23rd of December, which, of course, was the clipping off, the tying off of the femoral vein, and I think you have haemostasis after that, but as soon as the bleed had stopped, you think he should have been transferred to Brisbane?-- I think that's right. Once you immediately deal with the patient's problem and stabilise them, I think a vascular surgeon should have been called and he should have been referred. 20

Why do you say that? Why do you think it was worth a trip to Brisbane?-- It is acute vascular injury and there is no vascular specialist at Bundaberg Hospital. Dr Thiele I think was away at the time, so that's what should have been done, in my opinion.

You mentioned earlier that when you worked at the RBH from '99 to November 2002 you did some - you worked in the vascular surgery unit?-- That's right. It was just as a resident junior doctor. 30

What advantages does that unit have over the Bundaberg Base?-- Just there is specialist vascular surgeons that deal with arterial and venous related surgery. So Dr Patel wasn't a vascular surgeon, he was a general surgeon. So the best management would have been to send him to Brisbane.

Right. Doctor, can I take you then to P22? 40

COMMISSIONER: Well, before you do or before you go into any detail with P22, I have read what the present witness has to say about P22. That case isn't really relevant to our Terms of Reference, it didn't involve Dr Patel, there is no evidence of improper clinical management of the patient.

I am quite happy to indicate now that I have absolutely no concerns about the treatment of P22 and we can treat that as an irrelevancy, unless either you or anyone else wishes to say more about it, Mr Atkinson? 50

MR ATKINSON: I don't. I am grateful to my learned friend Mr Perry for eliciting that evidence because it was a patient that had been discussed in passing at the start and I thought, to be fair to everybody, I should explain that Dr Kariyawasam thinks it is much less sinister than I certainly thought at the outset.

COMMISSIONER: Not sinister at all, now we know the real facts.

MR ATKINSON: Yes, I won't take it any further.

COMMISSIONER: Thank you.

MR ATKINSON: Can I take you then to P52? That's at paragraph 86 and following. You were involved with Dr Patel in the management of P52? Can you say what options were offered to P52 prior to surgery?-- P52 was a diabetic with poorly controlled disease. From what I gather, very non-compliant at times. When she - the initial operation was to perform an amputation of the toes because the toes were infected and required an amputation. This was done but later she had problems with healing, and so Dr Patel made a decision to remove the leg or do a below-knee amputation. I wasn't involved in any of those decision-making processes. I assisted Dr Patel with the surgery.

If I can just address this issue squarely, doctor: it is expected there will be evidence from Dr Jenkins, who you may know from the RBH?-- Yeah.

It is expected that he will make three criticisms about the management of P52. The first is that he understands that she wasn't offered a bypass as opposed to an amputation, but that's not something you can comment on?-- No, I can't.

The second is that he understood, I understand, that there was no review by Dr Patel of the patient after the surgery, but that's wrong?-- Yeah, I saw the patient a few days after the surgery, and I felt that the wound was healing well. There was a small wound dehiscence at the outer edge of the wound but no obvious signs of infection. The sutures at that time were too early to come out. That was when she was last seen. The actual care of the patient was transferred over to Dr Miach's team and there was a consultant-to-consultant transfer. So that was probably about a few days after her surgery for the knee amputation. And, so, the medical team were directly involved in the patient's management, change of the dressings and things like that. And the only - and they were happy the plan on transferring the patient to the other medical team was to get her to be seen in outpatients.

Can I ask you this, doctor: Dr Patel reviewed P52 on 27 September 2004?-- Okay, I wasn't aware of that.

Sorry, it is in your statement, that's all. Paragraph 91?-- Was that on the ward round?

Sorry, I am asking questions about your statement, actually?-- Okay.

This is in paragraph 91?-- I see, okay.

That may have been gleaned from the chart, do you think?--

Yeah, I'd read the chart. We - on the 27th Dr Patel saw the patient on the ward round, and on that day that was when the transfer of care was handed over to Dr Miach's team. So that was the last time he'd actually seen the patient.

Can you say whether Dr Patel saw P52 between the date of the operation, 20 September 2004 and the 27th of September 2004?-- He would do a ward round each day. Every morning at roughly 7.30 he would see the patient.

And you know that or are you thinking that was his normal practice?-- She was on the surgical ward and each morning we would do a ward round at 7.30, and I do recall we seeing her because she was in the first bed of that ward - of that unit, so we saw her each day up until the handover was done.

Dr Kariyawasam, the third criticism made by Dr Jenkins is that the sutures might have come out before four weeks but I understand your evidence is that the lady had been transferred surgical to medical-----?-- That's right.

-----well before then?-- Yeah. I think the other issue is unfortunately the patient self-discharged two days after I had seen the patient and that wasn't anything that was handed over to me or the surgical team, and at the time there was no follow-up arrangements made with the surgical team, and I think that was probably where the problem lay and why she wasn't followed up, unfortunately. The expected plan - there was a note on the 27th for the patient to be reviewed in the surgical outpatients in two weeks and a booking should have been made or should have been given to the patient so she did have the follow-up. I think, usually in these situations with people when people self-discharge it is a very - the patient's desperately trying to go home and the doctor is trying to convince them to stay and I think the doctor that was attending the patient at the time explained the complications of self-discharge and the risk of self-discharge and it is a very stressful time and the appropriate follow-up may not have been arranged. Certainly we weren't made aware she had self-discharged.

Doctor, you talk about P44 there and I won't bother to go into that. You also speak about P170. That's a man who we call Mr B. And you talk about in paragraph 104 about the fact that this patient had a severing of the vas deferens?-- That's right.

Dr Patel was actually explaining to you how to do the operation and you were following his instructions?-- That's right.

Right. Do you know how it happened that the vas deferens was divided?-- First of all, this was a very large, very difficult hernia repair. The patient had this hernia for a good couple of years, from my recollection. So at the onset it wasn't a very easy hernia to repair. During the process of separating the cord structures and the hernia, it was difficult to try and get correct planes. I was directly

guided by Dr Patel and as a basic trainee I am learning basic surgical skills, and he was pretty much telling me what to do. And during that process I was asked to make an incisional cut at a particular spot, which is what I did, and unfortunately that involved the stromatic cord. So unfortunately it was a very difficult hernia, the patient was advised of the risks of cord damage and that's a standard thing that you discuss with the patient prior to the surgery.

In retrospect, doctor, is it really an operation of such complexity that perhaps Dr Patel should have carried it out?-- It is not - it was difficult in that it was a large hernia. Certainly the procedure itself, once the hernia is reduced, gets a lot easier. As a general rule, I didn't feel this was something that was out of my depth and I was confident with Dr Patel guiding me, that he would get a good outcome. So I felt comfortable in doing that provided Dr Patel was guiding me through the process.

But then how did the mishap occur, do you think?-- I think it was the issue with separation of the cord structures and the scar tissue and the hernia. In retrospect, you know, it may have been better dissected but it appeared during the process that the tissue was adequately dissected at the time.

COMMISSIONER: Would it be fair to say that - and please don't take this question the wrong way - but would it be fair to say that the mishap wasn't the result of your lack of experience; it is a complicated process which even the most experienced surgeon could have had that mishap occur?-- I think, unfortunately, it was one of those situations where it could have happened to anyone.

Yes?-- I think during that procedure Dr Patel adequately explained how the process was done and guided me through it. It wasn't an obvious thing that we saw at the time of the surgery.

Yes?-- I think that's what happened, unfortunately.

Yes.

MR ATKINSON: Right. Lastly, can I take you to the paragraphs at the start of your statement that deal with P11?

COMMISSIONER: Mr Bramich.

MR ATKINSON: Mr Bramich. That's at paragraph 38 and following. You made the point that you saw Mr Bramich when he first came to the hospital?-- That's right.

At paragraph 40?-- That's right.

At paragraph 43 you make the point that after Mr Bramich had stabilised, you arranged for his admission to the ICU under Dr Gaffield's care and you weren't involved further?-- No, that's right. When he presented to the emergency department, there was issues with his respiration and his gas exchange.

He had fractured ribs on the right side which required a chest tube. That was inserted by me. And once that procedure was done, the chest tube was working and that was evidenced by the fact that his oxygen saturations came up to 100 per cent and his respirations improved and he was a lot more comfortable. Once he was stabilised he was - and the process of inserting the chest tube, I might add, was with Dr Patel in attendance. He was later taken for some CT scans to exclude any other injuries. Once it was decided there was no other significant injuries, he was transferred and when he was stable he was sent to ICU.

When it was ascertained that there were no other significant injuries, he was in a state where he could have been transferred?-- Certainly, yeah.

He was quite chipper?-- He was - well, I gathered that he was stable enough to be managed overnight in the ICU at Bundaberg. I didn't think he was in any distress. The acute problem of his fractured ribs was managed and his chest tube was working and he was, for all intents and purposes, stable.

And he was talking?-- He was talking, he was sitting up, talking. So in that regard there was - I felt that his immediate management was adequate and stable to stay in ICU, but this was in discussion with Dr Patel.

Sure. Was there any discussion or consideration at that stage to whether or not the patient - his condition warranted a transfer?-- No, there wasn't.

And that's - you didn't see him again after that?-- No.

That's the evidence-in-chief.

COMMISSIONER: Thank you. Doctor, I want to ask you something that's not related to anything that's in your statement. We've heard a lot of comment about the impact of Dr Patel or Dr Death saga on foreign-trained doctors throughout Queensland. Now, I appreciate, of course, all of your training has been in Queensland, but for obvious reasons you might be mistaken for a foreign-trained doctor. Are you able to comment on any personal or other experience you have had as a result of this?-- From personal experience I don't - I haven't had anyone implicate me with the foreign-trained - inadequately trained foreign doctor dilemma. I think that's mainly because I have got a very Australian accent and don't come across as that.

Yes?-- But I do know whilst I was working at the Gold Coast Hospital there were other registrars that had had patients question their training, and certainly there have been consultants as well that have had questions about their training and been asked by the patients.

Thank you for that. I certainly hope I haven't caused you any embarrassment by raising those questions?-- That's all right.

MR PERRY: I have one matter I might pursue in chief, if I may.

EXAMINATION-IN-CHIEF:

MR PERRY: I want to ask you, doctor, about Mr Kemps. The leading site was identified as being either the aorta or vessels leading from the aorta, is that correct?-- It was the vessels that were directly supplying that segment of the oesophagus that was coming off the aorta.

You had the opportunity to observe Dr Patel undertake this operation. From what you saw, and by reference to the identification of the bleeding site, is there any cause that you can help us with as to why it was there may have been damage to or laceration of those vessels?-- I - during the procedure of mobilising the lower oesophagus, there was some blunt dissection with the fingers that Dr Patel used to do that. That's the only point at which time I think that may have - the injury may have occurred during the blunt dissections stage of mobilising.

Are you able to say from your experience that when undertaking such a process of blunt dissection it is necessary, almost as a matter of course, that a particular degree of care or subtlety be used in pursuing that process?-- Definitely.

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

COMMISSIONER: Thank you, Mr Perry. Mr Harper?

CROSS-EXAMINATION:

MR HARPER: Doctor, my name is Justin Harper. I appear on behalf of the Bundaberg patients. I just have a few questions. You answered some questions from Mr Atkinson regarding your induction training and I think your answer was to the effect that you didn't have a formal induction process but that you were taken around the wards and shown a bit of paperwork?-- That's right

You also were asked a question by the Commissioner about training you received in relation to coronial processes and process for referral to the Coroner, do you recall that? And you replied that you did get some training. Could I ask firstly in relation to the coronial training, do you remember when you received that training?-- Coronial training?

In relation to what's required about referring to matters to a Coroner, when a matter should be referred to a Coroner?-- I

didn't get any formal training, it was more what I'd read.

Okay. Was that at the Bundaberg Hospital?-- No. That was in the past. Just as a student and as a resident medical officer and reading in regards to writing previous death certificates and things.

So no formal training from the Bundaberg Hospital about when matters should be referred to a Coroner?-- No.

Could I ask, you're aware, are you, of the policy in Queensland Health about the reporting of adverse events and sentinel events?-- Yes, that's right.

Did you receive any training in relation to those?-- No.

So you didn't attend, for example, a training session conducted by Dr Keating and Ms Mulligan?-- No.

Are you aware that there were some training sessions?-- I knew there were training sessions. Often it was very difficult to get to the lunchtime meetings, purely because you were running around on your feet all day and there were always patients to see. Every effort was made to try and - I think I attended one of those meetings, but it was often difficult to get there.

COMMISSIONER: And as you say, often Dr Patel would work past-----?-- That's correct.

-----the stipulated theatre period.

MR HARPER: Did you get any training otherwise in your employment within the Queensland Health system about those policies?-- No.

You mentioned about the surgical audit meetings - and I preface this by saying I understand this can be difficult in hindsight, but can you recall at the time what your understanding was of the purpose of those meetings?-- The purpose was to discuss complications and make steps or provisions to try and prevent those from happening. So it was an education session as well as a management session of trying to prevent that. My understanding is it should be a no-blame scenario where the whole idea is to learn from complications, to hopefully prevent them from happening again.

So that was your understanding at the time about them?-- Yes.

And were you informed when you first went to one of those meetings that that was the purpose of them?-- No. I was informed - I briefly discussed my first audit meeting with - Dr Patel had a chat to me about the presentation and he said, "Gather the data about the complications", and that would be an ongoing process during that month, to keep a mental note or a record of complications, and then write a brief summary of those patients and then present them at the meeting and they would be discussed at that meeting.

Okay. You realised at the time, in the period you were attending these meetings, that they weren't really meeting their purpose though?-- Yeah, I think to a degree, and more, I guess, in hindsight that there really wasn't any genuine or frank discussion about how to prevent problems from happening again.

I'll move on to another topic. The transfer policy which you talk about at paragraph 23 of your statement, you mentioned

that you would always speak with the consultant about a transfer to Brisbane?-- That's right.

Can I just ask, you answered some questions earlier from Mr Atkinson - and I'll just redirect - in relation to Mr Bramich you didn't discuss a possible transfer?-- No. At the time there was no mention of a transfer. Dr Patel felt that he was stable enough to go to ICU, and it was felt that he could be managed safely in ICU. There was no discussion about a transfer.

Do you accept, though, that that would qualify as a trauma situation?-- There are certain traumas that are managed at Bundaberg, and are safely managed at Bundaberg. We don't - the policy wasn't to transfer every patient that was involved in a trauma to Bundaberg. The decision to keep the patient was a consultant's decision based on his experience and his ability, and at that time Dr Patel felt that he didn't need to be transferred. He felt - this is - I'm guessing Dr Patel's thinking. There was no discussion about a transfer. He just said, "Send him up to ICU."

Further in relation to Mr Bramich, you mention at, I think paragraph 44 of your statement - you recall that the police requested that you write a short statement "with respect to my involvement with P11's care." Do you recall when they contacted you and when you provided that statement?-- I think it was roughly about six to eight weeks. I can't recall exactly.

Six to eight weeks after the-----?-- I think, roughly.

Were you also aware that there had been a Sentinel Event Form filled out about the death of Mr Bramich?-- No, I wasn't - that was Dr Gaffield's team that were managing the patient. My only involvement was I was on call that evening, so I assessed the patient and managed him until the morning, and then he was directly transferred to Dr Gaffield's team, and I was aware of the fact that - what his problems were, but I wasn't - I didn't get involved in his management. There was another PHO that was my equivalent who was managing the patient.

So you, under the guidance of Dr Patel, treated him for that initial period?-- That's right.

Stabilised him?-- Yep.

The decision was made not to transfer, although there was no specific discussion, and then he was transferred to Dr Gaffield?-- Yeah, in the morning - Dr Patel was on call that evening, but the consultant that would accept the patient the next morning was Dr Gaffield.

Back then to my original question, sorry. You weren't contacted by anyone to discuss the investigation of the sentinel event?-- No.

So you weren't contacted by Dr Keating?-- No.

Or anyone on behalf of him?-- No, not at all.

By Mr Leck?-- No.

Or anyone on behalf of him?-- No.

In relation to the treatment of Mr Kemps, you mentioned that you weren't involved in the pre-operative treatment - preparation, sorry, other than that you briefly saw Mr Kemps for about two minutes beforehand on a ward round with Dr Patel, and you recall that Dr Patel showed you a CT scan and said something to the effect of, "This is the tumour and this is what I'm going to do."?-- That's right.

Were you aware that Mr Kemps had previously been treated by Dr Smalberger?-- I was aware that Dr - it was a handover to Dr Patel - or Dr Patel and Dr Smalberger did discuss the patient.

They did discuss - they discussed it?-- As far as I was aware Dr-----

COMMISSIONER: Doctor, you weren't present at any such discussion?-- No, no.

I'm not sure it helps, Mr Harper, to have that-----

MR HARPER: No, that's fine. Can I ask, were you aware that Dr Smalberger had recommended that Mr Kemps be transferred to Brisbane for alternative treatment?-- No, I wasn't aware of that.

Dr Patel didn't mention anything to you about that?-- No.

Just a final series of questions, and I'll preface them by saying I intend no criticism of you in this. I'm concerned more about the general culture around the hospital. Can I ask, this, as a workplace, had the normal sort of workplace camaraderie? By that I mean you'd talk about things in the workplace?-- Yes, that's right.

You'd talk about who was who?-- Certainly in my associations with the other staff - theatre staff or nursing staff - I thought it was a very friendly, hard-working environment. I had no issues with any of the staff there. I found them all to be very friendly.

So you had pretty open discussions with the other doctors?-- With regards to certain patients, and also on a social level as well.

And similarly with the nurses?-- That's right.

Can I ask you, when did you first become aware of concerns about Dr Patel?-- My first - well, when I first arrived - I can't remember exactly when - there were concerns regarding

his high rate of infection and wound dehiscences, and that would be the first time I was given a heads-up, so to speak, about his history in the past. 1

Who gave you that heads-up? Do you recall?-- I think - it's a vague memory, but I think it was the CNC of the surgical ward, Di Jenkins.

Sorry?

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COMMISSIONER: Di Jenkins.

WITNESS: Di Jenkins.

MR HARPER: At paragraph 28 of your statement you refer to Dr Patel talking to you about Dr Miach not using him for catheter insertions. Can I just ask, when were you made aware of that?-- That was probably the middle of my six months there. Three months into my term.

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Did you only hear about that from Dr Patel?-- That's right.

So no-one else informed you of that?-- No.

Did you think it a little odd at the time?-- I knew there were - I wasn't aware of the complications Dr Patel had, and he never discussed that with me. I had very little to do with the medical - or Dr Miach's team. I could only go on what Dr Patel told me, and he said he didn't have a good working relationship - or didn't get on well with Dr Miach, and as a result the catheters and those types of procedures were referred to Dr Gaffield. 30

So Dr Patel basically put it down to a personality difference between them?-- That's what he said. I wasn't aware of his complications at the time.

I have nothing further, Commissioner.

COMMISSIONER: Thank you, Mr Harper. Mr Fitzpatrick? 40

MR FITZPATRICK: We have no questions of doctor, thank you, Commissioner.

COMMISSIONER: Mr Allen?

MR ALLEN: No, thank you.

COMMISSIONER: Ms McMillan?

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MS McMILLAN: No, thank you.

COMMISSIONER: Mr Diehm?

MR DIEHM: Nor do I.

MR CHOWDHURY: No, thank you.

MR FARRELL: No cross-examination.

COMMISSIONER: Any re-examination?

MR PERRY: No, Commissioner.

MR ATKINSON: Nor I. May the witness be excused?

D COMMISSIONER VIDER: Just before the witness is excused, can I just ask one question? It's coming out of the social relationships, the working relationships. We've heard evidence that if Dr Patel was asked by another consultant for an opinion, in accordance with Australian normal practice, the consultant asked for the opinion goes back to the referring doctor and says, "Thank you for asking me to give that opinion, and here it is." We've had evidence that Dr Patel didn't observe that procedure, that he would see the patient and then act. Had you become aware of that at all during your time in Bundaberg?-- I can't say that I did. I can't recall any situations, I'm afraid, where he specifically did that. He may have done it. I'm trying to think of some examples.

Mr Kemps was an example?-- That-----

Where Dr Patel was asked for an opinion before the transfer to Brisbane, and it was expected that his care would possibly follow a palliative route, but before Brisbane would accept him they usually required an assessment by a surgeon?-- I wasn't aware that Dr Smalberger had asked him for an opinion. I wasn't involved in that discussion, I'm afraid. My first understanding was that this was the patient and this was what was going to be done. So I can't say that I was ever made aware of that.

Did you ever witness any situations where Dr Patel would go into the Radiology Department and see patients, have a look at their x-rays and then decide that he should treat them?-- I had heard things like that, but during my time there I didn't witness that.

You didn't see it.

RE-EXAMINATION:

MR ATKINSON: The other thing, I guess, doctor, is that you mentioned earlier that Dr Patel would often come to the hospital early in the morning, like 7.30-----?-- That's right.

-----and see patients in the ICU, certainly before the junior doctors arrive?-- That's right.

And perhaps before the referring doctor for that patient arrived?-- That's right.

COMMISSIONER: Did anyone have any questions arising out of those last few questions? Dr Kariyawasam, we do want to thank you for taking the time and effort to come and give us your evidence, but having spoken to the other two Deputy Commissioners during the break, we also feel it's very important to make it clear to you that none of us sees the slightest problem in anything that you did. We think it's regrettable that you've got caught up in this situation and that that's made it necessary for you to come here and give evidence. At a personal level, may I say I'm delighted to see that you're represented by counsel of the experience of Mr Perry, and I'm sure he's already explained to you that really you have nothing to worry about here. We can imagine that this has been a very distressing episode for you, and we just want you to leave here knowing that none of us have the slightest concern about any aspect of your involvement?-- Thank you.

MR PERRY: Thank you for that. May we be excused?

COMMISSIONER: Thank you indeed. You're excused from further attendance, doctor?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Now, I think Dr Cook is going to come back.

MR ATKINSON: Yes. My learned friend - my learned leader Mr Andrews will be calling him.

COMMISSIONER: Thank you. We welcome Mr Lyons back as well.

MR LYONS: Thank you, Commissioner.

COMMISSIONER: Dr Cook, can I ask you to come back?

PETER DALTON COOK, CONTINUING: 1

COMMISSIONER: Mr Andrews, at the close of play yesterday I think we'd finished Dr Cook's evidence-in-chief and Ms Gallagher had also asked some questions. Is there anything else that you or - Ms Gallagher, I think, is in consultation at the moment, but anything else you wish to raise?

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MR ANDREWS: I have nothing further, thank you.

COMMISSIONER: Ms Gallagher, was there anything else you wish to raise before cross-examination begins?

MS GALLAGHER: No, thank you, Commissioner.

COMMISSIONER: Mr Lyons, do you have any questions?

MR LYONS: Commissioner, Mr Andrews has been kind enough to intimate to me something of significance to my client. The effect of that is that I don't need to ask Dr Cook any questions. 20

COMMISSIONER: Thank you. Mr Harper?

MR HARPER: I have no questions.

COMMISSIONER: Mr Farr?

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MR FARR: Yes, I do have some questions, thank you, Commissioner.

CROSS-EXAMINATION:

MR FARR: Doctor, my name is Brad Farr. I appear on behalf of Queensland Health, and there's just a few questions that I wanted to ask you to try and clarify a couple of issues, if I may?-- Certainly. 40

Can I ask you this: when you prepared your submission, I take it that you conducted a search of whatever the relevant records were in an attempt to support the dates that you're speaking of, the chronology of events, that type of thing?-- Correct.

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And you have attached the relevant documentation that you were able to locate in the attachments to your submission?-- Correct.

Can I direct your attention to patient P18?-- Can we just clarify that's the Bundaberg oesophagectomy patient, Mr Grave?

Yes, referred to on the very first page?-- Correct.

This was a patient that you - just so that we're all clear - sent a letter to Ms Jenny Skinner on 7 July 2003?-- Yes.

Were you able to locate, in the course of your searches, any material - any letters, any correspondence, file notes, that type of thing - that would indicate if the letter that you sent to Ms Skinner in fact was onforwarded to Queensland Health?-- No, I was not. However, that did not surprise me, and I keep an eye on the correspondence that crosses my desk and I file it, and I was aware that there was no written record of that occurrence. That's part of the reason that I have included other evidence around that, including the agenda of the meeting I had prior to writing a letter with Jenny Skinner and the subsequent - and the e-mail correspondence with John O'Donnell concerning the funding issues in relation to the patient - the treatment of that patient, including that. So the letter itself refers to the fact that I spoke to Dr Keating. The e-mail which actually pre-dates the letter notifies southern zone that - southern zone management that there was this case which, in my view, should not have been performed at that hospital.

Yes?-- And - however, I don't have any direct correspondence back from Queensland - saying that this had reached Queensland Health. I was aware that I didn't have that. I had followed it up, and I wasn't surprised that I couldn't find it because I knew that it was not in my possession.

I see.

COMMISSIONER: Mr Farr, if you will forgive me, Mr Andrews, to put this issues out of its misery, my understanding is - but I'd ask you to confirm - that your investigations - or investigations by staff of the Commission of Inquiry are unable to obtain any satisfactory evidence, or any evidence at all that the letter to Ms Skinner was in fact referred on to Queensland Health, and you won't be advancing any contention to that effect.

MR ANDREWS: It's not possible to conclude that it was sent to Queensland Health, though it is possible that it was.

COMMISSIONER: Yes.

MR ANDREWS: One can't reach a state of comfortable satisfaction as to what's happened to it, or determine anything on the balance of probabilities.

COMMISSIONER: I don't know, Mr Farr, if that helps, but it may shorten the issue.

MR FARR: I was going to make this submission after a couple more questions, and you've probably shortened that process. But my understanding is that inquiries regarding this issue have been made, and investigations have been made by Queensland Health, Mr John O'Donnell, officers from the CMC, and I was assuming Commission officers, none of whom have been

able to locate anything consistent with the letter having been onforwarded.

COMMISSIONER: Yes.

MR FARR: Could I make the submission that we can proceed on the basis that the Commission would take the view, until evidence to the contrary appears, that it was not onforwarded.

COMMISSIONER: Well, I would certainly, on the advice of Mr Andrews, take the view that there is no evidence at this stage, and probably never will be any evidence from which we could arrive at a conclusion that it was onforwarded.

MR FARR: All right.

COMMISSIONER: If that answers your question.

MR FARR: It probably takes the matter as far as I can with this witness in any event. I don't know if statements have been taken from Ms Skinner. I haven't seen one.

COMMISSIONER: I understand there's a lot of confusion. Obviously Dr Cook thought that Ms Skinner was sending it to Queensland Health, Ms Skinner is unable to recall doing so, but sent it to Mr O'Donnell, Mr O'Donnell can't say that he sent it on. So no-one can really put their hand on the Bible and say it got to Queensland Health.

MR ANDREWS: But for the comfort of one of the persons you've just named, I think you suggested that Mr O'Donnell couldn't recall sending it on. Mr O'Donnell, I think, if the matter were pursued, would say that his practice would have been to have sent it on.

COMMISSIONER: Yes. But he's got no record of having done so.

MR ANDREWS: Correct.

COMMISSIONER: And if he had done so there probably would have been a record.

WITNESS: Commissioner, could I speak to that? Yes, all right. Yes?-- Sorry. I can - there were regular meetings with the Southern Zone Management Unit, which was the line of reporting from the senior executive staff at the Mater with Queensland Health. My understanding is they occurred on a monthly basis. At that time they were unminuted, and they were unminuted for a period - and historically had been unminuted, and they were unminuted for a period of six months subsequently, and then issues arose in relation to what was discussed and since that time they've been minuted on a regular basis, and that was the forum that Jenny Skinner had envisaged, in my discussions with her, presenting the correspondence.

COMMISSIONER: Yes. And it remains the case - perhaps, Mr Lyons, we should hear your-----

MR LYONS: Yes, thank you, Mr Commissioner. There is some evidence that the document was communicated to Queensland Health. It arises from Dr Cook's written submission, Appendix A4, where, in the second paragraph the doctor said, "Jenny fed back to me at the time that the Southern Zone Management Unit was going to refer the matter on to the Central Zone Management Unit for action." So-----

COMMISSIONER: But it really is only then third-hand hearsay, isn't it?

MR LYONS: It is hearsay, yes, but it is evidence that's before you.

COMMISSIONER: I must say that if that's the highest it gets to, I'm very inclined to accede to Mr Andrews' proposition, which I think is substantially the same as Mr Farr's, that there is just no cogent evidence on which we could base any finding adverse to Queensland Health. Do you wish to submit to the contrary of that?

MR LYONS: Only to the extent that the Mater is - in terms of any criticism of the Mater, there is evidence that it has been referred to Queensland Health.

COMMISSIONER: Well, I don't see it as a basis for any criticism of the Mater either. I mean, on any view there is simply no dispute that Queensland Health got the e-mail in which Dr Cook very properly raised his concern about the standard of these - or about the suitability of performing these operations in Bundaberg. Whether or not the Mater also managed to communicate the letter to Queensland Health doesn't seem to me to add to or detract from that, but having said that, I accept what Mr Andrews and Mr Farr say, that the evidence just doesn't reach the standard where one could make a comfortable finding that that letter got its way to Queensland Health, and that's not saying it was the Mater's fault or the fault of Mr O'Donnell or Ms Skinner that it didn't. It's just that there is no evidence that it did that we can rely on. It's certainly not Dr Cook's fault.

MR LYONS: Thank you, Commissioner.

COMMISSIONER: Are you happy with that, Mr Farr?

MR FARR: Yes, Commissioner. I can indicate I wasn't in any way attempting to lay fault on any person or organisation.

COMMISSIONER: No.

MR FARR: Dr Cook, can I then just take you, on the same patient, just to the chronology of events in so far as they're relevant to yourself? The first - we know that the patient was admitted to the Mater on 20 June, if I remember correctly. I think that's correct, 20 June 2003. If we then look at attachment A3 to your submission, which is, I think, the one document but contains about three e-mails - and if I

understand the e-mail system correctly, we look at the bottom one as the first in time?-- Correct.

We see that that's an e-mail from you to Mr John O'Donnell who was the Chief Executive Officer of the Mater Health Services. That's correct?-- Correct.

Okay. In that e-mail you refer to the admission of the patient. You say, "You asked me to contact you when this occurred so that you could bill Queensland Health", and I think you've explained the process in your evidence-in-chief. You spoke of the patient's ongoing problems - health problems. You then refer to the fact that he had been refused at the RBH, the PAH and Gold Coast Hospital, and that you, the Mater, didn't have a bed until 20 June and they couldn't get in anywhere else in the interim?-- Correct.

You then refer to the sentence that has been referred to previously, "In reality, an oesophagogastrectomy like this should not be done at a hospital without robust ICU backup", and then you speak of the patients that you have at the Mater at that time in ICU I assume?-- Correct, correct.

Okay. It would appear, just on the face of that document, that the principal purpose of that e-mail was to notify Mr O'Donnell of the fact that there has now reached an excess of the number of beds that you ordinarily receive compensation for, if that's the correct term, and that specific compensation would need to be sought for this one matter which takes it over the limit?-- I think there are a lot of purposes of that e-mail. I can think of at least three. Certainly that is one purpose of the e-mail. The second purpose of the e-mail is to highlight the fact that at that time there is an - there was an inadequacy of supply of intensive care beds in south-east Queensland and that's why I went into some detail about the units that my colleagues were responsible for and the problems that they had accepting the patient. I think there is the point the surgery, in my view, should not have been done in a centre like Bundaberg, and I guess the last point is by way of emphasising to Dr O'Donnell that the patients that we have in our intensive care unit are - and there are really two points here. The first one is that they're sick, and that's why I've included some clinical details, and the second point is that they are not all our own home-grown patients.

Right?-- So we have reached - it's an emotive area in terms of intensive care bed availabilities.

I see?-- However, you know, this is approaching crisis level and when you have a lack of capacity at the major tertiary referral units in the city, then that's a very dangerous situation and that situation needs to be brought to the attention of Queensland Health. Subsequent to this, and actually - and I've had a fairly major role in establishing this, we have an on-line password controlled database which can identify a hospital - hospital's intensive care bed and gives an idea as to whether an intensive care bed is likely in that institution and that's used for when patients need - to transfer patients needing intensive care.

Is that a recent introduction?-- Subsequent to this. I started talking about this when I returned to Brisbane. It took - realistically, it took three years to establish it.

Is that now all of south-east Queensland or the Brisbane metropolitan area?-- It certainly involves hospitals as far north as Nambour, as far west as Toowoomba and it does include the Gold Coast.

Yes?-- For issues, IBM and passwords, it doesn't include Tweed and other Gold Coast hospitals.

I understand the intention behind the e-mail. Would you agree with me that upon reading the e-mail, and I appreciate this is

the same day as the admission of the patient, it would appear that the primary intention was to notify Mr or Dr O'Donnell of the necessity to undertake whatever was required to receive funding for that patient?-- I have difficulty identifying a prime purpose of writing the e-mail now.

No, just so that you don't misunderstand-----

COMMISSIONER: I think Mr Farr's question though is from the viewpoint of the recipient rather than you as the sender. To put it in a very perhaps over-trivialised way, if a filing clerk in Dr O'Donnell's office was deciding whether this is an e-mail relating to billing issues or an e-mail relating to clinic standards issues, it would appear on its face to be a billing-----?-- Billing I would agree.

MR FARR: Thank you. Thank you, Commissioner. If one then looks up the page, the next e-mail is from Dr O'Donnell to Tracey Silvester with CCs to Jenny Skinner and yourself?-- Yes.

That's three days later, the 23rd of June?-- Correct.

That e-mail would seem to have picked up on that function of the previous e-mail relating to funding and that seems to be the only thing it speaks of?-- I would agree with that.

Okay. And I take it, and I understand from your evidence and particularly from the answer you gave just a moment ago, that you are in no way critical of Dr O'Donnell for interpreting your e-mail in such a way that he focused upon the funding side of things, because that was a reasonable thing for him to do in the circumstances at that stage?-- I would agree. I'd go as far as to say if there was wasn't the funding issue, I would not have sent the bottom e-mail.

All right. Thank you. And then if we look at the top e-mail, we can see that that in fact is from Dr O'Donnell to yourself on the 24th of May 2005, so it's two years later, and I assume that it was sent to you for the purposes of helping you prepare your submission?-- I'd agree with everything except the last line.

I see. I just thought I noticed your submission was dated the 25th of May 2005, so if it's for another reason, then that's fine?-- It is in relation to the issues that were becoming - I'd have to check the dates but I would think that it would be following on from Dr Molloy's referral to the letter and the Mater reviewing correspondence from around that time.

All right. Anyway-----?-- The only reason that I make the difference there is because on that date, my understanding is that Dr O'Donnell was not aware that I was proposing to put a submission to the Morris Inquiry.

COMMISSIONER: But in any event, Dr Cook, the third e-mail was in the context of this inquiry?-- Absolutely.

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Yes.

MR FARR: Thank you. So we have got the 20th of June, the 23rd of June 2003. If we then turn to attachment A1 to your submission, we can see that's an e-mail from yourself to Allison Kingsbury, which is the 4th of July 2003, although I see it's headed "Jenny" so I'm-----?-- Sorry, could I clarify that. My computer was not working on that day and I had to print it out on the Nurse Unit Manager's printer so her name goes on the top.

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All right?-- It is an e-mail to Jenny Skinner and her secretary just listing the topics that I need to discuss with her at the meeting.

Okay. So I take it that was the e-mail you sent to Jenny Skinner prior to meeting with Jenny Skinner and having the conversation with her on the topic that has been of interest to the Commission that you referred to yesterday?-- Correct.

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And I take it that at that stage you were pondering in your own mind what is the appropriate steps for you to take in relation to this issue?-- That's - that's putting it too mildly.

I don't mean to do that. But you were wishing, I take it, to raise it with her to discuss what avenues might be open or what should be done?-- I was hoping to recruit her to - the reason this is important is it's from the time that I had the discussion with the general surgeon Chris Elmes.

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Yes?-- That the decision was made in my mind that action had to be taken. The agenda item here is a polite way of saying, you know, "Action has to be taken here." You know, "I want you on board with the process. What can you advise me?"

Certainly. And I take it that at that stage you were not treating your initial e-mail of the 20th of June as being the appropriate action for you to take or to bring it to other people's attention; you were considering what further action you should take to ensure that this type of situation doesn't re-occur?-- This is a very serious issue.

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That's right?-- And it needs a very well thought out strategy to address this situation.

Certainly. Because I assume that you were not intending for the one sentence in the e-mail of the 20th of June to be all that needs to be said about the topic. That would be completely inadequate in your view?-- The e-mail that I sent to John O'Donnell - clearly, in this I was results focused.

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Yes?-- What had to happen here was a change in practice. My view is that the notification of John O'Donnell may not have resulted in that action and we had to embark on a course that - a campaign, if you will, that would result in that.

I take it that when you spoke to Miss Skinner, you would have explained to her, as you have done in your subsequent letter, the concerns that you had, the reasons you held such concerns and perhaps the steps which you believe should be taken to ensure that it doesn't re-occur?-- Correct. Correct. It's very much along the lines of my making the bullets for her to fire.

Certainly. She said to you, "Could you please put all of that into written form for me", which is what you then did and gave to her on the 7th of July, which is attachment A2?-- Correct.

I think, as you've said, that took some amount of work on your part just to ensure that you had all the facts correct and you had the chronology correct?-- Correct. And - and the consultation, and I would emphasise that the consultation is perhaps the largest part of that two-page letter.

Certainly. And just again so that we're clear, I'm in absolutely no way being critical of you at all, Dr Cook. I'm just trying to get the chronology and the reasoning behind it sort of thing?-- Sure. Absolutely.

All right. And you were obviously, as you've told us, expecting then that that letter would be forwarded on to the appropriate person or department in Queensland Health?-- Correct.

Okay. We can compare and contrast if you like the process that was adopted on that occasion to the process which was adopted on the other occasion that you had cause to write a letter, that was in relation to Hervey Bay, and on that occasion you, if you like, side-stepped some areas and went straight to people you considered to be relevant people to know about the problems?-- Absolutely. I didn't follow the direction I was given and so, in response to the second case, I was advised to write to Jenny Skinner's replacement. However, it at that stage had become obvious that oesophagectomies continued to be performed at Bundaberg and problems had arisen and so I instead changed the emphasis slightly. Fortunately the order as to - you know, the request to write to the Executive Officer was given to my deputy at a meeting that he had with Jenny Skinner's replacement and then he communicated it to me. So no-one had actually told me to write to someone at the Mater.

Right?-- And so I just changed the emphasis slightly and I wrote to Dan Bergin with a copy to Jenny Skinner's replacement.

Right. Again just looking at the chronology of what occurred on that occasion, on the 20th of April 2005 you wrote to Dan Bergin. It's attachment B1?-- Yes, yes.

If you then go to attachment B3, on the same day, the 20th of April 2005, you sent an e-mail to Karen, the surname of Karen Roach, indicating the letter that you'd posted to Mr Bergin. And so, giving her notification-----?-- Correct.

-----of what you've done and the contents of the letter?-- Correct. I need to add for completeness to say that a meeting had occurred, which was the same meetings which were occurring on a regular basis two years prior to that-----

Right?-- -----between Jenny Skinner's replacement, Dr O'Donnell, and Karen Roach and the case of the Whipple's procedure at Hervey Bay was raised and it was from that meeting that the request came to write to Jenny Skinner's replacement so that this could be addressed through Queensland Health. So Karen Roach already knew about the Whipple's and it was her advice that this had to be communicated to Dan Bergin and so I just indicated to Karen Roach that that had in fact occurred.

All right. Again just following the chronology, if you then turn to attachment B4, which is an e-mail from Karen Roach back to yourself dated the 21st of April, the very next day, she's indicated that she has already spoken to Mr Bergin, who will deal with this issue immediately. So that was the next notification that you received if you like?-- Yes.

And if we then go to attachment B2 - sorry, yes, B2. There's a letter from Mr Bergin to yourself dated the 22nd of April, so the next day again?-- Yes, correct. Could I just clarify for completeness to say that we - in relation to Hervey Bay, we're discussing two separate cases.

Yes?-- Yes, yes.

On the 22nd of April Mr Bergin advised you that the decision had already been made at that stage as a consequence of your contact to cease all further Whipple's procedures at the Hervey Bay Hospital and to thank you for your persistence and bringing to his attention the potential problems?-- Correct, correct.

As I understand it - putting aside the case itself, but as I understand it, you're of the view that the way that your complaint was dealt with on that occasion was most appropriate?-- Oh, absolutely. And I think that was assisted by the political climate at the time.

Oh, I'm sure there was no question of that but that was a good example, if you like, of how something can be dealt with well and quickly and satisfactorily?-- Yes.

There was just one other matter that I want to ask you about, if you turn to the last page of your submission.

COMMISSIONER: The last page of the body of the submission.

MR FARR: Of the body of the submission, yes, page 8.

COMMISSIONER: Page 8.

MR FARR: And in the last paragraph you say, "In reality the

events at Bundaberg and Maryborough can be looked upon as a logical conclusion of a formal Queensland Health policy rather than the unwise actions of junior administrators." As I understand it, and please correct me if I've misunderstood something, the policy that you had been discussing immediately prior to that was this reversal of flow. Do I read that correctly, that's the policy you were speaking of?-- Sorry, you're referring to the first complete sentence at the top of the page?

Yes, starting with the words "In reality"?-- I think it's an oversimplification. I think reversal of flow had a significant - had a significant role in what happened.

Right?-- But the other Queensland Health policy which had a significant role and I think has already come out in evidence is the method of funding of hospitals in general with activity related funding and I think those two policies in conjunction need to be - are relevant. I just need to read the whole the paragraph again.

Certainly, there is no rush. Take your time. I just wanted to know the correct way we should read that statement, that's all.

COMMISSIONER: Dr Cook, you'll find we lawyers tend to be a little bit literal about these things and if you look at the foot of page 7, the paragraph starts talking off about reversal of flow and being Queensland Health policy. It goes on, "Reversal of flow is no longer discussed by Queensland Health." And then the final sentence of the paragraph says, "In reality, events of Bundaberg and Maryborough can be looked upon as the logical conclusion of a former Queensland Health policy." So it reads as if you're saying, "This used to be their policy. It isn't their policy anymore, and the events at Bundaberg can be looked upon as the logical conclusion of that policy that used to exist but doesn't exist anymore"?-- Commissioner, can I just ask you, does that - on your copy, does that say "former" or "formal"?

I'm sorry, you're quite right, I'm misreading it as "former". The formal Queensland Health policy?-- I guess if we're referring to this - personally, I think it is - could be interpreted in that light.

Let's forget about what's in writing. You tell us what you meant to say rather than quibbling over what-----?-- Quite clearly, both policies have a significant role in what happened.

When you say both policies, you mean the reversal of flow policy and also the underfunding, if I can put it that way?-- Well, underfunding is a component but the funding of hospitals with a component that is activity dependent.

Yes?-- Without any-----

Outcome or quality factors?-- Correct, yes. I think both of

those things have important implications to the events that occurred.

Yes.

MR FARR: Thank you. As I understand your evidence and as I understand the situation, the reversal of flow policy is an outdated policy now. Is that your understanding?-- I have raised reversal of flow at intensive care meetings of directors with senior health bureaucrats to be told that that is not spoken of anymore.

I see. And excuse the pun, but do you take the view that it still has a potential flow-on effect if you like?-- Well, the important thing you need to remember is that reversal of flow is introduced at a time when the big Brisbane teaching hospitals were being redeveloped.

Right?-- So a reduction in activity at Royal Brisbane and Women's Hospital and PA at a time when the hospital is being redesigned and reconfigured has a long-lasting effect. It's an effect that could potentially last for the - for the life of the building.

I see. Yes, thank you, that's all I have.

COMMISSIONER: Thank you, indeed. Mr Harper, did you already tell us no questions?

MR HARPER: Yes, I did.

COMMISSIONER: Mr Allen?

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: Ms McMillan.

MS McMILLAN: No, thank you.

COMMISSIONER: Mr Perrett, I see you lurking in the back there.

MR PERRETT: Yes, I'm lurking in rafters, I do have some questions of this witness.

COMMISSIONER: How long are they likely to take?

MR PERRETT: Ten minutes.

COMMISSIONER: Mr Diehm, will you be long?

MR PERRETT: About 10 minutes.

COMMISSIONER: Mr Chowdhury?

MR CHOWDHURY: I don't think I have any questions, Commissioner.

COMMISSIONER: If you're confident of your estimates, we'll keep going. Mr Perrett. Dr Cook, Mr Perrett represents the Health Rights Commission and he has some questions for you.

CROSS-EXAMINATION:

MR PERRETT: Good afternoon, Dr Cook. I'm interested in just taking a few minutes to explore with you based on your experience the issue of systems of accountability and your views on how they might best fit with the function of an external complaints body such as my client, the Health Rights Commission. Now, I understand your evidence to be that you see direct resolution of patient complaints at the local provider level as being the preferred form of complaint management. That is direct resolution between the complainant and the service provider?-- Although this is not included in my letter, subsequently a major oversight has occurred there because, clearly, prevention has the most important role but if we assume that an incident has occurred, then the - a peer review at a local level is going to be the most effective form of addressing problems that have arisen.

Yes. And I understand your evidence to be that it's desirable that that review occur in a no-blame environment?-- Oh, absolutely.

So if we were to take as an example a patient complaint concerning a surgeon in a hospital setting where the complaint relates to an issue of clinical competence, addressing that complaint may involve peer review of the clinician concerned by another practitioner of appropriate skills and experience?-- It's more along the lines of a regular meeting where - where deaths and complications are discussed, where each practitioner has to stand up and justify what they did. Now, in a group of appropriately trained collaborative people, if you haven't done the right thing, it's a very uncomfortable experience.

Yes, and if in that process you speak of an individual competency concern was identified, one would seek, if possible, to address that concern in a collaborative way with the practitioner concerned. That might involve further training or supervision or mentoring or something of that nature?-- There are a whole variety of strategies which could be used. Some are collaborative and some are less so but if the simple measures don't work, then it would be escalated by people at the meeting who would be concerned that these issues had been discussed and would be aware that the existence of the meeting and their presence at the meeting may be called to account in a legal forum subsequently, that they would have a responsibility to ensure that appropriate action is taken, and that could be, "Don't do this operation again", and the person saying, "Okay, I won't." But it may be something more dramatic and it may be restriction of privileges by the

medical advisory committee of the hospital.

But at its most fundamental level, you would seek to address the issue within that environment and develop an appropriate solution acceptable to the practitioner concerned?-- You would do the simple things first.

Yes. And it may be that such a review would reveal no culpability whatsoever in respect of the particular practitioner but might identify some form of systemic issue, and in that event the service provider would look to address that issue through improved systems or a change of practice or something of that nature?-- Oh, absolutely. And it would be important that the meeting and the actions would be followed through.

Yes?-- And that is crucial. To just expand on that a little bit, and I think it is important, what we are talking about here is that, you know, if you do major operations on sick people, not all of them go smoothly and it's very difficult under these circumstances to sort out what is a fair complication or bad luck versus what is something that has resulted from a decision which was made which should not be made again in future. That's why you need experienced people to look at it. If you have a wound infection, well, you know, there is a percentage that will get a wound infection but if all your patients have having wound infections, possibly there could be something else going on and that's the situation that requires a quorum of experienced people to sort out.

Indeed, there may be a combination of causes some directed to the people, some systemic?-- Absolutely. Absolutely.

I think you've touched upon this but there will occasionally be those rare cases where a serious issue of competence is identified or a serious issue of conduct is identified and in the public interest, that will then be elevated to a registration board or something of that type for further action?-- You would go on a step-wise process and this is something I have experience of in a different jurisdiction. There is a step-wise process that you would go, but it could end up at the Medical Board depending on what the problem was and what could be addressed.

Yes?-- But if I could use the example I used before, it may be a credentialing issue where a procedure is specified that someone is - no longer - or agrees to no longer perform a procedure in a certain hospital.

But there will be complications, hopefully rare events where the public interest requires that it be elevated?-- Oh, absolutely. Absolutely. And the people who attend those meetings find the responsibility onerous under those circumstances.

Yes?-- And that - and I'm aware of that, directing their cause of action from that point, although I must admit that was not in Queensland.

And you would agree, I take it, that having been through that process and having dealt with the complaint of the patient, the hospital would then give feedback to the complainant as to where that issue got to?-- Oh-----

The complainant would be told the outcome?-- Correct.

That's the important part of the process?-- Absolutely, but it would be obvious to the person anyway, under most circumstances. If someone is no longer doing an operation it would be obvious.

If I properly understood your evidence-in-chief, you agreed with Commissioner Morris that despite the desirability of direct resolution of the complaint at the provider level, there will nevertheless exist the need for an external complaints body?-- I - yes, I accept that, absolutely.

And because there will be cases where the patient, for whatever reason, is dissatisfied with the outcome at the local level and will want to elevate that-----?-- Yes.

-----there will be cases where the patient will want to bypass the local level, for whatever reason, and go to some independent body?-- Can I just clarify, my recollection of evidence-in-chief was that we discussed two models for the independent body, one being an investigative body, the other being-----

A clearing house?-- -----a clearing house which directed the complaint to an appropriate level and could give feedback.

Yes?-- And my evidence, from memory, was the second option appeared far more practical to me.

But without getting to that detail, all I am seeking to establish is that you accept there will be cases where local resolution would be ineffective, for whatever reason, and some other form of independent body, however structured, will be required?-- Oh, yes, yes, and I would go as far as to say it is a dangerous situation to leave a patient or their relatives dissatisfied with a concern that they have.

COMMISSIONER: All else aside, it just invites litigation?-- Absolutely.

Just picking up, if I may, on Mr Perrett's point, with the sort of clearing house structure that you and I discussed yesterday afternoon, Dr Cook, when you gave your endorsement to that proposal, as it were, you were seeing that as operating in a system where there will still be bodies like the Medical Board and the Health Rights Commission to which those problems can be redirected if the clearing house feels that they haven't been properly resolved at hospital level?-- Certainly. Clearly in relation to the Medical Board. The Health Rights Commission, in my view, struggles with its current workload, and I think that is an issue, and I don't

mean to be rude but that is - from the small involvement I have had with the Health Rights Commission, there seem to be some difficulties there and that may be an area that could be reviewed and approved.

I don't think you are being rude, I think the Health Rights Commissioner has identified that as one of the problems of the present system, and has acknowledged the huge effort that will have to be made and is being made to overcome that.

MR PERRETT: We might return to that, but at the moment I am looking at systemic structures, if I can, and get the benefit of your experience in that. There will also, of course, be just people who won't know what their rights are, patients or somebody independent that they can go to to say, "What will I do?"?-- Correct.

They will be directed somewhere. Now, given what we've discussed, and your preferred form of complaints management being the peer review process, I take it that where complaints are received by an external complaints body, your preference would be that that body approach the issue of resolution with a collaborative rather then a confrontational style approach?-- Oh, absolutely. In the first instance.

Yes?-- Absolutely.

And if I can refer you to some evidence that Dr Molloy gave, just to perhaps illustrate this, his evidence before the Commission in discussing the role of an external body like the Health Rights Commission, Dr Molloy spoke of the need for fairness, both to the people who work in the health sector and to the consumers of health services and of the need for balance between a patient's right for proper redress and health professionals being able to work in a system without big brother looking over their shoulder. Is this a concept, that issue of balance and fairness as between the ability of the provider to get on with what they do without feeling they're being overborne and the consumer to have that right of redress?-- I think balance of fairness I agree with entirely. The idea of big brother in the Health Rights Commission is not a concept I have even considered, to be frank.

Just touching to the role of the Health Rights Commission against the background of what you see as being the most appropriate mechanism for resolution of such complaints, are you aware that in Queensland under the Health Rights Commission Act, prior to the Commissioner accepting a health service complaint for action, he must be satisfied that all reasonable steps have been taken by the complainant to resolve that matter with the provider?-- No, I may not have been aware of that, no. I would say no.

But that's an approach you would endorse?-- Oh, absolutely. I would go as far as to say that it is the practicality of the Health Rights Commission as it operates at present that I have reservations about rather than the principle of the Health Rights Commission existing or having a role.

We may come back to that but just could I mention to you something else you may not be aware of, that in 2001 the Department of Premier and Cabinet commissioned an independent review of the Commission as it then existed. Is that something you are aware of?-- No, I am not aware.

And one of the recommendations from that review was that the Commission promote the direct resolution between the provider and the complainant as the primary preferred complaints resolution strategy?-- That makes a lot of sense.

That falls entirely in line with what we were discussing?-- That's correct.

Just moving away from that, in your statement you speak of the performance of bodies in other States similar to the Commission and in particular the Health Care Complaints Commission in New South Wales. Is that a body with which you had some experience during the course of your time as Director in Lismore?-- Only once. And it related to some correspondence I received concerning patient care. I responded in writing but heard no more, which I thought was odd. However, the reservations - you know, to be frank, that in itself is not a hanging offence. The concerns in relation to the Health Care Complaints Commission in New South Wales really relate to issues in relation to Camden and Campbelltown Hospital, where after a reasonable investigation my understanding is the Health Care Complaints Commission was subject to some criticism.

You may - I don't want to go into that track - I don't think it is relevant to what we're doing - but you may then not be able to comment on what I am going to put to you. Based on your knowledge, are you able to say whether the relationship between the Commission and the medical profession in New South Wales was a somewhat strained relationship?-- I can't comment.

So you, I take it, would be unable to comment then on a suggestion that within the New South Wales system, the culture of investigation of complaints by the Commission could perhaps be characterised as having elements of culture of blame?-- My understanding is completely the reverse, to be honest, from what I have read of Campbelltown and Camden Hospital investigations, one of the criticisms that the Health Care Complaints Commission came under was that they didn't apportion enough blame.

I appreciate that in respect to Campbelltown?-- Yeah, and so I - you know, clearly a no-blame environment is going to be far more productive for all concerned, and is clearly the important first step, but could I just add that there needs to be a more disciplinary option, and that could be through the Medical Board, but there needs to be a more disciplinary option which can be referred to, or which the complaint can be referred to, if appropriate, particularly for the environment where people are not cooperating with a no-blame approach.

I did want to come to that because Dr Molloy in his evidence said that he wanted to put on record, perhaps slightly contrary to yourself, that the Health Rights Commission in Queensland, which had a model which mirrored the Victorian model, was an extremely good organisation. Now, are you aware that there are different models under which these commissions operate throughout Australia and that the Queensland model is in line with the Victorian model?-- I am not. I am more familiar with the Medical Board approach under these circumstances and I am aware of the New South Wales approach, and in Queensland there has been a move over the last six years, at a guess, to move it more to having a choice between punitive and no blame, starting with the no blame but being able to move to a punitive approach if there is a lack of cooperation.

COMMISSIONER: I think, Mr Perrett, it is worth bearing in mind that Dr Cook's evidence, as I read it, doesn't involve any criticism of the Health Rights Commission model. The criticism that he has advanced is relating to that organisation being under-resourced.

MR PERRETT: Yes, but what I was trying to elicit from Dr Cook is an understanding of the various models.

COMMISSIONER: Yes.

MR PERRETT: And how they best fit with his preferred model, as it were.

COMMISSIONER: Yes.

MR PERRETT: And I think you were really touching upon this in your evidence: but in all States other than New South Wales, the model now for commissions is what might be described as a conciliatory or collaborate model, with the disciplinary process separated out in a registration board, or something of that type, whereas in New South, Wales uniquely those functions are confined to the Commission - all of those functions are confined to the Commission. Is that a distinction you are aware of?-- In New South Wales - if from your question the implication is that the Medical Board in New South Wales doesn't have a two-pathway approach-----

COMMISSIONER: No, no, I think the implication of Mr Perrett's question is merely that the Commission in New South Wales, the Health Care Complaints Commission, unlike similar commissions, including the Health Rights Commission in Queensland and similar bodies in other States, has both conciliatory or dispute resolution functions, but also disciplinary or punitive functions, and I think Mr Perrett is suggesting to you that the model we already have in Queensland of having the Health Rights Commission simply concerned with resolution and conciliation and disciplinary and punitive issues being dealt with by an entirely separate body in the Medical Board is closer to your preferred model?-- I don't think you need - I agree entirely. I think the Health Rights Commission doesn't

need the disciplinary components because they are available through the Medical Board.

MR PERRETT: Yes. And, indeed, to achieve the level of cooperation between someone like the Health Rights Commission and a service provider, that is much more likely to be achieved in an environment where the Health Rights Commission might not then turn around and prosecute that provider?-- Absolutely.

Yes. Just turning then, doctor, to the general observations you made in your statement concerning the Health Rights Commission itself in Queensland, I understand those observations to be primarily matters of impression rather than based on actual knowledge of things, such as, for example, staff turnover ratios?-- It is from my experience with dealing with the Health Rights Commission. I have only had one case of relevance with the Health Rights Commission. It is not a case I treated personally. Every time I'd gone to a meeting - I think this is correct - certainly the broad principle is correct that there would be another - a different person sitting across the table from the Health Rights Commission, I am unfamiliar - or getting familiar with the case and trying to pick up from there and move on. I can appreciate that that position - those positions must be very, very difficult, requiring both legal and medical knowledge and trying to get people together in a collaborative environment, but the turnover really needs - it was a dysfunctional process, in my view.

That was a case where you, I think, assisted with the interpretation of some clinical records, or something of that nature?-- Correct.

Do you recall when that was?-- Oh, it has been ongoing and I guess that's another feature, that we're talking about a case which occurred when I was still practising in New South Wales and as far as I am aware it is unresolved.

If, for example, I was to put to you, dealing with the issue of turnover for the 12 months just gone, the Commission had a turnover of two staff out of the complement of about 30, that's detail you would be unaware of or couldn't comment on?-- I would be referring to a time prior to the last 12 months. I haven't had any dealings - my understanding is I haven't had any dealings with the Health Rights Commission within the last 12 months.

Just touching upon that issue of skills that you referred to, you are not - I don't think you're suggesting that within the Commission itself there should be skills to deal with each area of discipline in respect of medical practice?-- Oh, no, no.

And it is appropriate to go to independent experts-----?-- Absolutely. Absolutely.

Nothing further.

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COMMISSIONER: Thank you, Mr Perrett. Look, we might take the lunch break now, if that's not inconvenient, Dr Cook, until 2.30.

Just before we rise, may I mention a couple of matters? One is that Sir Llew has a meeting of the university senate this evening, so we will finish at 4.15 punctually. The second matter is tomorrow morning Deputy Commissioner Vider has a similarly important professional meeting so we won't be starting till 10.15 tomorrow morning. 10

Mr Andrews, or possibly Mr Atkinson, can you inform me - we've got Dr Fitzgerald coming to follow Dr Cook this afternoon. Who else do we expect to hear from tomorrow?

MR ANDREWS: I expect Dr Fitzgerald will take most of tomorrow in the circumstances.

MR ATKINSON: That's right, Commissioner. There is two other potential witnesses, and I should say that their statements would be provided to my learned friends over the lunch hour. One is a man called Viv Chase who was on the Health Council in Bundaberg. 20

COMMISSIONER: Yes.

MR ATKINSON: He has a range of reasons, though, why he says he can't attend in person and can only give evidence by telephone. I imagine my learned friends will have to look at his statement and see if they accept that. My concern is those reasons won't go away. 30

COMMISSIONER: Yes.

MR ATKINSON: The second person is a man called Jimmy Mullet, and he is also on the Health Council up there. He is the opposite. He has a plane and he can fly down on an hour's notice in his plane to be here, but I am reticent not knowing how long the party----- 40

COMMISSIONER: He couldn't give Mr Chase a lift?

MR ATKINSON: It is not the transport that's the problem, Commissioner.

COMMISSIONER: All right. I just wondered, it looks like we will have a full day tomorrow anyway.

MR ATKINSON: And some of the parties have said if we were to finish early and they could prepare for Townsville, that wouldn't be a bad thing. 50

COMMISSIONER: What's the weekend for.

MR ANDREWS: It would be difficult-----

MR FARR: That's for fatigue.

MR ANDREWS: It would be difficult for anyone to prepare for Townsville. For the moment there are no statements for them to peruse.

COMMISSIONER: All right. The other thing I was going to mention is that there have been some patients referred to in the evidence of both Dr Cook and Dr Kariyawasam. That, I think, have now assumed the level of importance that we should consider lifting the suppression orders in respect of their names. That includes patients P18 referred to by Dr Cook and P43 and 44 referred to by Dr Kariyawasam, but before I do anything about any of those patients, I would like everyone to give it some thought, and it might be possible for Ms Murphy or someone to contact the patients, or in the case of deceased patients, their families, to see if there is any difficulty. Those are the three I am contemplating; P18 and P43 and 44.

I will just say in that regard, I think everyone here is familiar with my view that patient privacy is tremendously important, but these issues get to a stage where there is a sort of star chamber or KGB flavour to the proceedings if we're hearing evidence about people without knowing who they are and without the general public having the opportunity to follow the evidence in an intelligible way. 2.30.

THE COMMISSION ADJOURNED AT 1.20 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.34 P.M.

PETER DALTON COOK, CONTINUING:

COMMISSIONER: Mr Diehm, we'll see if your estimate is any better than Mr Perrett's.

MR DIEHM: I think it was 20 minutes I said, was it?

COMMISSIONER: I think it was.

CROSS-EXAMINATION:

MR DIEHM: Doctor, Geoff Diehm is my name. I'm counsel for Dr Keating. Just looking at your correspondence concerning the issues regarding patient P18, the first of the items of correspondence that we have from you, of course, is the e-mail of the 20th of June 2003 which is Appendix A3 to your statement. That's the one to Dr O'Donnell where you conclude by saying that in your view these procedures should not be being done at a hospital without robust ICU back-up?-- Correct.

The next document that we have in the chain, as I follow it, is your e-mail to Allison Kingsbury on 4 July 2003 that's apparently destined then for Jennifer Skinner concerning the agenda for the meeting, where again in the second item you raise the issue about P18, and you express the view, "Clearly this is not appropriate surgery to be done at a centre with such a small level of support services, particularly ICU."?-- Could I just qualify that by saying you're following this order chronologically.

Yes, that's what I'm endeavouring to do?-- And the second thing I'd have to say is Appendix A1 was printed out on Allison Kingsbury's printer, however it is - the original message was sent directly to Jenny Skinner.

I'm sorry. I was trying to understand something. I misunderstood how you explained that earlier in your evidence?-- Yes.

Then the next document that we have is Appendix A2, which is your letter to Jenny Skinner dated 7 July 2003, the contents of which we've already gone through. But we see there, that having raised again your concern about this sort of surgery being performed in a centre like Bundaberg without the back-up of a robust ICU, you then raise what you describe as a second issue relating to the accreditation of the surgeon, and then specifically a question mark about whether or not there was

some technical problem with respect to the surgery, as I follow what you've set out in that last substantive paragraph on page 2?-- Broadly speaking, that's correct.

Of course, as you point out quite fairly and clearly, you're not a surgeon. These are just matters that concern you and need to be investigated by somebody who is appropriately qualified to look into them?-- Correct, but in reality I had discussed it with people who were surgeons, but I didn't quote that within the letter.

All right. You didn't think it fair to them to go quoting what you thought they had to say?-- I would put it the other way around. I would say I wouldn't want to make a claim which could prove to be false in a letter such as this. This letter is designed to be read widely, and I wanted to make sure that what - the contents of the letter was a fair representation of what's true.

Thank you. The difference, though, that we can see in terms of the issues that you've raised in those three items of correspondence - quite clearly from the beginning you were raising a concern about the issue of this sort of operation being performed at Bundaberg without the back-up of a robust ICU, and that was raised in the first two, but what wasn't raised in the first two was any issue about the technical competence, as it might be put, of the surgeon?-- I think you need to understand that the first two appendixes that you referred to were brief notes indicating that there is a bit of an issue going on in this area. They were not designed - one is at the end of an e-mail which raises about, broadly speaking, four separate issues, and it's not meant to be an end in itself, whereas the letter to Jenny Skinner is an overview of all the relevant issues, and I think we've touched on those, and I think it's important if I could just go over those again briefly. There are three separate issues here. One is the size of the institution. The second one is the number of operations like this that the surgeon is doing, and the third one is the training of the surgeon. Now, sitting in Brisbane, all I can speak about with authority is the size of the institution, but if you take into account the size of the institution, it calls into question the other two. So I can speak with authority about the size of the institution, and if someone is doing that operation in that institution, it calls into account how many they're doing per year - I don't have that data, but someone needs to check that out - and also what their training is, because if you're-----

COMMISSIONER: But doctor, I think in a more direct answer to counsel's question, you weren't raising specific concerns about Dr Patel's clinical competence?-- I think it's fair to say, Commissioner, that I was concerned that someone had proceeded with an oesophagectomy in the presence of palpable lymph nodes at the time of surgery.

Right.

MR DIEHM: At what point in time did you develop that concern?-- After discussion with the surgeon at Mater.

Do you know when that was?-- Immediate - in the period between when the patient was admitted to the Mater and writing this letter, quite clearly.

Yes, but it would be difficult for you to you recall now with precision just when in that timeframe it was?-- It was a corridor consultation. It's the sort of thing that does happen from time to time where - in fact we have had another patient from Bundaberg from the same surgeon who has been admitted to our Intensive Care Unit, and I stood at the end of the bed with another general surgeon and said, "Well, this is what happened here. What do you think?" He said, "Well, it's not what I'd do, but it's probably within the broad scope of acceptable practice", and there was no feedback concerning that case.

Did you have more than one conversation with the surgeon concerned about this patient, P18?-- We're talking about conversations two years ago, but I think I did. I think I only had one at the bedside, which is the one where the notes are, and the notes are really important here because if you go to the fact that they - that the patient had palpable lymph nodes and they proceeded with an oesophagectomy, then you really need to consult the notes and go back to the operative note for that. But my understanding is that I had discussions with the surgeons away from the unit - with that surgeon away from the unit as well.

Doctor, to put these questions into context, I'm going to put to you certain matters about the communication that you had with Dr Keating regarding P18 and invite your comment as to whether you agree or are unsure or disagree as we go along.

COMMISSIONER: Before you do that, Mr Diehm, just so that there's no misunderstanding, often when counsel put things to a witness, that involves at least the implication that you're proposing to call evidence to this effect. Obviously any such intention on your part depends on things that will take place in a different tribunal next week.

MR DIEHM: That's so, Commissioner, yes.

COMMISSIONER: When you put these things to Dr Cook, you're not, in effect, waiving any rights or anything.

MR DIEHM: Thank you, Commissioner. No, I'm not. I'm not intending to do that.

COMMISSIONER: Yes.

MR DIEHM: Doctor, firstly, the conversation that you had with Dr Keating was by telephone, was it?-- Correct.

On the 1st of July 2003, I suggest?-- I don't have a record of the date. I have gone back through my files and I've just

got some longhand notes in the files - very rough - concerning the fact that - leading me to believe that this - or more evidence that this conversation in fact took place.

All right. But it doesn't assist you anything more than to confirm that the conversation happened?-- Correct.

All right. Now-----?-- Which is my clear recollection as well.

Thank you. The next issue then - well, I'm sorry, just to clarify that. If I suggest to you that the conversation happened on 1 July 2003, your answer, I take it, is that you can't be certain whether it was that date or some other?-- If you suggest that to me, I would suggest that it's a fair possibility that's the case.

Around about that time?-- Yes, yes.

That when you contacted Dr Keating - or he contacted you, as the case may be, the - you raised with him issues about the patient's management at the Mater and his course during his time there, and that you described his course initially as being very rocky. You need to speak your answer?-- Yes, yes.

Thank you. That you told Dr Keating that the patient's discharge was pending, because he'd improved sufficiently that he was likely to be leaving soon?-- I'd have to go back and check the dates as to when the patient was in fact discharged from the unit, but it was - from memory, the patient stayed two weeks. They were admitted-----

20 June, I think?-- So that's highly likely.

That would be about right? You then raised with him whether an operation of this kind should be done at Bundaberg?-- Correct.

In particular, you made mention to him about the need, when such operations were performed, to have a robust ICU back-up?-- I'm not certain that I used those terms, but certainly that meaning.

Thank you. Dr Keating responded to you by saying words to the effect that he would discuss the issues that you had raised with his director of his ICU and his Director of Surgery - that is Dr Carter and Dr Patel. Whether he used their names or otherwise, he indicated that he would discuss the issues with them and with the Credentialling and Privileging Committee at the hospital - at the Bundaberg Hospital?-- I have no recollection of that. In fact the only recollection I have of this conversation occurring was the fact that I discussed the - whether it is appropriate to perform a procedure like this in Bundaberg and those three factors that would lead me to have that view that it may not be appropriate. The only other impression I got from the phone conversation was that it was important, as a result of that conversation, for me to raise this with the Health Department.

So in answer to my suggestion that Dr Keating told you that he would discuss these matters with Dr Carter and Dr Patel - or if he didn't use those names, the Director of ICU and Director of Surgery - you'd say to that, "I don't know."?-- Yes, correct.

COMMISSIONER: Doctor, do you have a recollection of any response from Dr Keating?-- The only recollection I have is that when I got off the phone, it appeared to me unlikely that the surgery was going to be proscribed in future at Bundaberg.

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MR DIEHM: But you can't recall what it was that caused you to think that?-- No.

COMMISSIONER: What has been put to you by learned counsel, that Dr Keating in effect told you he would take it up with the Director of Surgery and the Director of ICU in Bundaberg, is that inconsistent with anything you can recall?-- Oh no, not at all, and to be fair, I think that would be a reasonable answer from a Director of Medical Services.

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Yes.

MR DIEHM: Thank you. I put it to you that you did not in fact say anything to Dr Keating about specific concerns regarding the surgeon for P18, his competence, or any issues of technical deficiency that you had concerns about with respect to the procedure itself?-- If you're referring to proceeding in the presence of palpable lymph nodes, my recollection is no, that's correct, but I did make the point that if someone is doing this procedure in this sort of venue then you would - there are concerns about the currency of their practice, and it raises issues in relation to training as well. But I didn't specifically mention the lymph nodes and proceeding - because that's quite a technical issue.

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Thank you. Doctor, you gave some evidence yesterday about visiting Rockhampton Hospital - well, I think you made attempts to start this process in 2003, but perhaps weren't successful until some time later - to visit their ICU, but you did also mention that you had made a similar offer to Bundaberg Hospital at around the same time?-- August '03, correct.

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And you in fact did visit the Bundaberg Hospital in late August 2003?-- Correct, and met Dr Carter.

Yes. The original plan, was it not, was for you to meet with Dr Keating. I'm sorry?-- That's a difficult question to answer without giving you the full story. We were trying to work on linkages between the Mater Hospital in Brisbane, the Mater Bundaberg and Mater Rockhampton. Those hospitals don't have intensive care units, so to assist them in doing more complex surgery, we were also trying to assist the public hospitals in those towns to develop intensive care services. The visits were focused on the Mater Hospital, but as part of the visits I had to visit the public hospitals, I corresponded

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with the District Manager, Mr Leck, and he suggested I meet with Dr Keating. In fact I didn't meet with Dr Keating and I met with Dr Carter instead, and to be honest, to this day I'm not sure why.

If I make this suggestion - this may be relatively unimportant, but in short, there was a time arranged for which the meeting was to take place, but your earlier commitments in the day at the Mater saw you running a bit late, so Dr Keating was unable to meet with you, but you met with Dr Carter instead?-- I think that would be quite likely.

Thank you. The content of your meeting with Dr Carter was perhaps a bit along the lines of what you just said, but it wasn't about raising any specific issues. It was about liaison, getting to know people, being able to put names to faces and establishing a working relationship?-- Exactly, and it would have been inappropriate to raise any of the concerns in any of the correspondence that we've been discussing at a meeting such as that.

Yes. And so you didn't?-- No, absolutely not.

Thank you. Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Diehm. Mr Chowdhury?

MR CHOWDHURY: No questions, thank you.

COMMISSIONER: All right. Any re-examination?

MS GALLAGHER: No, thank you, Commissioner.

COMMISSIONER: Mr Andrews?

MR ANDREWS: One matter, Commissioner.

RE-EXAMINATION:

MR ANDREWS: Doctor, you wanted to allude to Exhibit 220 at page 100. I wonder if I can be shown Exhibit 220 at page 100 and have it put up on the screen. If you hand it to me, I may be able to locate a page that has that number on it.

COMMISSIONER: Exhibit 220 is Dr Cook's submission. My copy isn't paginated, I'm afraid.

MR ANDREWS: There is - no, the document isn't paginated, but at the very back of the document, Commissioner, there does appear a document entitled, "Guide to Role Delineation of Health Services" which is - oh, no, Commissioner, I've misled you. The submission is not Exhibit 220. The submission bore a different number. Exhibit 220 - I'm holding it. It's a-----

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COMMISSIONER: Yes, you're perfectly right. Exhibit 218 was the submission. Exhibit 220 is the document from the Northern Rivers Health Service.

MR ANDREWS: Is this an appendix to that guide?-- Yes.

Is it a draft?-- The document that was sent to me was in draft form, but I don't have a copy that's not got "draft".

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Is the point you wish to draw to the Commission's attention on the right-hand side under "Complex Major Surgical Procedures" such as oesophagectomy?-- And pancreatic resection.

And what is it about the fact that they are included under the heading "Complex Major Surgical Procedures"? Is there something on the page that suggests that they should be done in a particular place?-- Correct. The "Guide to Role Delineation of Health Services" is a New South Wales document trying to match levels of healthcare with levels of hospital resources. So if you have a complex hospital you can do complex surgery, and if you have a very basic hospital you can do very basic surgery, and it tries to match up the two. So there are a variety of criteria. It judges how your pharmacy is, what your radiology department is like, and then it suggests what's appropriate for that type of hospital, and types of surgery are listed, and it is envisaged that complex major surgical procedures would normally be done at, to use the phrase, more robust hospitals.

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COMMISSIONER: When you say "more robust", are you talking only about tertiary teaching hospitals or something below that level?-- Yeah, hospitals with robust support services in a variety of areas, which really means tertiary - it doesn't mean only tertiary hospitals, but you need to have that sort of facilities before you embark upon things like this, and this has applicability to the private sector as well. So if you would like to perform an oesophagectomy on a private patient at a private hospital in New South Wales, this document could be tabled as to whether that was a fair clinical approach to the patient care.

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I'm really just interested in the practical application. I mean, obviously the big hospitals in Brisbane - the PA and the Royal Brisbane - would be suitable for these sorts of operations. Similarly the Prince Charles, except that, as we know - that's limited mainly to - I think it's chest and cardiac surgery. What about, for example, Toowoomba or Townsville or Rockhampton?-- You would have to look at their range of facilities, but they would have - just speaking from the intensive care perspective, and extrapolating that to the other areas, they would have Level 2 intensive care facilities, which in terms of the Joint Faculty of Intensive Care Medicine - that's my college - that allows long-term organ support.

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Yes?-- Bundaberg is - would not meet the criteria of having a Level 2, and they would have closer to a Level 1 intensive

care facility, and the expectation is that the consultation would occur soon after the patient's admission, plus or minus transfer to a hospital that can look after a long-term ventilated patient.

Right.

MR ANDREWS: I've no further questions for Dr Cook.

D COMMISSIONER VIDER: No questions.

COMMISSIONER: Sir Llew?

D COMMISSIONER EDWARDS: No.

COMMISSIONER: Doctor, it has been my standard practice to thank all witnesses for their coming to give evidence, their assistance, and I certainly extend that thanks to you as well. But may I say that your evidence has been quite outstanding for the care and preparation that you've obviously put into it, and I suspect a lot of that in your own time, and we are for that reason all the more particularly grateful for your assistance with the difficult issues we have to deal with. Thank you for coming along, thank you for your time, and thank you for your assistance?-- Thank you, Commissioner. I'd like to thank the staff of the Commission because they've been very helpful. From my perspective, I viewed this as an opportunity to improve the healthcare of Queenslanders. It may only come once in my life, and it's been a pleasure to help.

Thank you. I hope, Mr Lyons, that you will also convey to your client, the Mater Misericordiae Hospital, our thanks for their assistance and cooperation in making Dr Cook available to give this evidence.

MR LYONS: I will do that, Commissioner.

COMMISSIONER: May I simply say that if I need to utilise the services of an Intensive Care Unit in the next little while, I hope it's in the region of Woolloongabba or South Brisbane?-- I hope next time we meet is socially, not professionally.

Thank you?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Mr Lyons-----

MR LYONS: Might I be excused?

COMMISSIONER: Indeed. Thank you for your assistance again.

COMMISSIONER: I did raise earlier, Mr Andrews, the question about the three patients, P18, 43 and 44. Have we made any progress yet?

MR ANDREWS: No.

COMMISSIONER: Also, consistently with my views about transparency and openness, I want to place on the record two items of correspondence. There is a letter which I sent to The Honourable The Premier today relating to progress of the inquiry. That letter will be Exhibit 233.

MR FARR: 223, I think.

COMMISSIONER: Thank you. Exhibit 223.

ADMITTED AND MARKED "EXHIBIT 223"

COMMISSIONER: There's also a letter which I sent to the clerk of the legislative assembly, Mr Laurie, regarding issues of parliamentary privilege and inviting a submission from the clerk's or the speaker's office regarding some of the points that have arisen in evidence here, particularly concerning situations where Queensland Health employees feel impelled to make complaints or grievances to members of the Legislative assembly. That will be Exhibit 224.

ADMITTED AND MARKED "EXHIBIT 224"

COMMISSIONER: Yes, Mr Andrews?

MR ANDREWS: Commissioner, I call Dr Fitzgerald. While the doctor comes to the stand, may I inquire whether the Commissioners have copies of Dr Fitzgerald's large statement?

COMMISSIONER: We do, but speaking only for myself, I've only just browsed through it.

GERRY JOSEPH FITZGERALD, SWORN AND EXAMINED: 1

COMMISSIONER: Doctor, please make yourself comfortable?-- Thank you, Commissioner.

Do you have any objection to your evidence being video filmed or photographed?-- No, I have no objection, Commissioner.

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Thank you.

MR BODDICE: If the Commission pleases, we seek leave to appear on behalf of Dr Fitzgerald.

COMMISSIONER: Thank you, Mr Boddice.

MR ANDREWS: Doctor, would you tell the Commission your full name, please?-- Certainly. Gerard Joseph Fitzgerald.

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Doctor, you have prepared a statement, indeed, three of them but their dates are the 2nd of June 2005, to which there are annexed about 32 annexures. You'll find the date at the back of this statement?-- At the back, yes, thank you.

Are the facts deposed to in that statement true to the best of your knowledge?-- They are.

Are any opinions you express in it opinions you honestly hold?-- They are, yes.

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COMMISSIONER: What I'll refer to as the principal statement of Dr Fitzgerald dated the 2nd of June 2005 will be Exhibit 225.

ADMITTED AND MARKED "EXHIBIT 225"

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MR ANDREWS: Doctor, you have prepared a further statement signed 20 June 2005?-- I'll just check if this is the right one if I may. Yes.

Which deals with testimony from Mrs Kemp?-- That's correct.

COMMISSIONER: Did you say 20 June?

MR ANDREWS: I did. There is another dated 23 June.

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COMMISSIONER: Right. Yes, I'm sorry, I didn't find that. The statement of 20 June will be Exhibit 226.

ADMITTED AND MARKED "EXHIBIT 226"

MR ANDREWS: You prepared a further statement dated 23 June?-- That's correct.

Those two further statements, are the facts expressed in them true to the best of your knowledge?-- Yes, they are.

And the opinions expressed in them honestly held by you?-- Yes, they are.

COMMISSIONER: The third statement dated the 23rd of June will be Exhibit 227.

ADMITTED AND MARKED "EXHIBIT 227"

MR ANDREWS: Doctor, I'll dispose of those statements for the administrative convenience of the parties because I expect they could be lost in paper involved in the first statement. Your statement relating to Mrs Kemps' testimony refers to pages 7 and 8 of Exhibit 126. I will have them put on the monitor and you can confirm for me that these are the sections on pages 7 and 8 of Mrs Kemps' statement that you address in your own statement at paragraphs 5, 6 and 7?-- Yes, that's correct.

You wished in Exhibit 226 to make the point that you didn't say or don't believe you've said that Mr Kemps wouldn't have been operated upon in Brisbane, rather, you recall saying he may not have been?-- Yes. I feel confident I would have avoided being so sure about it because I - it's not my area of expertise so I would have left it to the clinicians involved.

Could page 8 be shown of Mrs Kemps' statement. You wanted to make the point that that is correct. That is, that you told Mrs Kemps that the Bundaberg Base Hospital was not equipped to provide the standard of treatment required for the operation performed on Mr Kemps?-- Yes, I believe I did. That's certainly my views.

COMMISSIONER: So it's both true that you said it to Mrs Kemps and also true as a matter of fact?-- Yes.

Or certainly as a matter of your opinion?-- As a matter of my opinion, Commissioner, yes.

MR ANDREWS: But you don't recall telling Mrs Kemps that Mr Kemps had 12 months to live. It's your practice not to give that kind of prediction?-- That's - that's correct, and certainly in this area, I wouldn't have sufficient expertise to be able to provide that advice. Although, I could - I think what I tried to indicate in my statement, I could understand if Mrs Kemps had formed that view from words that I may have said but I suppose I was just trying to be clear that

I wasn't in a position to give that sort of accurate prognosis.

Now, within your statement Exhibit 227, you express the view that it would not be appropriate to conduct operations, that is Whipple's procedure operations, at Bundaberg Hospital because it had a level 1 ICU, suitable only for short-term ventilation?-- Yes.

You will see that at paragraph 13?-- Yes, certainly that's my view.

And that's consistent with your view that oesophagectomies should not be performed there either?-- That's correct.

COMMISSIONER: Doctor, can I ask you this. As I understand it, it is part of your statutory role to approve or certify private hospitals in the state. Does that certification involve any delineation of the nature of the procedures permitted to be performed at those hospitals?-- It does, Commissioner. There is a document which is called the Service Capability Framework-----

Yes?-- -----which had been prepared and renewed last year to apply to both public and private hospitals. It was a document that we had used in my office or the staff in my office prior to and subsequent to my commencement there to license the private hospitals and judge the level of service. The document however is not specific to particular procedures. It gives a broad, general scope of practice that should be performed in, say, a level 3 surgical service.

Bundaberg Base Hospital had been a private hospital and had been licensed by your office. Would there have been restrictions in the framework that you referred to which would have indicated, perhaps not naming the procedures by name but which would have indicated it was not licensed to undertake this sort of surgery?-- Yes, the difference between the public and private sector in this regard is that, really, the staff in my office allocate the level of service-----

Yes?-- -----dependent on the expertise and equipment that's there in the service. Whereas because the Service Capability Framework has only applied to the public sector in the last 12 months, that's been a self-reporting exercise from the hospitals. So in the private sector, before they would commence services our staff would undertake a review of the location and the equipment facilities and provide me with advice which I'll then determine the level of service that they would be able to provide.

And in a hypothetical situation where, for example, Bundaberg Base Hospital were privatised, are you able to give any indication as to the types of restrictions which would exist for a private hospital the same as the existing Bundaberg Base Hospital for operations like Whipple's and oesophagectomies?-- There's two elements to the controls that are in place. One is the Service Capability Framework and the allocation of a

level of service. 1

Yes?-- The second is the credentialing and clinical privileges process. Our licensing arrangement with the private sector is such that we require the credentialing and clinical privileges prior to people starting a service within the - within the hospital. So it's the checks and balances are - between the categorisation of the level of service that's provided, say, a level 3 surgical service, level 1/level 2 intensive care service, which are dependent on the capabilities of the staff and et cetera that are available there. 10

Yes?-- And the second part of that then is that the individuals who seek to practise there have to be credentialed to undertake particular procedures by the credentialing and clinical privileges committee of the hospital. So I think in answer to your question, if it were privatised then, we would require that to be done prior to, for example, Dr Patel commencing service there.

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And the upshot of all of that is that if Dr Patel had been working at a base hospital - sorry, at a private hospital equivalent in size and facilities to Bundaberg Base Hospital, there is a high level of probability that he would not have been permitted to perform these operations?-- I think that's so, although ultimately of course it's the specific part that's specific to that operation would be the credentialing and clinical privileges committee.

Yes?-- So it would be up to his peers to determine that he has the level of expertise and experience required to perform that procedure within a hospital of that level. I would be surprised if the peers would approve somebody to do those sort of procedures in a location that had a level 1 intensive care ward. 30

We now know that if such a committee had started looking into Dr Patel's background and his surgical experience, he probably wouldn't have been allowed to practise surgery at all?-- He certainly would have, I suspect, severe restrictions put on the sort of surgery, and of course, if we knew - if the committee knew then the history in the United States, which we weren't aware of at the time, I'm sure those restrictions would - if he was employed at all, those restrictions would have been fairly severe. 40

Yes. Doctor, did I take it from something you said a moment ago that the system that has existed in private hospitals is now being extended to public hospitals?-- That's correct, Commissioner. Prior to July last year the Service Capability Framework was a document that was used for the licensing of private hospitals. It creates a framework, then refers to a whole series of standards that are developed by the relevant colleges and et cetera. In this regard, in regards to intensive care, they're the standards developed by the joint colleges - the intensive care college. So that document applied to the private hospitals and was used in the private hospitals. A considerable amount of work was done early last 50

year and the year before to review that document, to update that document and then a policy decision was made that it should apply to the public sector.

I guess a critic of Queensland Health could say that that's a bit late and that patients in public hospitals should always have had the same level of protection as patients in private hospitals?-- I'm sure it's a fair comment that the - I suppose what happened last year was to obviously try and bring some alignment between the public and private sector.

Thank you, Doctor.

D COMMISSIONER VIDER: Dr Fitzgerald, could I just ask you further to that about the Service Capability Framework. Does that go down and make connections between the services and their availability? For example, does it talk about the fact that you need to have onsite radiology services, you need to have pathology services available to support many of these direct services to the patient?-- It does. It usually refers to relevant standards around those rather than being specific about the types of those services but it certainly says that if you're, for example - and I'm sorry, I don't know the details of it but if I may use an example that may be incorrect, but if it's, for example, a level 3 surgical service, it requires a level 1 intensive care, a certain level of radiology service, et cetera. There are a number of other requirements that are built into the standards to say that you really can't designate yourself a level 3 intensive care ward-----

No, you must-----?-- -----unless you meet these other criteria and that support.

And that criteria is there, it's clear enough, for any institution to be able to see what they can and can't do?-- Well, I think so. Again, I'm not - I don't know the details of some of those elements but we've have had no concern raised, certainly in the private sector, in being able to allocate a level very clearly. There's obviously from time to time concerns raised about the impact of that on-cost infrastructure, et cetera, but I think our staff are very assiduous in ensuring that they do meet the standards.

Thank you.

MR ATKINSON: So, Doctor, from July of 2004 hospital administrators will have been concerned to comply with a document that was supplied to the public hospitals?-- That's correct. Yes.

And that document, would it have gone to such detail as to explain to the administrators for instance at the Bundaberg Base Hospital that it was appropriate for there to be a consideration about the degree of complexity of surgery that would be performed at their hospital?-- Yes. The descriptor in the document says that there are - it links together the level of complexity of the surgery with the risk of the

patient. So, for example, a certain level of surgery may permit complex operations in patients who are of low risk but not complex operations in patients who are of high risk. So it's-----

Would you remind me of the name of that document so that I can locate it?-- Certainly. It's Service Capability Framework.

Thank you.

COMMISSIONER: Was there a phase-in period for this or did it sort of come out on the 1st of July and all hospitals have to apply it immediately?-- I think, from memory, the instruction was that it - that hospitals would have a year to bring their services up to the required standard.

Presumably that means that from the 1st of July last year, hospitals like Bundaberg ought to have been actively reviewing their operations to see if they come within the framework?-- Yes, that's - that's correct, yes.

D COMMISSIONER EDWARDS: And if they didn't, what would be the official approach to that problem?-- I suppose at this stage that there was no checking regime, although what has happened is I know a number of the zones or certainly the zonal structure within Queensland Health has started to look at some of the hospitals and they do their own sort of inspection arrangements to see if they are complying with a whole range of standards, including, obviously, the Service Capability Framework. But there is no independent validation I suppose apart from that administrative structure.

MR ANDREWS: Doctor, are you in a position to determine whether by the time this document was distributed to the administration of the different public hospitals - let me abbreviate that. Are you in a position to determine whether by July 2004 administrators ought, in any event, to have been aware of the need to consider the service capability of their own hospitals?-- I'm not sure I understand the question but perhaps if I could-----

Well, so that I can clarify it?-- Yes.

Before this document came to the attention-----?-- Mmm-hmm.

-----of the administrators at the Bundaberg Base Hospital, ought those administrators anyway have - ought they to have been concerning themselves with the question of what levels of service capability their hospital was capable of?-- Look, I think so. I mean, I'm sure the Service Capability Framework, as we've talked about, has been around for 12 months, but for the last 20 or 30 years that I've been involved, I mean, medical superintendents of course have been very aware of what hospitals - what range of services should be provided within their hospital and have tended to actively manage the restriction of that, bearing in mind of course that over that time the specialisation in medicine has changed fundamentally so that procedures that used to be done in provincial

hospitals quite regularly, such as oesophagectomies, now tend to be done by people who are doing them all the time. So, a degree of specialisation. But the principle that you raise, which is an awareness by medical superintendents, the medical administration, of the range of services that would be provided in their hospitals I think is intuitive and part of a professional manager's responsibility.

D COMMISSIONER VIDER: Doctor, does it put additional strain on the implementation of such a document in those areas that have medical staff that are there either under special services classification or Area of Need classification because their level of competence is not that that is easily recognised, having been accredited by colleges, whatever? So does that put a degree of responsibility on to the individual hospital executive as to them then determining what their level of service is, given that they're the ones that know their medical workforce?-- Yes, look, I think it does. I think the - what we'd be used to in my career in hospitals was that - for example in surgery, is that the surgeons would work out amongst themselves what should be done there and what shouldn't be done. They rarely needed to be guided in that matter. It was a matter of their own professional judgment and responsibility. I think the difficulty that we're confronting as a result of the crisis in medical manpower that we're facing across this state and across this country is that we have people who perhaps don't have that knowledge of the Australian health care system. So I think it does place a greater responsibility on the medical administrators, medical managers, to ensure that doctors who are coming in from overseas who perhaps aren't aware of the system or who perhaps have come from a completely different medical system where people are - where, you know, sort of procedures may be done in an environment - in whatever environment they possibly can be as opposed to being done in a special environment or an environment which would have high standards. So I think the point is right. That's a, probably, very long-winded way in saying, yes, I think you're right.

COMMISSIONER: I suspect the other thing, certainly from what we've heard over the last two or three decades anyway, is that medical administrators or superintendents as they used to be called have ceased to be part of the clinical team at a hospital and more and more of necessity have become, as it were, non-playing captains?-- Mmm, mmm.

I guess 20 or 30 years ago, because a medical superintendent was often, for example, a surgeon, the chief surgeon as well, that he or she would know precisely what was going on in the operating theatre?-- Commissioner, I think that's correct. I mean, I was at Ipswich in the 1980s and at that time most of the medical superintendents would be surgeons around the various hospitals because they - it was necessary to have someone on staff who had surgical skills for the trauma and usually the only way of retaining somebody on a staff position in those days, when most people sought to go into private practice of course, was to - for them to be the medical superintendent as well. So that role was conjoined. I think

what's happened in subsequent years of course has been the increasing complexity of the - not only the environment we all work in in terms of the community environment and the degrees of accountability required, et cetera, and the complexity of the various categories of staff has led to a greater need for management as opposed to - that is more concentrated as opposed to part-time management.

I think that we would all agree that there are obvious merits in having a medical superintendent or Director of Medical Services who is a specialist in medical administration rather than a specialist in surgery just as there are advantages in not using up the available resources of surgeons by letting them do jobs for which they're not qualified?-- Sure.

But my question to you was really addressed to the point that maybe this creates an even greater onus or responsibility on the superintendents to make sure that they carry out ward rounds and see what is actually going on in the operating theatres so that the sorts of issues we're talking about here don't arise?-- That's correct and, I mean, a lot of the good medical managers of course have systems and structures in place to ensure that they are appropriately advised. So while the medical superintendent, or whatever name you use, may well be a professional manager, medical manager, they would have Directors of Surgery who would hopefully fulfil that function around surgery, Director of Medicine who would be active clinicians, as well as consultative committees or advisory committees. So the good medical managers usually put in place the systems and structures to ensure that they are getting the correct information or the proper information from the clinicians directly. And, of course, you're absolutely correct: the better managers of course walk the hospital, get to know the place and certainly should suffer no surprises in terms of what's going on in their hospital.

D COMMISSIONER VIDER: And, therefore, to meet the elements, certainly the one that refers to peer review, that component that underpins the Service Capability Framework in the outer metropolitan areas, in metropolitan areas as well but certainly in the outer ones, you would therefore be very reliant on a great mix of specialist staff available to you so you would need the input of VMOs as well as staff specialists if you're going to be able to maintain some form of clinical peer review?-- Oh, that's - that's absolutely correct and - I mean, if - I think a good clinical privileges committee should have independence built into it.

Yes?-- So there is no reason why, you know, a city like Bundaberg, that there shouldn't be - there couldn't be one committee for private and public sector. It could quite be - could be appropriate, if there was a degree of cooperation with all the staff. But I think the importance or the concept among credentialing and clinical privileges committee is it shouldn't just be management. It's a check and balance. So it shouldn't just be management checking off the employment and meeting the service delivery requirements but it should have a degree of independence about that

judgment.

Yes?-- So I think the capturing of VMOs into that process is very important.

And, certainly, we would agree from the evidence we've heard that, for example, in a place like Bundaberg there could have been a combined M&M committee and that would enhance the whole learning coming out of that sort of review?-- I think so, yes. It certainly would be, I think, very appropriate to have a city-wide collaboration.

Yes?-- I think again, perhaps in the days that we were used to, the - there was a much more active integration of the public and private sector than perhaps there is at this stage.

MR ANDREWS: Doctor, I would like you to consider a hypothetical situation. I'm trying to discern the degree of knowledge that a reasonable practitioner would have about service capabilities matters?-- Mmm-hmm.

And the hypothesis I'm asking you to consider is that you have a Director of Medical Services, a non-clinical Director of Medical Services, a Director of Surgery and an anaesthetist considering in 2003 whether or not it's appropriate in a hospital such as Bundaberg for that hospital to be performing oesophagectomies?-- Mmm-hmm.

Now, it could well be that the degree of knowledge about such matter that would be possessed by the anaesthetist, the surgeon-----?-- Mmm.

-----and the administrator could be different?-- Yes.

And it's because of that possibility that I ask you to consider which of them ought to have known that a hospital such as Bundaberg's should not have been permitting oesophagectomies. All three of them?-- Intuitively, I would say, yes. The obvious - the person who should be most attune to that would be the surgeon of course, because they should understand more than the other two the risks and complications associated with surgery of that type. But I suppose my reaction, when I first heard or saw the information about the type of operations that were performed there, was surprise, and I would suggest that most of the other senior colleagues I've spoken to who are - who may also be medical administrators - I suppose my point that I'm trying to make is that I would have expected the medical administrator to have expressed that surprise as well.

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COMMISSIONER: Doctor, I know I am going to lead Mr Andrews off his train of thought, but I feel this is important. One of the concerns I have is that the traditional structures, having been done away with for no doubt very, very good practical reasons, not having a medical superintendent who has a surgical or clinical basis, in a major metropolitan hospital, and, indeed, maybe even in major hospitals like Townsville or Toowoomba or Rockhampton, there is still a sufficient complement of clinicians in the hospital to deal with the sorts of issues we're talking about, but one of the key problems at Bundaberg seems to me that once Dr Patel became Director of Surgery, he was really at the apex of the clinical decision-making system. There was no-one clinical above him in the system. Dr Keating - I will be careful what I say - may or may not be criticised for his failure to perceive that Dr Patel was going outside his level of competence, but the reality is that Dr Patel was his own master in terms of clinical decisions?-- Yes, certainly that's true. You would rely, in that circumstance, on the Director of Surgery to direct the surgery, and the unfortunate consequence of him becoming the Director of Surgery is that really most - most medical superintendents would rely on the Director of Surgery to determine what surgery is being undertaken.

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D COMMISSIONER EDWARDS: Could I-----

COMMISSIONER: I was going to say - perhaps I am anticipating what Sir Llew is going to say. We have heard a number of proposals, if I can put it that way - Dr Thiele from Bundaberg, for example, suggested that there should be a clinical chief of staff, a doctor who is perhaps even elected by the other doctors within the hospital to be the figurehead for their profession. We have heard from Dr Jeannette Young earlier this week from the PA that they have positions of Chair of Medicine and Chair of Surgery within that hospital. I must say, I am very inclined to the view that within each hospital there should be a clinician - and possibly more than one; maybe a medical clinician and maybe a nursing clinician - but there should be a clinician who is titular head of the hospital - not doing an administrative job, but being there as a role model, a mentor, a final point of reference, a last court of appeal for clinical issues within the hospital?-- Mmm. I think it is a model that could work. It is very similar to a lot of the United States hospitals where they would have the Chair of Surgery, or the Chief Resident they often call them-----

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Yes?-- -----who would be the clinical head. I mean, there would need to be some detailed thought, I am sure, put into the relative role of that person versus the medical manager.

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Yes?-- And the accountabilities of the two in terms of delivering the services and organising the resources, et cetera, that's required. But, I mean, a lot of hospitals have a medical advisory group within the hospital.

Yes?-- Usually the chair of that has considerable influence in what is occurring in the hospital and would deal with many of these sort of clinical issues, where the medical manager may not have that sort of expertise.

One of the things that has again disturbed me greatly. We have heard evidence from a number of the younger doctors who are in traineeship at Bundaberg Hospital and working under Dr Patel - and candidly one's heart goes out to these young people who found themselves in a very difficult situation but felt that there was no-one to go to?-- Mmm.

My view is that even if it is not a house officer within the hospital, that as long as there is some figurehead within the hospital, even if it is a visiting medical officer, or even a local GP who is the - respected as the chief medical person for that hospital, hospitals need someone at that level that can be the last resort?-- Yes, I with agree with you. There is another position that is in a lot of hospitals called the director of clinical training who is responsible for supervising junior - particularly the junior house officers and senior house officers. That's another position from whom junior staff could take counsel were they concerned about a particular issue. But I think the model that you are suggesting certainly has merit, and all I say is that we just need to work out the relative accountabilities of that individual versus the medical manager so there was no confusion around that circumstance.

Of course. What in my view makes it even worse, in a sense, in Bundaberg - and I am sincere in saying I don't mean this as criticism of Mr Leck - but you have a regional manager who has no medical qualifications at all. So once you get to Dr Patel, you have reached the limit of the clinical hierarchy?-- Yes.

Once you got to Dr Keating you have reached the limit of any form of medical training or competence?-- Yes.

And the ultimate decision-making within the hospital is vested in a man who, whoever his other skills, has no medical training or background at all?-- Yes. And can I say that I think that's another area where we've changed from the past, where in the past the medical superintendent's responsibilities were very clear.

Yes?-- When there was a hospital manager, those responsibilities were not able to be directed by the manager in their area of responsibility. And perhaps one of the options for the future is to look at whether those responsibilities, the medical superintendent or whoever that position is, would in fact be defined perhaps even in legislation, and similarly with the Director of Nursing, I think, to say that there are responsibilities those people hold which is outside of the normal organisational direction and control systems that are in place, and that may allow some checks and further checks and balances. And in a professional sense, they perhaps could report to whatever central

professional bodies there are, such as we now have a Chief Nursing Officer, Chief Health Officer, et cetera.

I am interested you say that because that really takes me into another area of particular interest - to me, anyway. Really since the inception of this inquiry, it has concerned me that we have Queensland Health as a huge provider of medical services, by far and away the largest in this State, and probably if not the largest, one of the two or three largest in the country-----?-- Mmm.

-----also being the regulator and, for example, in your - I was going to say your current position, but your position till earlier this week?-- Still at the moment.

You are, in a sense, a subordinate officer within Queensland Health rather than an independent decision-maker, although obviously the role involves some very important independent decision-makers?-- Mmm.

It is the experience in so many industries that being a service provider at the same time as you are a regulator just doesn't work, and at least those of us as old as you and me will remember the days when the Postmaster General's Department or Telecom was both the regulator of telephone services and the provider, the exclusive provider and there was therefore no effective regulation at all. I am strongly inclined to the view that those sort of regulatory functions should be outside the body which provides services, and that, for example, an officer like that, a chief health officer shouldn't be part of the department that's providing the services, it should be quite independent and be seen to be quite independent of Queensland Health. Perhaps that's not a fair question given your current position, but do you have views about that?-- Look, I think the core of your point, which is that there needs to be a separation between service provision and the policy or regulatory arm of government, is something that I personally feel needs to be strongly considered. I think for several purposes; not only the government's issue which you raise, which is there needs to be some separation of government's purposes, but I think it is also probably important from the point of view of the ability to focus people in a managerial sense, in a management sense. But if you - if you look at the department in its current structure, I think there are a lot of very good people who are trying desperately to both support business as well as regulate, provide policy advice to government, and I think if there was some mechanism whereby the people who do the service provision could be allowed to get on with it without the confusion of trying to forge and support or do the policy analysis at the same time, and even regulate themselves, the point you make very validly, I think, that would actually help us manage the organisation as well. I mean, it would allow us, I think, to make simple guiding statements to people along the lines of that, you know, the hospitals could just get on with caring for the sick, and that the people in central office and in the regions or zones or districts, or whatever administrative structures are there, should be there to

support them doing that and I think it would help, I think, allow those people to just get focus back.

Yes. I am not a big fan of the expression conflict of interest, which people bandy around a lot. It does strike me that there is a very genuine conflict between having a department which is under very, very genuine, very legitimate public concern that the level of service should be increased and waiting lists should be reduced, which is under very strong political concern about those issues - again for very legitimate reasons - but at the same time has to regulate whether those services are being performed at an acceptable level. And when you talk about the framework that was implemented a bit over 12 months ago, you can almost see that conflict arising, when on the one hand our political masters and the community want to get as much operations done as possible as quickly as possible, and on the other hand good medical practice and governments means not doing as many operations as possible but doing only those you are competent and capable of doing well?-- Yes. Look, it is very valid. And the other element to that, of course, is that in the current climate, it is very difficult to maintain quality services without the expertise of people to be there to do the services, and that is a very broad and very sharp community and political focus as a result of people not wanting to lose services that we can't provide safely.

Yes?-- So I think it is an extremely difficult environment that we're in for all of those reasons. So there are obviously some structural elements to that. But, as I am sure we're all aware, there is no perfect structure because if there was we'd all have got there, I think, by osmosis, but clearly there are significant, I think, impediments in the current arrangements.

Sir Llew, I am sorry.

D COMMISSIONER EDWARDS: You have covered the point I was going to raise, Commissioner.

COMMISSIONER: Thank you, Mr Andrews.

MR ANDREWS: Doctor, speaking of conflicts, as Chief Health Officer you're obliged by statute to be a member of the Medical Board of Queensland?-- That's right, yes.

Among the other situations that creates, one of them is that there is a representative of perhaps the most needy employer in the State on the Board which considers the standards to be met by those applicants for employment-----?-- Mmm.

-----who are coming from overseas. Do you see that there is the potential for a representative of Queensland Health to desire more candidates and for that to be in conflict with the duty of the representatives of the Board to be vigilant about the standards of the candidates?-- I think that's so. Obviously any individual can, in their behaviour and conduct, avoid that, but structurally, which is what you are talking

about, is that-----

Yes?-- However, it probably isn't as stark as you suggest, in that the Chief Health Officer has no line responsibility in the department. So the position is off to the side, and I think if it were more so legislatively and very clearly so, then I suspect there probably isn't as much a conflict between the role of the Chief Health Officer as perhaps a regulator of the health system in some way as well as a monitor and regulator and quality check on the health system. And, as well, having very significant professional roles in terms of medical profession, professional leadership, et cetera, but there probably is then a reasonable grounds for the Chief Health Officer, being an independent officer of the government as opposed to a member of Queensland Health, to be on the Board. I think that probably is consistent.

COMMISSIONER: Perhaps a clearer example of the sort of not only potential for conflict but actual conflict Mr Andrews was driving at was the situation with certifying areas of need that existed until recently, and I think, doctor - well, I know you have recently set out new guidelines - for which on behalf of the Commission I thank you; they are extremely well thought through and I am confident will address the problem for the future - but in the past there is every indication that when Queensland Health wanted an Area of Need declaration, the District Manager simply submitted a form and it got the tick. There was really no independent mind being addressed to those sorts of issues?-- Mmm. Yes, I think you are right. However, of course, there is now a similar conflict in that as a member of the Medical Board I chair the Registration Advisory Committee.

Yes?-- So I do now currently find myself with that difficulty in terms of approving the Area of Need and then also determining the individual to meet that Area of Need. I suppose all I can say is I am mindful at the moment, and that's a temporary arrangement until we can put in place some alternative arrangements.

Why I said earlier I don't like bandying about the term conflict of interest because as a technical legal concept what it recognises is that a person of integrity can manage a conflict very easily if he or she recalls that there are different duties to different sources at different times, but the reason the law generally doesn't like conflicts of interest is that they always involve the risk that someone will ultimately come into that position who isn't a person of integrity and will support the interests of one interested party over the other?-- Mmm.

Fortunately for the moment that's not happening?-- I certainly find it a bit difficult at the moment that I find myself approving an Area of Need knowing full well tomorrow night I am not going to approve the person to be in that Area of Need.

Yes.

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MR ANDREWS: Doctor, I see from your curriculum vitae that you have some expertise in emergency matters. You were a foundation Fellow of the Australasian College of Emergency Medicine, and you won an Australasian College for Emergency Medicine gold medal in 1993, and for 10 years you were Director of Emergency and Outpatients at Ipswich General Hospital?-- That's right.

The reason I raise that is that I wonder whether you can assist. In the emergency department at the Bundaberg Base hospital, with respect to its staffing after hours, there has been a conflict of evidence as to whether it is orthodox to staff it with the most senior people or not?-- Orthodox in terms of the patient needs or-----

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Patient needs?-- The - perhaps in addressing that could I suggest to you that the history of emergency medicine is that - prior to the formation of the college is that Casualty Departments, as they were then known, were staffed by the most junior doctors we had. So the paradox is when the patients were at their sickest and most vulnerable, we sent out most junior staff to look after them. I suppose the policy context behind the formation of the college and the development of a specialty of emergency medicine was to address that very issue, to say that perhaps it would be better to have very senior people dealing with people when they are most at risk and that junior people could learn their trade by observation, by participation in that exercise. So if you asked me if we - who would be the best people to have in Bundaberg Hospital emergency department after hours, I would say the most senior people we can find because of the lack of support in a hospital of that size. At the Princess Alexandra Hospital there are on duty registrars in everything, whereas in a location like that, it would be much more difficult to have that sort of support. So somebody who is experienced would be, I think, in my regard preferable - if possible.

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Is it because of your specialty in that area that you know this, or would it be a matter of orthodox knowledge in 2003?-- It is probably a matter of my passion, I suppose, having spent all my life being involved in emergency medicine as the reason for that, is to ensure patient outcomes. I would suggest that it would be a debatable issue amongst most non-emergency medical fraternities.

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So if a Director of Medical Services was unaware of it in 2003, you wouldn't regard that as a failure to understand?-- Unaware of that debate, do you mean?

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Unaware that it was preferable to have the most senior available persons staffing casualty after hours, you wouldn't regard that as a breach of standards by a Director of Medical Services?-- I think I'd say that that view is probably still relatively widely held amongst a number of other professions, but perhaps I am sounding a little defensive of emergency medicine as an area of endeavour. But I would still hear even today people defending that it is appropriate to have junior

staff.

COMMISSIONER: So to cut to the chase, if in 2003 Dr Keating was of the view that it was at the very least appropriate to have emergency staff with junior doctors at night and at the weekends, he would probably have then been with the majority of medical administrators and non-emergency specialists?-- He would have considerable support, I think, with that view around the State still.

Yes.

MR ANDREWS: The Medical Board released a recency of practice discussion paper in 2005, and I notice at paragraph 16 of your major statement you make the observation your personal view is that "recency of practice should be a subsidiary to the much broader but more important issue of competency of practice of medical practitioners." Can you explain for me what you mean by competency of the practice as opposed to recency?-- The term recency of practice has been used - it has been introduced particularly with the Nursing Council and has been included in legislation for all of the other professional Boards in Queensland but has not yet been implemented, as you have indicated, as part of a general public discussion or professional discussion at the moment. However, the term - and just using the plain version of the words - is that the intent of recency of practice and how it has practised in other location has been to deal with the professional who has perhaps not been practising for a number of years and who then seeks to return to profession. So the concept behind recency of practice is that that individual - any individual seeking registration would have to determine that they have been in contact with the profession or undertaking the profession. The concept behind that, I think, assumes that the person has maintained their competency as a result of that contact. My - the point, I suppose, I was trying to make with that, and as I have made with discussions with the Medical Board about this issue is that I think the mere fact that somebody has had contact with the profession is no guarantee of competence, and the fact that they have been apart from the profession is no guarantee of incompetence. So it would seem to me that we, rather than just dealing with recency of practice, which to me is a relatively small part of what should be a competency management framework for professions, that is when reregistering they need to demonstrate that they have maintained contact with the profession or undertaken the profession in some form with a more comprehensive regime which says that all practitioners should be able to demonstrate in some way that they have maintained their competency in their particular area. In medicine it is obviously a very, very complex area because of the diversity of medical practice which may range from, you know, somebody who is a topflight cardiovascular surgeon, through to somebody whose medical job may be undertaking medical examinations for insurance purposes. So I think what we do need to do is have some means of determining that people can identify their area of practice, that they can maintain competence in that area of practice, and that we should have a regime in place which says

that that could be tested in some way or demonstrated in some way, and that if people seek to apply for registration, then they should be able to demonstrate their competence either by evidence that they have maintained, you know, a - there are a number of things, number of schemes that are in place about "Have you undertaken progressive studies in service education?", et cetera.

D COMMISSIONER VIDER: Dr Fitzgerald, would you see into the future - you mentioned the Queensland Nursing Council and certainly recency of practice became not an issue but it was a characteristic there because traditionally that was a predominantly female workforce?-- Oh, yes.

And there were periods in a woman's life when she stopped practising the profession actively and was engaged in other activities and then was seeking to come back into the workforce?-- Mmm.

And that recency of practice came about by the fact that there were big gaps?-- Yes.

And there had been such advances in the actual practice of nursing that that was necessary to address how long it was since that person had actually actively been involved in clinical nursing?-- Mmm.

And that led to the introduction of reentry programs?-- Yes.

I am wondering, now that we have got evidence that, you know, 50 per cent, roughly, of medical graduates now are women, that that may be something that becomes a feature, you know, into the future rather than the big problem now, and that may be a way of recapturing for them some of them that might leave the profession in terms of actively practising for a number of years, and forward planning might mean that some reentry programs - admittedly they would be difficult because of the diverse nature of medical practice, but it may be a way of helping some of the practitioners reenter?-- I think that's very true. What - and, I mean, women in medicine is the same issue as you have indicated, but there are also issues related to people, particularly again with the diversity of medicine as there is with nursing. I mean, take me as an example, I practised in emergency medicine for over 10 years. I have really not touched a patient since that time and I have been a medical administrator. And if I then sought to go back and practise in emergency medicine, we do need to have mechanisms in place which says that that's not automatically acceptable.

Yes?-- The mechanism currently there, of course, is the professionalism of the individual who would not do so, and obviously the risk associated with any negligence claims that may arise as a result, et cetera, they are real impediments, but I think we do need to have mechanisms which says that there are - that, firstly, it is not appropriate, and if you wish to do it, then as you correctly point out, there should

be retraining, reentry, refresher programs that are available which could enable it to happen because it may well be an appropriate thing to do. I do feel from time to time it would be very tempting to go back and to look after patients.

We've certainly had evidence presented to us from some of the medical practitioners that have come before us that suggest very strongly that in the re-organisation of medical services that needs to go on to meet 2005 practice needs, time allocation needs to be looked at very differently from imagining that 100 per cent of somebody's time is always with patients, and that we should be allocating time for the other legitimate activities like case reviews?-- Yes.

And the afterhours/on-call business has been something that's been raised, rostered working hours has been raised?-- Yes.

And I think legitimately, because they're practising now in an environment where those things have not kept pace, even with modern workplace practices?-- I think you're correct. I mean, apart from the - to have time to study and research and keep your skills up-to-date is an important part of any professional's conduct. The dilemma we confront system-wide, if we were to say let's put aside 20 per cent of the time of clinicians, then we then have to work out how we're going to fill that service delivery demand that is met by that 20 per cent gap in an environment where even money won't fix it.

Yes?-- Because there just aren't enough practitioners to fill that gap.

And certainly the evidence that we've received has been more an acknowledgment of - it is a fact, but it's also recognition that this won't be fixed overnight?-- Yes.

But more the plea that it gets put into the planning and put into any change?-- Well, I think we are in the right environment, aren't we. With the four medical schools now there is a significant number of medical graduates. It's going to change quite significantly from something a little over 200 last year to just short of 500 in 2009. So we are in the time now where we can start planning and getting our systems in place that when the medical situation - particularly junior hospital doctors is ameliorated to some extent, that we should be able to address those issues.

Some of the issues they were referring to were the ones that we've said are important, like their attendance at Morbidity and Mortality Committee and other sorts of peer review audits and case reviews and those sorts of thing?-- Quite right.

But if we just leave it to a lunchtime arrangement then we have to accept that people at times won't get there?-- That's correct, yes.

COMMISSIONER: Doctor, just moving back to this recency of practice requirement, it seems to me from what you're saying that the issue shouldn't be so much merely recency of practice, but recency of relevant practice. In the same way in my own profession, I would be quite incompetent to do a criminal trial because I haven't done one for 10 years. I'm authorised to, I'm qualified to, but I haven't done that sort of work, and I imagine in the medical profession it's exactly

the same. If you've been practising in pathology for the last 20 years, that doesn't mean you're capable to help out in surgery or even in a GP's clinic?-- Yes. I can envisage a time when all medical practitioners would be registered in their particular area of practice. So, for example, I'd be registered at this stage of my life in medical administration. I'd be required to maintain my competency in medical administration to determine that, and if I sought to go to an alternative area of activity, then I would need to demonstrate my competency in some way in that alternate area of activity. It's probably not a very popular concept at this stage, but it's a concept I think we need to have the public discussion about.

And one of the difficulties is that the current legislative structure has this rather peculiar, if not bizarre effect that any person who is registered as a medical practitioner can perform any medical procedure. The GP down the road can do open heart surgery if he or she chooses to as a matter of legal entitlement. The only restriction under the Medical Act, as I understand it, is that if you're not registered as a specialist, you can't call yourself a specialist. Otherwise you can do anything that a specialist can do?-- And it extends to the community as well. There is nothing legally that I know of which would stop a member of the community who is not medically trained practising medicine as long as they don't call themselves a doctor. If they call themselves a medical practitioner then they're in breach of the Medical Practitioners' Act, but there is no legislation which defines the scope of practice, and while that seems superficially, I would suggest, of concern, I would imagine the complexity of doing so in legislation would also be extraordinarily difficult to achieve.

But it does seem - I've used the word bizarre before - even more bizarre that we have legislation saying that a person cannot act or practise as a veterinary surgeon unless qualified, and yet there is no legislation that says a person can't provide medical services unless they're qualified?-- And I mean the legal issues, of course, are not for me, but however, it does seem that we then run into a difficulty in defining what medical practice is, bearing in mind that obviously there's many areas that are marginal in that activity. As well as that, of course, I think medical practice in the future will be even less definable because there will be much greater flexibility about the scope of practice of a range of practitioners - nurse practitioners or optometrists undertaking treatment of eye disease et cetera. So it will be an interesting challenge to work out how to address that somewhat bizarre situation that you outlined.

And also an increasing community interest in alternative therapies, if that's the right terminology, but also to some extent an increasing interest on the part of qualified medical practitioners to explore what those alternative therapies have to offer, whether it's acupuncture or what-have-you?-- Yes. I mean, it's all part of the complexity of the scope of practice issue - defining scope of practice - medical

practice.

D COMMISSIONER VIDER: Do you think that the scope of practice issue and its difficulty to be defined will then become much more relevant for the Credentialling and Privileges Committees, because they will credential a practitioner very specifically?-- I think you're absolutely correct. I think that's the issue that we would - certainly at hospital level - of course outside the hospital environment we don't have those checks and balances as much, but certainly in the hospital environment, I think that's the importance of those mechanisms, to ensure that not only is the hospital capable of supporting such a procedure - and it's that issue I think that's important, but the individual has the experience and qualifications to undertake that procedure. I think that's the issue of Dr Patel, that we probably still don't know whether he had the experience to undertake those procedures because we don't know the details of his past history.

D COMMISSIONER EDWARDS: Sorry to keep Mr Andrews standing up so long, but could I ask just one other thing? I'm coming to the view that I'm not quite so concerned - and I may be totally wrong - on whether the Board registers somebody, provided they have adequate qualifications and so forth. It's the right to practice. And we are here because of Dr Patel who was registered, went through all the procedures and had the right to operate as a surgeon. It took a long time for the system to actually pick up his incompetence and his failures tremendously, and we hear there are other kinds of incidences that have happened over the last 20, 30, 40 years. What worries me is I get the impression that the Medical Board has made enormous emphasis on whether you've got the write dot ticked and the right box to be filled, rather than the competency of people, and how do you find out who are out there in the system now who are the ones who are causing all the damage?-- I think the determination of competency can't be left to one body. It can't obviously be-----

As I understand it, that's not necessarily in the act Yet as a mechanism for re-registration or being registered?-- The only bit that's in the Act is the recency of practice. I suppose the argument outlined here, and that I've made with the Board, is that I think we should go the next step and use that provision to try and deal with the issue of competency to practice.

It wouldn't stop the Patels?-- No, exactly right. The system has to be a series of checks and balances. One step in that is the registration, which at the moment, as you correctly point out, is rather limited to, "Have you got the right qualifications" et cetera. There is no step around, "Are you competent" except from the scrutiny of that experience. That is a very blunt instrument, as I'm sure you are aware. We do from time to time get confronted with people who have practised for the last 10 years in, say, surgery, seeking to enter general practice. Now, in that environment the Board is able to say, "There is a problem here", and we will challenge that, but we don't know if it's a general practitioner seeking

to enter general practice if they have the competency, but I think even if we do develop that sort of regime within the legislation with the Board where there is some mechanism to assess and evaluate the competency of a individual and to do so on some sort of regular basis, it still won't deal - it is still a very blunt way of dealing with the competency and the checks and balances around clinical governance. It has to be supplemented and complimented by employment related checks and balances as well and professionally related. So the Clinical Privileges Committee should not only credential in the first place, but should be responsible for monitoring their conduct and performance.

COMMISSIONER: Am I right in thinking, doctor, that at least as matters presently stand, the Medical Board's largely a gatekeeper role, that once you're inside the gate, as long as you don't call adverse attention to yourself, you can maintain your registration for the rest of your life by paying the annual fee. There's no periodic review of a person's skill or competence?-- That's correct, and I suppose that's the issue I think we need to challenge and take on.

Yes?-- It is obviously not an issue that's going to be easy, because there will be significant interests within all professions who will find that very threatening.

But, for example, our own profession - much to the annoyance of people like Mr Andrews and myself - has recently introduced requirements that barristers have to get an annual practising certificate and at least have to satisfy a minimal standard of continuing legal education. I don't say for a moment that that's a perfect system, but at least it's heading in the right direction to say people have to satisfy an authority that they're keeping abreast and up-to-date of what's going on in their professional discipline?-- I think it can be done. There are mechanisms being developed. It's not an absolute greenfield site by any means. Most of the colleges now have some maintenance of professional standards system, and satisfying that may be at least sufficient in those people who are members of colleges. There is obviously then the junior staff which - we need some alternative way of doing that. In effect the university issues the first certificate to practise by entitling people to registration. I think there are ways of doing it which are perhaps not as threatening or cumbersome or overtly bureaucratic, but which can at least provide a system of checks and balances in place, and at least encourage people to maintain professional competence.

And do you see that inevitably involving some degree of identifying - doctors identifying their areas of specialisation or area of interest so that in establishing recency of practice it has to be recency of practice with respect to a particular medical discipline?-- Well, I hope so, because I'm not sure that I'd want to handle the obstetrics questions. So I think it has to be focused on a particular area of expertise that you're actually practising. Bear in mind that may be very, very focused for, say, somebody who is a specialist hand surgeon or a cardiovascular

transplant surgeon who may be the world authority in that area. So I think that's the way of dealing with it, that we're registered to practise in a particular field, and we have to demonstrate and maintain our competency in that field.

It does then become extraordinarily difficult, though, doesn't it, because at the one hand you have the generalist - even a general surgeon who does everything from toenails to the top of the body, as compared with a specialist surgeon - a hand surgeon, as you say, or a colorectal surgeon or somebody like that - how do you define competency and recency of practice for all those different cases and categories?-- It's probable that it could never be that focused. I mean, I think if we led to a situation where, for example, an orthopaedic surgeon whose practice may specialise in knee replacements, but of course there is nothing stopping that individual doing surgery on other parts of the body, and probably do so on a regular basis anyway. So I would imagine their area of practice would be orthopaedic surgery as opposed to focused down to, you know, the right knee surgery or something as focused as that.

And also, you don't want to lose flexibility. You may have - as we've heard already with Dr Thiele, you may have in a country town - and Dr Thiele was for a while Director of Medical Services at the Bundaberg Base Hospital who happens to be a specialist vascular surgeon, but it would be throwing the baby out with the bath water if you said, "Well, all he can do is practise vascular surgery."?-- Of course.

So if an emergency case comes in, he's not allowed to touch that patient?-- And a number of people hold dual qualifications, and it would be quite appropriate, of course, for them to be qualified or certified to practise in a number of areas.

D COMMISSIONER VIDER: Dr Fitzgerald, would you see it as the future that there be will new and very different working relationships - partnerships, for example - to deal with this sort of issue? For example, it may be that there's the Board, the colleges and the employer in a much more collegial - and in a proper partnership, if you like, because they will each have a role to play in this that may end up in the public being secure in the competence of the practitioner. I'm thinking of the colleges who virtually set the standards and do the training?-- Yes.

And if somebody is not up to being accredited as competent, that would be most likely the body that would provide the supervision and additional training to let them have the opportunity to improve their competence?-- I suppose the only part of your question that I haven't thought through is the word "partnership", because while yes, they are all in it together in that context of the term, I think it's also important that they do have separate elements of that that they are individually responsible for, because I think that's the important part that gives the checks and balances, and avoids the conflicts of interest-----

I'm thinking more of a partnership as opposed to silos that never communicate?-- Of course.

I'm looking at this - we need this outcome, what process will we engage in to get there?-- That's right, and I mean, I would imagine, for example, somebody who is operating as an emergency doctor in a hospital, their college would issue their certificate of practice on a regular basis if they've continued to undertake their skills maintenance et cetera - competency and maintenance. The registration body then would accept that as demonstration of clinical competence and register the person, provided that their performance and behaviour was in accordance with the appropriate standards, and that the employer, of course, would be reliant on those and also provide the opportunities to - for individuals to obtain that certificate of practice.

COMMISSIONER: Doctor, I'm afraid I'm going to have to stop things there because Sir Llew has a University Senate meeting to attend. Dr Fitzgerald, does it suit you to come back tomorrow morning and hopefully finish your evidence tomorrow?-- Yes, Commissioner. If I may say, I'll be out of town Monday and Tuesday.

Well, we'll be out of town on Tuesday as well. We're going to Townsville. But we'll adjourn then until 10.15 tomorrow.

THE COMMISSION ADJOURNED AT 4.17 P.M. TILL 10.15 A.M. THE FOLLOWING DAY