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Queensland Government
Department of Justice and Attorney-General

Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

MR D C ANDREWS SC, Counsel Assisting
MR E MORZONE, Counsel Assisting
MR D ATKINSON, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 29/07/200

..DAY 30

4th Floor, The Law Courts, George Street, Brisbane, Q. 4000 Telephone: (07) 3247 4360 Fax: (07) 3247 5532

THE COMMISSION RESUMED AT 10.18 A.M.

GERARD JOSEPH FITZGERALD, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Andrews?

MR ANDREWS: Good morning, Commissioner. There are - Mr Diehm, I know, has a matter that he would like to raise with you and there are some housekeeping matters that should be discussed soon with respect to the possibility of hearing evidence from two witnesses who are residents of Bundaberg.

COMMISSIONER: Oh, yes. I am sorry you have to sit through this, Dr Fitzgerald. Mr Diehm?

MR DIEHM: Yes, thank you, Commissioner. The matter I wanted to raise, Commissioner, is a concern about something that has arisen out of a few questions that have been asked during the course of this week.

COMMISSIONER: Yes.

MR DIEHM: If I can just go back in time, on the 21st of June when we were in Bundaberg at page 1,193 of the transcript, you raised with us your invitation that had been made by the local AMA. I think it was to the three Commissioners to go to that function-----

COMMISSIONER: Yes.

MR DIEHM: -----at Bundaberg later on in the time of the sittings. And you said there that you could "see no difficulty in attending that meeting and we're grateful for the courtesy of being invited, needless to say we won't be discussing matters of substance at that meeting.", and there was no objection taken-----

COMMISSIONER: Yes.

MR DIEHM: -----on the face of that. Commissioner, you did raise, for completeness, I will say, at page 1,688, the morning after that meeting, a couple of things that arose out of that meeting that didn't really touch upon the inquiry. I accept that.

COMMISSIONER: Yes, I recall they related to the difficulties that overseas-trained doctors were experiencing, and employers of overseas-trained doctors were experiencing in obtaining Area of Need declarations and so on.

MR DIEHM: Yes, quite so. The two matters that have arisen this week have both been, as it happens, questions asked by Sir Llew.

COMMISSIONER: Yes.

MR DIEHM: And the first of them was during the evidence of Dr Young, and it appears at page 2,875 at 40 of the transcript, where it was asked, "Finally, in some of our discussions with medical practitioners over an evening in Bundaberg, there was a repeated statement made to me, particularly - I can't say if it was made to my colleagues - that there was so many committees in the hospital none of them worked, and secondly the patients were therefore not being considered as the most important part of the hospital."

COMMISSIONER: Yes.

MR DIEHM: And there was then another matter raised during the evidence of Dr Nankivell on the 27th of July, page 2,968 of the transcript, concerning matters that had been mentioned in discussions with doctors at Bundaberg when the Commissioners were there about the impact of the Medibank agreement between the State and the Federal Governments.

COMMISSIONER: Yes.

MR DIEHM: Commissioner, what is of concern that I raise is that it appears from those two questions, with respect, there were matters of varying importance to different parties in these proceedings that were the subject of discussions at those meetings, and if that is the case, then in my respectful submission there should be disclosure about the nature of those discussions.

COMMISSIONER: Thank you for raising that, Mr Diehm. I will explain the situation to the best of my memory and I will invite the two Deputies to add any comments.

The evening really consisted of three parts: there was some welcoming drinks when the three of us mingled with members of the local profession. My recollection is that each of us moved into separate groups. Since we were there as guests of the local profession, we thought it was our responsibility to mingle with separate groups rather than stay in a clump. Obviously I don't know what was said either to Sir Llew or to Deputy Commissioner Vider during that discussion.

My discussions, I have to say, were very much off the topic. There were two visiting ophthalmic specialists in Bundaberg at the time and they were - I was about to say young - they were men of about my age, so I assumed we would have people that we knew in common, and it turned out we did, and we talked about friends and people we had gone to university with and so on. I can't recall anything even remotely relevant to the inquiry during that discussion.

The next stage of the evening was an occasion when the Chair asked me to explain the work of the inquiry and what was going on, and I did that, and that involved me talking rather than anyone else. There were some questions and there were some

comments, but, again, my strong recollection is it wasn't anything that went into details. The comments were things like, "We're pleased you have come to see us, we're pleased this issue has been raised and ventilated." I think one of the comments was negative, in the sense, without being quite as brutally frank as this, that the implication was "you always have enough problems in your own profession, why should you be coming to try and sort out our profession?" But any commentary was very general of that nature.

The third stage of the evening was a medical lecture by the visiting ophthalmic surgeons and, needless to say, we didn't stay for that. We then left the building or left the room and, as we did so, two or three of the doctors who were present followed us out, really just, I think, out of courtesy, to shake our hands and say hello and that sort of thing. The only one that spoke to me happened to be Dr Kees Nydam. He said nothing relating to the substance of the inquiry. In fact, to the best of my recollection it was quite a humerus conversation where he was suggesting that what hospitals need is more hairdressers because hairdressers sort of massage people's scalps and talk to them and discuss their problems and they achieve a lot of things that maybe trained nurses and doctors don't. But that was the tone of the conversation. There was nothing of substance.

The issue in relation to overseas-trained doctors did come up from one of the questions asked during my presentation and I made it clear, as I had made it in open sittings, that we weren't on a witch-hunt for foreign trained doctors, that from the evidence we'd heard there was some 15 or 17 hundred overseas-trained doctors in Queensland and the indications are that the huge majority of them perform a wonderful service to the State and our medical system would be lost without them. There were comments of that nature, but then we were told a lot of these doctors are facing problems and Bundaberg seems to have a lot of overseas-trained doctors amongst general practitioner surgeries as well as in the hospital and that they were finding difficulties with patients refusing to see them or making offensive and abusive comments. So that issue was raised.

Then there was a doctor present who apparently owned or recruited staff for a number of general practice surgeries, and he raised with us the concern that following our interim report there were difficulties in getting Area of Need certifications through promptly, and that was the matter that I raised the next morning, and either Ms McMillan, or it might have been Mr Devlin at that stage, undertook to take the matter back to the Medical Board, and I think within the next couple of days responded advising the steps the Medical Board had taken.

So I can't recall any discussion that could be of concern.

But let me make this very clear, Mr Diehm: under the Commissions of Inquiry Act, we're, of course, allowed to inform ourselves of matters howsoever we think fit. All of us

move in society in different groups. Deputy Commissioner Vider still has her connections with the Holy Spirit Northside Hospital, Sir Llew has his connections with, for example, the university. It is quite inescapable that people make comments to us as we go about our daily lives and I don't see that that is a negative thing. But when it comes to issues that are of relevance to people like your client and Mr Chowdhury's client, we will decide those matters on the evidence. That is the evidence that is given under oath, the documents that are tendered and the evidence which you have an opportunity to challenge and put to the test.

If people raise issues with us which are of concern to them, what we do about it is do precisely what Sir Llew did earlier this week and say, "Well, people have made this comment to me. Can you confirm that it is the case?", so that it is out there in the open, the witness comments on it and anyone who has a contrary view can either cross-examine the witness or propose evidence to the contrary.

We have received, for example, I would say literally hundreds of submissions from members of the public, many of them medical practitioners, many of them otherwise involved in the hospital system as nurses or administrators or even wardsmen or clerical staff. Many of them from patients. The Commission staff analyses those submissions and every submission that comes in is reviewed by one of the Commission staff. If there are issues of interest or concern or importance, then they are the subject of evidence. If they are not, then they are put to one side.

But we will not be making any decisions or any recommendations based on hearsay or scuttlebutt or things we hear outside the formal proceedings. We will be making our ultimate findings and recommendations based on what takes place here.

And if I can say in relation to your client, Dr Keating, I am absolutely confident his name was not mentioned at any time - and when I say his name was not mentioned, it wasn't simply a matter that the name Keating wasn't mentioned, nothing was said at that occasion in Bundaberg even referable to Dr Keating. I can't say the same about Mr Leck, because I do recall a sort of parting comment from Dr Kees Nydam that Peter Leck is a good bloke and he hopes that Leck won't be the scapegoat for what happens in these proceedings. But that was just a comment. It wasn't invited by us, we didn't put any weight or substance on it. If Dr Nydam wishes to say that when he comes to give evidence, then we will give it such weight as we think appropriate, and if anyone wants to cross-examine Dr Nydam on those views, then no doubt that will take place as well.

But, you know, I think quite candidly, Mr Diehm, that it is a bit precious to think that the three of us are going to spend five months of our lives living in a vacuum when we don't see what goes on in society and when people don't make comments to us. We read the papers, we have friends, we have feedback and input and comment. We're not like a jury who are sequestrated

from the rest of the world.

What I can assure you, with the utmost sincerity, is two things: one is that if anything was to come to my attention, from any source whatsoever, which was adverse to your client, he would be given the opportunity to deal with that, either by calling of formal evidence so that you can cross-examine that evidence or by way of the matter being put to your client as and when he gives evidence and giving him the opportunity to respond to it. Unless there is something in the transcript or something in the documentary exhibits to support it, it will not be taken into account, and the same obviously applies to Mr Leck. So I don't have any difficulty with anything that's happened.

That's the situation to the best of my honest recollection, but I will invite, firstly, Sir Llew to comment on whether he sees things differently.

D COMMISSIONER EDWARDS: Mr Commissioner, I don't see things differently at all and I am surprised that this suggestion has been made. I happen to have a face that is known by most people and it is inevitable that people will say things to me. I can assure you my record speaks for itself over a long period of my professional life, that I have not been influenced very easily by anybody and will make up my own decision on all matters. However, I do gather information that is given to me with sincerity, even with passing comments, and if it gives me the opportunity to raise a matter that has convinced me that I should raise for the benefit of the outcome of this inquiry, I shall do it.

It was in that context that somebody mentioned a couple of matters to me that evening which gave me enough concern to raise the questions I did and I make no apology for that.

COMMISSIONER: Anything to add, Deputy Commissioner Vider?

D COMMISSIONER VIDER: My recollection of the evening was as the Commissioner has outlined it, my mingling with the members of the AMA that were there - I think there were about 33 or 35 members at the meeting - and that surprised me, the number. So I was interested in finding out whereabouts they'd come from because some of them had come in from the surrounding districts. And then, I must admit, I got into discussion with the ophthalmologist from Brisbane, which I thought afterwards was a bit sad because I could have talked to him in Brisbane, but I was interested in what he was going to lecture on because he was going to talk about a new technology that had arrived that he was bringing to Bundaberg, and he had a regular session there, I think once a fortnight. So my conversation was very general.

I think I made a comment to the group at the end of summing-up generally about the commitment that medical staff that I had spoken to in Brisbane, as the Commissioner said, people want to tell you whatever their bit might be. People that had a difficulty with Queensland Health's approach to the

appointment of VMOs were very interested to make it known that they wished to participate in the public sector in that way because it was the system that had nurtured them, but more importantly they had a philosophical commitment to the public health system, and I made a comment I think at the end of your presentation that simply said that I just thought that they were to be commended for the fact that there were some difficulties obviously Statewide for the appointment of VMOs and that they still wanted to be involved in the public healthcare system with a strong commitment to it.

COMMISSIONER: Is there anything else you wish to say, Mr Diehm?

MR DIEHM: Commissioner, only this: you most certainly will appreciate, Commissioner - the non-legal members of the Commission may not - that my submissions don't amount to a personal attack or criticism on any member of the Commission.

COMMISSIONER: Of course not, Mr Diehm, and may I say that in a difficult position, you have also conducted yourself with the utmost professionalism throughout this inquiry and I for one have appreciated that enormously.

MR DIEHM: Thank you. Commissioner, the matters that I raise go to two issues: they go to one, being the notice of matters, and a party who is, as you know, Commissioner, subject to potential adverse findings, are entitled to notice of what findings might be made and also the evidence that might be relied upon in that respect.

COMMISSIONER: Well, you have - on that subject you have my unequivocal assurance that if there were any question of adverse findings against Dr Keating, he would be given the clearest possible notice of that. My recollection is that, when we were in Bundaberg, I think on the second week, I outlined to you orally what I considered to be at that stage the only issues that were of continuing relevance to Dr Keating from the viewpoint of potential adverse outcomes, the views I then expressed have not changed, but were the situation to be different, you would have the clearest formal notice of that.

MR DIEHM: Thank you, Commissioner. The second matter that these issues go to is not actual bias but the appearance of bias and the reason why that arises is that - and it is not to do with comments that might be made by friends or somebody passing in the street, along those lines. The issue becomes more acute, though, when it is statements that have been made to Commissioners by persons who were or are in fact witnesses to the events which happened. And when that sort of information comes to the attention of the Commissioners, rather than to counsel assisting or other Commission staff who might be, for instance, sifting through submissions sent into the Commission, then it is my submission that the parties are entitled to notice of that evidence or that information having been passed on, for good or for bad, as the case may be, and the second problem with it is, is that that occurrence is not

disclosed and the parties are left in a position to assume that there has not been any such disclosure, then that gives rise to an apprehension of bias with respect to the matters the subject of that information.

COMMISSIONER: Mr Diehm, again I thank you for the very proper professional way in which you have raised those concerns. I am very conscious of the fact that there are matters to be ventilated in the Supreme Court next week, and I ought not to say anything that transgresses on that, because the three of us have submitted to the outcome of that decision and I don't want to say or do anything that might be thought either to preempt the Supreme Court's decision or to be some sort of discouragement to your client or to Mr Chowdhury's client to pursue their rights, whatever they are, in that venue. And I will repeat again something I said in Bundaberg, that I certainly don't want to be taken as discouraging either of your clients from exploring their rights in the appropriate forum.

But having said that, I do think that any realistic appreciation of the concept of apprehension of bias must start from the viewpoint that you don't jump to the conclusion that because a Commissioner has been in the same room as a person who is a material witness, therefore the Commissioner has heard something that is material, let alone that the Commissioner is going to disregard all concepts of natural justice and give weight to what he or she has heard rather than what is evidence in the proceedings.

I mean, the presence here of Dr Fitzgerald raises the situation that, in company with counsel assisting, I had lunch with Dr Fitzgerald. I have said on a number of occasions we discussed nothing concerning Mr Leck, we discussed nothing concerning Dr Keating. It was simply a background discussion regarding the administration of Queensland Health. If there was something that had come out of that lunch that was adverse to your client's interests or adverse to the interests of Mr Leck, then you would be given notice of it, then it would be in Dr Fitzgerald's statement, then we would be hearing evidence about it, then you would be given the opportunity to cross-examine on it, and then when all of the evidence was in, we would decide what if any weight we give to that evidence.

But there was no such discussion, there is nothing to raise. As I say, if there were, it would be in Dr Fitzgerald's statement and we would be hearing about it now. It just didn't happen and the same applies with the meeting in Bundaberg. The two instances you raise are the point about the Medicare agreement and the impact of that on Queensland Health and the point about the excessive number of meetings. Now, obviously neither of those points is directed to your client. I have said repeatedly that I do not hold Dr Keating, or Mr Leck, or Mrs Mulligan, or anyone else responsible for the fact that they operate within a system. It would be plainly unfair and unjust to do so. And if Dr Keating operates within a system where there are too many meetings or where there are problems of implementation of the Medicare

agreement, that is only a matter of exculpation rather than a matter of criticism of him. If someone had said at that meeting - and I emphasise I give this only as a hypothetical example - but if someone said, "No wonder there are all the problems at Bundaberg, because Darren Keating was never there", you know, "he was only in the office one day a week", or something like that, you know, if some sort of outrageous or inappropriate or offensive or harmful comment of that nature were made, then we would follow the appropriate course. We would give you notice on that, we would require the witness to come here and give that evidence under oath, we would give you the opportunity of challenging that evidence and we would give Dr Keating the opportunity to respond to it by sworn testimony. But that hasn't happened.

So I appreciate what you say about apprehension of bias. If my view of the law is wrong, then no doubt the Supreme Court will set me straight next week. But my view of the law is, as I understand it, that we have to follow the appropriate procedures of giving you an opportunity to challenge adverse evidence and to adduce evidence to the contrary, and we have to keep an open mind. And I don't know how many times I have to say it but I am happy to say it again: we have formed no final views, not about your client, not about Mr Leck, not about anyone else. We haven't formed final views. There is evidence which suggests some problems and we will pursue those problems. We will find out where the evidence takes us and at the end of the day we will make our findings.

I see your client's in Court, and if I may say so, I think it is hugely to his credit that he has chosen to be here both in Brisbane and in Bundaberg throughout the proceedings in circumstances which no doubt have been very difficult for him.

Given that he has been here throughout the proceedings, I hope that he would understand that I'm not here trying to target him. I've got no predisposed views about him. I, candidly, had never heard of him until the first day's evidence, which is why I'm so confident that we didn't discuss the matter when I had lunch with Dr FitzGerald, because I didn't even know his name at that time. The same applies to Mr Leck. I don't have any preconceived views.

I didn't come to these proceedings with some frame of mind that Dr Keating's a bad person or that Mr Leck's a bad person. I came here to hear the evidence and to make findings based on the evidence. If Dr Keating has a problem with that, either as to the actuality or the perception, then he will have his remedies in the Supreme Court, but as matters stand, I can say with the absolute candor that whatever happens in the Supreme Court next week, if these proceedings continue in their current form, Dr Keating will get every opportunity to clear his name against the suggestions that have been made to date, and an absolute open and impartial mind from myself and, I'm confident, from the two Deputy Commissioners in considering that evidence and in arriving at a conclusion.

I don't think I can say more than that, Mr Diehm.

MR DIEHM: Well, I have nothing further either, Commissioner. Thank you.

COMMISSIONER: Mr Chowdhury, do you wish to raise anything arising out of that?

MR CHOWDHURY: Nothing in addition to what my learned friend has said.

COMMISSIONER: Thank you. Mr Andrews?

MR ANDREWS: Nothing further on that topic, Commissioner.

COMMISSIONER: Does anyone else at the Bar table have anything to say on the points raised by Mr Diehm? Mr Boddice?

MR BODDICE: No. Thank you, Commissioner.

COMMISSIONER: You also mentioned, Mr Andrews, some housekeeping matters.

MR ANDREWS: Yes. The patient P18 may now be identified as Mr James Grave, G-R-A-V-E.

COMMISSIONER: Yes. It's sometimes been written as "Graves", but it is "Grave". That name is no longer the subject of a suppression order.

MR ANDREWS: Commissioner, there are-----

COMMISSIONER: Sorry, are we still waiting on 43 and 44?

MR ANDREWS: That's correct.

COMMISSIONER: Thank you. Yes?

MR ANDREWS: Commissioner, there are two witnesses from Bundaberg. One is a Mr Viv Chase. For personal reasons related to his health it may be inappropriate for Mr Chase to give evidence in Brisbane. You inquired as to whether it was feasible to attend at Bundaberg on Friday of next week for the purpose of hearing his evidence. It is, I am instructed, feasible to do so.

There is another Bundaberg witness who will - now, with respect to Mr Chase, his evidence is likely to be significant only to Mr Leck. Subject to perusing his statement again, it's possible that he may be relevant to Dr Keating, but my recollection is that he is not.

The other witness who resides in Bundaberg from whom evidence should be taken is a Dr De Lacey. His evidence should be quite lengthy. If he gives evidence in Bundaberg, I imagine it would take most of the day. His evidence will be of interest to several of the parties. I would expect the patients' group, possibly the Medical Board, and hypothetically even Dr Keating, and perhaps Mr Leck. His evidence is with respect to the competence of Dr Patel and the outcomes in respect of numerous patients.

COMMISSIONER: Yes. There was a third Bundaberg witness mentioned yesterday, Mr Mullett.

MR ANDREWS: Yes, Mr Mullett.

COMMISSIONER: But he's quite happy to come to Brisbane.

MR ANDREWS: By the sound of it, he'd enjoy it.

COMMISSIONER: It did occur to me initially that there would be some advantage in doing Bundaberg next Friday, simply because the entire caravansary is on the road next week anyway, and whilst our bags are packed and we're moving around the State, it might make sense to go to Bundaberg. But I will only do that, of course, if it will not cause significant inconvenience to the other parties. How do you feel about it, Mr Andrews?

MR ANDREWS: It occurs to me that travelling to Bundaberg to examine Mr Chase has something to commend it, because it's unlikely that many of the other parties need to attend.

So far as Dr De Lacey is concerned, I anticipate that his will be significant evidence, that many of the parties will wish to attend, and it may be more convenient to hear him in Brisbane.

COMMISSIONER: I think I was told that Dr De Lacey - who is, as I understand, a private specialist in Bundaberg - was scheduled to give evidence on Friday anyway.

MR ANDREWS: That's correct.

COMMISSIONER: It's sounding, from what you say, Mr Andrews, that it might be more convenient for Dr De Lacey to give evidence in Brisbane next Friday, and if we have to go to Bundaberg to hear from Mr Chase, to do that on another occasion.

MR ANDREWS: You're correct.

COMMISSIONER: The other factor which I guess inclines me in that direction is that whilst we have these proceedings in the Supreme Court next week, we can't be certain that they will be decided instanter. It may be then that Mr Diehm and Mr Chowdhury - or perhaps Mr Ashton, if he comes back - will be in somewhat of a dilemma having run their case in the Supreme Court, but not knowing the outcome, and it might be considered unfair to put them in the position of having to cross-examine Mr Chase to the extent that he gives adverse evidence whilst they're in that difficult situation of not knowing the outcome of the Supreme Court proceedings.

How would you feel, Mr Diehm?

MR DIEHM: Commissioner, my perception of the situation - this is the reason for the course that my client has taken since bringing - or since indicating his intention to bring his application - is that whilst so ever his application is on foot, and even when it's been heard but not yet determined, he can hardly be said to be waiving any right, having made very clear what his position with respect to the matter is, and therefore, given that I don't contend then or now that there is any compelling reason why there ought be the effect of an interlocutory injunction or an adjournment of the Inquiry until that matter is disposed, why the proceeding couldn't continue until such time as the Court has resolved the matter.

Now, that may get to a point in terms of, for instance, the parties themselves giving evidence that makes a difference, but in terms of other witnesses being called, whilst so ever my client's position's been flagged, I don't see any difficulty in the Inquiry proceeding and those witnesses being called.

COMMISSIONER: I thank you for that. It's probably inappropriate again for me to comment on the notion of waiver. I quite honestly don't know what arguments the learned Solicitor General is intending to advance next week, but I should have thought the issue wasn't so much one of waiver as one of laches and delay, the fact that your client, without applying for interlocutory injunctive relief, has stood by and allowed the State of Queensland, as well as private parties like the Nurses' Union and the AMA to spend millions of dollars allowing this Inquiry to proceed before bringing on the application to close it down. But that's the Supreme Court argument. That's not an argument from me.

MR DIEHM: And I wasn't inviting you to make any comment or to agree with what I say, but just to put on the record what my

client's position is and why, therefore, I don't make any objection to these witnesses being called.

COMMISSIONER: All right. Mr Andrews, I'll leave it to you to work out what is the most efficient logistical approach. I'm indifferent as to whether we go to Bundaberg next Friday or some other time, but it does sound like the most convenient course may be to hear Dr De Lacey in Brisbane and, as I say, if we need to go to Bundaberg, then we can do that on a day later in the sittings.

MR ANDREWS: From comments made to me before you entered the room, Commissioner, I'm sure that will meet with the approval of everybody at the Bar table.

COMMISSIONER: All right. Can I say, particularly to those who haven't been involved in the debate that just took place with Mr Diehm, I am very conscious of the pressure that we've been putting all counsel under, most particularly those who don't have juniors or leaders such as Mr Allen, who has had to be here from dawn to dusk day after day, and I am conscious of the inconvenience that that would cause to counsel in that situation.

Perhaps we should get on then with Dr FitzGerald's evidence.

MR ANDREWS: Doctor, the attachment GF4 to your statement, which is the recency of practice discussion paper, is of interest. I'd like you to look at the monitor at what is about page 4 of that attachment. At the bottom of the page - at the very bottom of the page, the paper observes that, "Before deciding on the renewal application, the Board may require an applicant, pursuant to" - one needs then the top of the page - "pursuant to section 74(1)(c) to undergo written, oral or practical examination." That is, I assume, with respect to applicants who are Australian trained medical practitioners?-- That's correct, bearing in mind this is a discussion paper as to how it could operate, yes.

Yes. Then as one proceeds down the page, again in the right-hand side column one sees that according to the discussion paper, recency of practice requirements don't apply to all categories of registrants, and indeed further down the page one sees that it's not intended that they should apply for the renewal of Special Purpose Registration, and the basis of that is that there apparently is a higher test detailed in section 131 of the Act?-- That's correct. There are mechanisms in place in the Act at present to deal with special purpose registrants at the time of any new registration, which is, in effect, what Special Purpose Registrations are.

But would you agree that it's an inescapable conclusion that an Australian trained doctor might be asked to sit some tests of competence while a special purpose registrant who could be an overseas trained doctor is not, pursuant to this paper, expected to sit any such tests?-- My understanding of where we're trying to go here is to have equal standards rather than different standards. I think the situation at the moment is

that there is a level of scrutiny around overseas trained doctors - and we're discussing, I assume, overseas trained doctors who are on Special Purpose Registration as opposed to those who have Australian qualifications.

That's correct?-- That the - but at present there are limited mechanisms at all to deal with the competency of Australian trained doctors, either in terms of their initial registration or in terms of the renewal of their registration, and the intent of the recency of practice - and bearing in mind this is a discussion paper which may or may not lead to the eventual framework - that the intent underlying it all, of course, is to equivalent standards for all practitioners in Queensland.

The commendable intent with respect to Australian trained doctors is that they may even be obliged to sit some form of examination, but it does seem that overseas trained doctors who are special purpose registrants - for instance, for an Area of Need - are not to be exposed to that form of testing. Would you agree?-- No, quite to the contrary. The intent of the regime - in fact there are mechanisms now whereby we could apply under the current legislation, on my understanding, the testing regime for overseas trained doctors. The principle of overseas trained doctors is that they have not met the Australian Standard, whether that Australian Standard is in the form of a university level education or some form of college qualification. So the gap, I suppose, is that they have not demonstrated they meet that Australian Standard. What we're seeking at the moment is mechanisms whereby we can implement some regime whereby we can in fact test their equivalency to Australian Standards so that they can confidently become Australian trained doctors. There is, of course, the mechanism through the Australian Medical Council examination or, alternatively, the college fellowship routes into permanent registration. So there are existing examination processes in place for overseas trained doctors to meet Australian Standards. What we are currently dealing with is because of the period of time it takes to obtain those qualifications, which may be anything at the minimum of two to three years, at present we have no careful mechanism short of scrutiny of their previous qualifications to determine the competency of doctors coming in from overseas. So we are working on that as we speak. I suppose the purpose of this discussion document is to apply a similar level of scrutiny to Australian trained qualified doctors.

When you say "we're" looking at that, you're in the fortunate position of being both a Chief Health Officer for Queensland Health and a member of the Medical Board. Which is the "we" that's pursuing this commendable outcome?-- The "we" in that regard is the discussion paper - is actually a Medical Board of Queensland discussion paper. So it's the Medical Board which is leading that, but I suppose if I split myself, then as Chief Health Officer I would obviously support such commendable process.

COMMISSIONER: Mr Andrews, Dr FitzGerald, I'm sorry, I'm going to have to interrupt you again. I sincerely apologise for this.

Mr Diehm, I've been thinking further about the matter you raised earlier. I did mention the conversation with Dr Kees Nydam outside the meeting in Bundaberg where he said, about Mr Leck, that he was a good fellow and he hoped he wouldn't become a scapegoat and so on. When I referred to that I said that Dr Keating's name wasn't mentioned.

Having thought about it some more, I do recall that Dr Keating's name was mentioned. It's not something that I regard as important, but I - in fact the remark was a slightly offensive one, but I'm happy to put it on the record if you wish me to do so.

MR DIEHM: Commissioner, might I ask that it be disclosed to Dr Keating via correspondence from the Commission to my instructing solicitors?

COMMISSIONER: I'll write it down now on a piece of paper and have it handed to you, and if you wish to say anything more about it we can take it from there.

MR DIEHM: Thank you, Commissioner.

COMMISSIONER: I'm sorry, Mr Andrews. Please proceed. I'll continue with this.

MR ANDREWS: Dr FitzGerald, is there any plan to explore the possibility of some kind of gatekeeper competency test for overseas trained doctors who are seeking to fill a one year position in an Area of Need?-- Yes, there are. As of last year the Medical Board imposed an English language test requirement for all overseas trained doctors - or exemption for people who could meet the appropriate exemptions. The Australian Medical Council is also currently working on a screening knowledge-based test which could in fact be applied in an overseas country prior to the individual coming to Australia. The intent is that that test would be available and applied as of the middle of next year, I understand, but - I'm testing my memory on the exact date of implementation, but certainly there is a national intent to undertake a basic level screening knowledge examination. I would also suggest that the number of other jurisdictions who don't have the numbers of overseas trained doctors that we have have, in certain categories, undertaken interview style programs, and there is an amount of work occurs as we speak in a number of agencies throughout Queensland to develop a model of a structured interview which could again be done over the phone or through some other form of telecommunications to try and screen overseas trained doctors for their specific knowledge.

COMMISSIONER: Just to interrupt again, I'm sorry, Dr FitzGerald, may I ask this to be shown first to Mr Andrews and then to Mr Diehm.

MR ANDREWS: I agree that it's appropriate to show it to Mr Diehm and to allow him to consider what should then be done with it.

MR DIEHM: Thank you. I'll need it take instructions, and we don't need to interrupt the matter for now.

COMMISSIONER: Don't lose that piece of paper, because what I propose to do is if nothing else is said about it, I'll have that made an exhibit, but a confidential exhibit so that it isn't published.

MR DIEHM: Thank you, Commissioner.

COMMISSIONER: Thank you.

MR ANDREWS: Doctor, aside from that practical course of considering the administration of a competency test while the applicants for Special Purpose Registration are still in their home countries, there's another matter of concern and that's that when the applicants arrive within Queensland they will be requiring some kind of orientation, and I have in mind the evidence with respect to one particular patient who required extensive vascular surgery in Bundaberg, and there has been evidence that within Queensland it's well known that during complex surgery in the regions, the surgeon is always welcome to ring vascular experts at the major metropolitan hospitals to seek advice. It seems to me that that sort of local knowledge is one element in a basket of knowledge that ought to be communicated to any overseas trained doctor. You'd agree with that proposition?-- I certainly would. I think probably the assessment process we were discussing before, I think, are just part of the picture of orienting an overseas trained doctor into the Australian system. The checks and balances that we are seeking to develop, some of which are partly developed, is initial assessment supported by some form of orientation, education into the Australian healthcare system, and the third part of that, of course, is supervision while they're in the Australian healthcare system until such time as they've demonstrated they met the Australian Standards. A number of services, of course, provide that. In fact some of the agencies - the recruitment agencies provide some level of orientation to the Australian healthcare system. Obviously it is a difficult task to achieve, because not only - there are, as you can imagine, in medicine, a numerous range of factors that you get to know about the Australian healthcare system, ranging from its structure to the financial arrangements to the sort of things that you're alluding to, which is the contacts and who to contact - the personal contacts that would be available. So I would agree with you - in a somewhat longwinded way, I apologise, but to say that it's all part of a structured approach that we need to perhaps get better at.

D COMMISSIONER VIDER: Dr FitzGerald, can I just clarify a couple of things with you?-- Yes, certainly.

In relationship to special purpose registrants that come in under Area of Need classification, did you say that the English language testing was only introduced last year?-- It was made compulsory - I think it was last year. I'm sorry, I'm testing my memory again-----

But it's recent?-- Relatively recently, yes.

And the competency testing in that preliminary phase, even in their home country, has that been introduced?-- No, it's still being developed by the Australian Medical Council. So it will be applied nationally as a result of the Australian Medical Council's efforts.

And then is it correct that if the special purpose registrant comes in under the Area of Need, that registration is for 12 months?-- That's correct - or a shorter period as required, but a maximum period of 12 months.

A maximum period of 12 months. Can they stay indefinitely under that classification if they choose not to upskill and move through the system? In other words, could you be here for 10 years, having renewed your application every year, but you haven't moved through the system?-- Subject to the Area of Need restriction there is no legislative impediment at the moment to that occurring. There are a number of doctors who - where that has happened. Certainly over my time at the Medical Board we have started introducing - we've introduced a relatively routine process where if they've been here for one to two years, we will always ask them at renewal what their plans are in terms of moving to a permanent form of registration and seek to try and encourage them to do so, but there is no legislative impediment to them doing so at present and obviously that's something that we would be seeking to try and - and decisions have already been made at policy level of government to address a legislative requirement for that to occur.

I understand the Registration Board then doesn't have any ongoing role beyond their annual renewal of registration?-- That's largely correct, yes.

Well then-----?-- Except, of course, for adverse management of any adverse issues that arise.

Who assumes responsibility for ensuring their competence? Because I suppose these people would sometimes be in isolated areas?-- Yes. The Board does have a role in terms of the Board requiring supervision and regular reports on the individual's performance at any time of new application or renewal. So the Board does provide that supervisory role, but generally speaking it would be the supervisor's responsibility, whether that's in an occupational relationship or whether it's in a supervisor appointed to mentor or provide some degree of direct supervision.

Who appoints that supervisor?-- The Medical Board approves the supervisor, so it's a matter - usually the nomination

comes from the sponsor of the applicant.

D COMMISSIONER EDWARDS: In general that system has worked reasonably well from reports that have been given to the profession in general, and as I understand, the continuation of the system appears that it's been a reasonably satisfactory mechanism for assessment and so forth?-- Well, I think that's right. I mean, obviously the vast majority of overseas trained doctors are fine in terms of their competency and skills. I think the system has worked reasonably well. Obviously - the issue, I suppose, that has caused most of the concern to the Medical Board has just been the vast increase in numbers, and therefore obtaining people who are able to supervise closely, and the fact that we now have overseas trained doctors who have not met Australian Standards in situations where it's difficult to provide immediate supervision. Many doctors are in very small country towns. So the supervision is really in the way more of a mentorship arrangement, and while that's better than nothing, it is a cause of concern, I'm sure.

Could I follow up with that. As I understand it - and I may not be right up-to-date on this aspect, but a similar provision is in existence in other states as well?-- I think - oh yes, certainly. I'm not across the details of the detailed legislation, but most of these sort of mechanisms are national. They're the same national approach. I suppose Queensland's brought in focus because of the huge numbers that we have in comparison to the other states.

D COMMISSIONER VIDER: And there's an opportunity - that would perhaps then be something to be looked at under the Commissioner's notion of the Chief of Staff in terms of in the future creating better networks and linkages with some of these remote located practitioners?-- Certainly. The other initiative that we're - in the Medical Board we have had a number of discussions recently with some of the other bodies, has been to provide a group of people who could actually do that supervision who may be independent of the sponsor, because that's a potential weakness in the current arrangement. If the sponsor organises the supervisor and the sponsor also has the responsibility to fill that position, then there is a potential of conflict. So a concept being floated at the moment is something like a number of doctors who are prepared to do that, perhaps recently retired doctors who are prepared to provide that, how would you describe it, fatherly supervision of an individual in a rural area, maybe going and visiting them, undertake their inquiries locally about the tests and standards. So that's a mechanism currently being explored and may be something that - obviously how that's funded, we have no idea yet but it is something worth thinking of.

COMMISSIONER: I was going to ask, Doctor, really following from Deputy Commissioner Vider's question, about Area of Need doctors being in the position for years without expanding their professional qualifications. I assume that was a more acute problem until fairly recently when Area of Need certifications were routinely renewed without further investigation. Now, at least there's the protection that under the guidelines, which you have laid down in recent weeks, each Area of Need will be reviewed fully at each annual turnover so we won't have the situation where a Jayant Patel gets to Bundaberg and can stay in Bundaberg, really, for the rest of his career?-- It will help but could I say that as the two issues are somewhat distinct, as I'm sure you're aware, that, for example, a doctor in a general practice in a small country town, we can now approve them for up to four years subject to - as you're aware from the guidelines, subject to those annual re-tests. But if at the end of that four years evidence is, under appropriate scrutiny, presented that it is still an Area of Need, as it is likely to be because of the manpower situation we currently confront, what we're concerned from the board's perspective is to put in a mechanism which says they can't just roll over to another four years and another four years; that we really need to say that if they have not made progress towards Australian registration in four years, then we need to have some teeth to do something about it.

Yes. Can I also ask, this is perhaps a little bit off the topic but it strikes me that there are really four categories of skills needed for an overseas trained doctor coming to practise in Queensland. One is the basic clinical competency and we've discussed that?-- Mmm.

A second is the English language skill and you've discussed that?-- Mmm.

But I'd be interested in your comments on what I perceive as being the third and the fourth. The third is an understanding of Australian practice conditions. For example, someone coming from the United States would have no idea about provider numbers and Medicare systems and so on. So, those sort of professional issues that aren't really of a clinical nature but just relate to how medical practice is conducted in this state. And the fourth one is, it's a word that is overused but cultural issues and perhaps that's best illustrated by an anecdote that we've heard and you've probably heard as well, and I don't know if it's true but the anecdote involves a doctor of Middle Eastern origin at the Gold Coast cancelling the prescriptive medication for a patient aged in their 60s on the basis that the system couldn't afford to and it was inappropriate to spend that much money on such an old person?-- Mmm.

Which may be a legitimate view in some parts of the world but certainly wouldn't be supported in Australia. So can I ask about those two additional categories of competency?-- I think they are. I mean, the one I'd add is the underlying knowledge, which supports all of that. But the issue of the Australian health care system, I think we discussed in terms of orientation to that system which could give the basic knowledge but obviously there's no - no alternative to being in the system long enough and know the various varieties around it. It is difficult to provide that very quickly to people. You can provide the basics through some form of orientation period but if we were, as you can imagine, to try and educate people in the whole complexity, then it could be they spend another two years trying to study the system, but I agree with you that it is an area. The other area is in fact the culture and I suppose it is somewhat of a paradox here that we have been concerned, as you know, in health care for a number of years about European Australians understanding some of the cultural variances that occur in our own country, particularly the indigenous issues, et cetera. I suppose we're confronted with where now the Australian culture has to be educated to people and, certainly, a number of people have started trying to work on how that could occur to people to understand - I mean, the anecdote you've mentioned is obviously one example but mostly it's around language and the use of language and the way Australians tend to speak to each other which is quite different in other cultures and certainly does cause some degree of consternation and confusion to overseas trained doctors and, of course, vice versa. So how we would do that, and I'm sure there is some course that could be arranged for people to understand a little bit about the Australian culture, to understand, for example, Australians' directness, that it's not confronting or necessarily rude, but some form of program of part of the orientation program which gave overseas trained doctors an understanding of that would be very helpful.

And my impression is that those sort of cultural issues you mention would tend to be even more acute in rural parts of the state where there's likely to be a more old-fashionedness and

more idiosyncratically Australian culture than you'd find in Brisbane. Instances that come to mind include the fact that there still is in rural parts of the state a very high level of respect for medical practitioners. You never ask for a second opinion or challenge the view of medical practitioners whereas perhaps city born Australian or city bred Australians these days are more likely to ask for a second opinion or to question the advice they're given?-- Mmm.

Or the tendency, and particularly amongst Australian males, to play down their medical problems and not to seek medical help until it's too late. Those sort of cultural issues strike me as being particularly important for an overseas trained doctor who is going to a rural area, particularly if they're going to be the only medical practitioner in that rural area?-- Indeed, I think you're correct, and add to that the fact rural communities have very high numbers of indigenous people as well, that the conflict between those cultures is important for them to know.

Yes.

MR ANDREWS: Doctor, on the monitor, in the recency of practice guidelines there now appears another page which is about page 19 and I notice that there's a recommendation that the testing of locals be not simply examinations of cognitive skills but of psychomotor skills. Do you see any advantage upon arrival of applicants for registration that they - well, presumably after their registration, there be conditions imposed that they undergo psychomotor skills testing?-- Yes, I do. Obviously that needs to be tailored to the particular individual; for example, you would test a general practitioner differently to a neurosurgeon. But there is, as you may be aware, the Skills Development Centre which has been established at Royal Brisbane Hospital which has very sophisticated equipment which would enable appropriate testing of individuals' competencies in that area, and we are now - Queensland Health is now trying to work out how that could occur in - bearing in mind it's a very large state and, of course, the diversity of medical practice. So there's a lot of work in terms of developing the programs of assessment through that but the instrument, if you like, the set-up is there, the centre is there.

COMMISSIONER: Excuse me, Doctor, you will have to excuse my ignorance but what do you mean by psychomotor skills?-- The ability to make judgments as well as exercise those judgments. "Motor" means movement.

Yes?-- So the connection between judgment and actually doing things.

I see. Which would be-----

D COMMISSIONER VIDER: That would also allow for some surgical tests?-- Yes.

You could look at procedural skills of people to see how good

they were at doing particular procedure?-- That's right. The facilities, for example, at the Skills Development Centre, which perhaps if the Commissioner had an opportunity to examine it would be of information, allows for quite sophisticated surgery to be practised on models and computer dimensions before, obviously, just not testing it on patients, which perhaps has been the traditional mechanism of learning and of assessment, has been to operate under supervision and be assessed by your supervisor. This enables a technological solution or approach to that.

MR ANDREWS: Now, if, for instance, one knew that an application for Area of Need registration was going to an area where because of desperate need there was unlikely to be close supervision, it would be an ideal opportunity, wouldn't it, to insist as a condition that that applicant might, for instance if it's a surgeon, go to the Skills Development Centre and be assessed so that the supervisor or the remote supervisor in the region would then have an indication of where that surgeon's strengths and deficiencies lay?-- That's correct. And in fact, in the last several months with the Skills Development Centre, the Medical Board in fact started doing that, of referring people to the Skills Development Centre.

If the Medical Board is doing so, it would be as a condition of registration or renewal of registration I assume?-- Indeed so, yes.

One last item in that document suggested that patient outcome data would be an ideal way of testing the competence of applicants for renewal. I imagine that would be a very difficult document to interpret?-- It would indeed. I mean, obviously as well as being very, very complex to collect. Obviously there are some elements of patient outcome that are relatively easy to collect, obviously mortality for example, which is the extreme end of outcomes, but most people of course survive - I was going to say survive their medical care. That's perhaps not what I meant. But most people - and measuring what outcomes are, getting a clear picture of that is very difficult but, obviously, that's where the work is and if there was some mechanism of being able to do that, of understanding how somebody practises, then that's the best evidence of somebody's competency.

COMMISSIONER: But there's also a big delay going to be involved because you need to have someone practising for a minimum period of time, I assume at least six months, maybe 12 months, before you can statistically compare their performance with a state average?-- Indeed so. I mean, obviously for very poor practitioners the information would come back very quickly, usually via way of complaint, but once you get down to, for example, competency - relative competencies over a procedure, then you need fairly large number of patients to be able to obtain that information.

And, in fact, what we've seen already from the Woodruff report in relation to Dr Patel suggests that his mortality rate and his error rate wasn't noticeable by being so different from

predicted averages. It's only when you look at the details of what went wrong in particular cases that you start to realise that there were serious problems?-- Indeed so. And it goes to the point of evaluating, I suppose, outcome data.

Yes?-- One - if I may use another example, one of the - of our roles of licensing private hospitals is we do monitor the outcome data in certain categories of patients and at times we notice a trend, but it really is a very rough, raw data and what needs to happen then of course is some degree of detailed scrutiny before - which has occurred in this case of course. We've detailed the scrutiny, the individual patients, to exclude things such as relative severity or complexity of those cases. A doctor, for example, who only operates on the most complex patients is more likely to have a poorer outcome statistically than somebody who selects only patients who are very - otherwise fit and well. So there is inevitably in any attempt to measure outcomes, has to be a two-stage approach to it where initially the raw data needs interpretation and needs further analysis and interpretation before conclusions can be drawn from it.

Indeed, we were hearing just the other day from Dr Cook that if you took the figures for the Mater Hospital in Brisbane in isolation, they might appear to be worse than some other hospitals because they get the most serious patients?-- That's correct. Yes.

D COMMISSIONER EDWARDS: That was the point I was going to raise. Is that taken into consideration anyway because it seems that the seriousness or otherwise of particular cases can have an influence on the outcomes of - as the Commissioner has indicated, such as the larger number of serious cases being treated in a major hospital?-- Yes. It can be in certain subcategories of patients and is. For example, in evaluating intensive care wards, they do severity assessment of patients and can therefore look at issues such as mortality or time in intensive care or whatever other outcomes by category of severity or intensity of the patient. It's difficult to do across a broad spectrum of patients of course because of the diversity of those patient groups.

COMMISSIONER: Mr Andrews, it has been a very disjointed morning so we might just take a short morning break, say, 10 minutes, if that suits everyone's convenience?

MR ANDREWS: Thank you, Commissioner.

THE COMMISSION ADJOURNED AT 11.32 A.M.

THE COMMISSION RESUMED AT 11.57 A.M.

GERARD JOSEPH FITZGERALD, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Yes, Mr Andrews.

MR ANDREWS: Commissioner, Dr Keating has no difficulty with that piece of paper being made an exhibit. There is no need to make it confidential.

COMMISSIONER: All right. Well, I'll read it into the record then so that we don't have to have it-----

MR DIEHM: Commissioner, I'm not insisting that you don't do it that way but my request on behalf of my client is he is happy for it to be made an exhibit but it seems unnecessary for it to be read into the record in my submission.

COMMISSIONER: Well, Mr Diehm, my point was simply that you had urged me to be candid about everything that was said and I wanted you to be aware that this was said. It is obviously not a remark which any person would give any weight to whatsoever and for that reason I didn't want to cause any unnecessary embarrassment to your client. But someone said something off the cuff that I felt bound to bring to your attention but only for the purpose of telling you that it's not something that I would regard as even worth mentioning.

MR DIEHM: I understand that, Commissioner.

COMMISSIONER: All right. Well, that document will be made Exhibit 228.

ADMITTED AND MARKED "EXHIBIT 228"

COMMISSIONER: It remains my preference, Mr Diehm, that it be a confidential exhibit but if you prefer it to be an open one-----

MR DIEHM: I do ask it to be an open one.

COMMISSIONER: That document will be Exhibit 228 and will not be confidential. I'll just describe it as note concerning Dr Nydam's remarks to the Chairman. Yes, Mr Andrews. I'm glad that's out of the way.

MR ANDREWS: Doctor, your attachment GF6 has a page to which I would like to draw your attention and I will have it put up on the monitor. "International medical graduates conditions of registration may include a requirement for supervised practice." Now, one sees the good sense of that?-- Mmm-hmm.

My concern is how does the Medical Board or Queensland Health propose to overcome the problem that arose in Dr Patel's case,

of his having been registered to fill an Area of Need position as a senior medical officer but when it seemed that there was no-one who had at that stage accepted a position as Director of Surgery, that he was almost immediately promoted to the position of Director of Surgery? How can you prevent that from happening?-- I suppose the errors that occurred in that was the position that Dr Patel was appointed to was subsequently changed without referral or at least clear referral back to the Medical Board. Ordinarily, that would be a requirement. If a person was appointed as a senior medical officer and that position changed, it would be a requirement to say that position has changed and therefore a renewed application for special purpose registration should be submitted. What the Medical Board has done in the last time is really tighten up those supervisory arrangements. What we're seeking obviously is people to in this regard - and in that particular reference, they're all junior positions. But in terms of senior medical officer positions, which is the one that Dr Patel was in, they are generally of two groups. There are non-specialist senior medical officers and there are specialist senior medical officers. Non-specialist senior medical officers fall into two categories. One is a rural senior medical officer, who are really generalists in hospital practice. They are generally under the supervision of the Medical Superintendent at the location or of somebody equally qualified but somebody equally generalist in their approach. The non-specialist - other non-specialist senior medical officers work in specialists area in support of specialists. The Medical Board at the moment now requires those doctors to be supervised by a specialist in the execution of their duties and that if a similar application was now received to that which was received from Dr Patel, then it would be made extremely clear on his registration it was subject to supervision by a specialist.

It's within the next document, which is your attachment 7, which is a Medical Board of Queensland Guidelines for Supervised Practice Draft Document, or the attachment is stamped "draft" on each page?-- Yes, it is.

Is it your understanding that it remains a draft?-- It is still a draft at this stage, yes.

One sees at page 3 of that draft - I will have it put up on the monitor?-- Certainly.

So that those in the courtroom can follow. That in the circumstances of hospital doctors, the principal supervisor will generally be the Director of Medical Services, Medical Superintendent or the Director of Clinical Training?-- Mmm-hmm.

In a regional hospital such as the Bundaberg Base Hospital, and I imagine in many other regional hospitals, the Director of Medical Services may not be a practising clinician?-- Mmm.

I'm correct in that assumption, am I?-- That's correct, yes.

And the Director of Medical Services would - if not a practising clinician, would not be an appropriate supervisor for a surgeon, you'd agree?-- That's quite correct, yes.

How in the Bundaberg setting would the proposed system work?-- The reason that that provision is there is to cover, largely, the junior hospital doctors because the junior hospital doctors generally rotate through terms and in any one term they may have two or three consultants that they work for. So it becomes a very pragmatic difficult situation to say that we should try and name each of those specialists who'd be the supervisors. So for them, the Medical Board's intent is to identify the Director of Medical Services or whatever name that fills as being the person responsible for the supervision. It's part of their administrative responsibilities to ensure that there are supervisor arrangements in place for those junior medical staff. In regard to the non-specialist senior medical officers, as a general rule the provision included in their registration is to name the specialist that they would actually be supervised for, who would normally be the Director of Surgery in the context of a surgeon.

Now, that's an improvement that's taken place since Dr Patel's departure from Australia, isn't it?-- Indeed so, yes.

So if, for argument's sake, a person with Dr Patel's qualifications applied for Area of Need registration in July 2005, that applicant would be likely to have imposed upon his employer a condition that the employer provide a supervisor who is actually named and identified to the Medical Board of Queensland before the Board would register the applicant?-- Indeed, that's so. And the applicants now are clear about that and usually provide the name of the supervisor at the time of the application.

D COMMISSIONER VIDER: Because at the time of Dr Patel's registration, he was not eligible to be appointed the Director of Surgery because his registration was specific to the title of Senior Medical Officer?-- That's correct, and it was also, I think, from my memory of the documentation received, made clear that he wasn't a specialist.

Yes?-- It is the appointment of him to a position which would ordinarily be considered a specialist position.

And that position description clearly said a Senior Medical Officer required supervision-----?-- I think that's correct. I am not familiar with the wording of the-----

-----from the Director of Surgery, because one of the difficulties then was when Dr Patel was made the Director of Surgery, he then became his own supervisor?-- Indeed that's so.

MR ANDREWS: A facet of the system that obtained when Dr Patel obtained his registration was that he could be registered as SMO surgery and there was an inference to be drawn from that that he was supposed to be supervised?-- Uh-huh.

Am I - do you agree with that proposition?-- Yes.

But it seems that that inference wasn't drawn or may not have been drawn by those at the Bundaberg Base hospital, which was where he was immediately promoted to Director of Surgery. As I look at this document that's on screen, I suggest to you that it remains possible that there could be some confusion by those who read it that some might read it as permitting supervision by a non-clinician?-- Mmm.

Do you think that there is a need to make it crystal clear that if one is appointed as an SMO surgery, the principal supervisor, or, indeed, a PHO or a JHO, that the principal supervisor ought to be a clinician?-- I think that could be made clearer, yes, certainly.

D COMMISSIONER EDWARDS: Would that create difficulties, though, in regional areas particularly?-- I think what we just have to ensure is that we made clear that when we say it is the medical superintendent for the junior hospital doctors,

it is not expecting the medical superintendent to personally supervise every JHO in the hospital but put in place administrative arrangements to ensure that there is a clinician identified who in fact signs-----

Takes that responsibility?-- -----performance report, et cetera, for the individuals.

COMMISSIONER: Dr Fitzgerald, my mind, I have to say, is going down the track that where an Area of Need's overseas-trained doctor is appointed to a position - can I say of a specialist character; the doctor is not qualified in Australian terms as a specialist but will be performing the work of a specialist - we really should have a system where one of two things happens: either that doctor is supervised by a specialist in that field - if it is surgery, then by a member of the College of Surgeons; if it is psychiatry, by a qualified Australian psychiatrist - or where that's not practicable, because it is, for example, a small town, then there has to be a probationary period at one of the major hospitals under the supervision of someone with those qualifications. Otherwise you get the risk that came up with Patel where he was captain of the ship in terms of surgery at Bundaberg without anyone there to supervise him or to make sure that he was doing the right thing?-- Yeah. Indeed, I think that would be very useful. We've confronted a number of cases recently where it is perhaps not so striking where a non-specialist Senior Medical Officer may be going into an area where there are specialists because that level of supervision can be provided on site. It is more of a difficulty where they are going to a location where there aren't specialists.

Yes?-- The area of particular interest, I suppose, is around anaesthetics, because many anaesthetics are not given by anaesthetists, they are given by general practitioners who have experience. In rural areas there have been a couple of cases where the Board has required the person to go into a location prior to going into that subsidiary location, smaller location.

I know I am going to get you off the topic here but it raised in my mind another thought. We heard earlier this week from Dr Young at the PA and her evidence included just a description of the success they have at the PA in recruiting doctors from overseas because it is a hospital with a good reputation and they have got a good network and so on?-- Yes.

And it seemed to me, in some ways, tragic that the hospitals in the greatest need, which are the small hospitals in rural and provincial areas, don't have that sort of resource when a large wealthy hospital like the PA does, and that led to my suggestion that perhaps recruitment of overseas-trained doctors is something which should be done centrally by Queensland Health rather than hospital by hospital?-- Mmm. I think that's probably a very good idea. We've certainly been trying to think through this problem, which is that the hospitals or the locations that are effectively at the end of a very difficult - if I can use the term supply line-----

Yes?-- -----are really very small hospitals which do not have the capacity to provide the level of security in terms of supervision, et cetera. And a concept around perhaps the larger hospitals, the metropolitan hospitals taking more of their share of a Statewide shortage of doctors would be, I think, partly a solution to that. It is not, however, without difficulty because the Australian graduates then feel that they are left to serve in the areas that may be considered less attractive.

Yes?-- So somehow or other we need to get a reasonable balance, and I think the process of central recruitment and allocating people would be - would in principle be better so that we can try and get a balance between those interests. Vacancies occur at Princess Alexandra Hospital. If they were to advertise them, then we wouldn't have anybody left at Mt Isa or whatever.

Yes?-- So a balanced approach and perhaps some more organised centralised management of particularly the junior medical workforce.

Yes?-- Is probably something we need to try and get better at.

And after all, I mean, you make a very valid point that we don't want to discriminate against Australian-trained doctors by saying they are the ones who have to go to Mt Isa and Bamaga, but on the other hand a medical graduate from the University of Queensland knows that he or she is going to have to do a rotation in a country hospital - generally speaking, that's the case. And it is difficult to see why the same shouldn't apply if the PA is able to recruit a topflight overseas doctor, why that doctor shouldn't do his or her share of work in the country hospitals?-- Certainly. There is a restraint usually in the registration conditions that are applied to the overseas-trained doctors, is they don't do country service until particularly as they have had some emergency medicine experience at the larger hospital. But the other provision that we've started to apply in recent times is to say that the condition should be that this doctor should not go out to the small country hospitals until such time as they have satisfied the - to the medical superintendent or the Director of Clinical Training that they are safe and competent to do so.

Yes?-- So it is, in effect, putting some responsibility back on to the medical superintendents to ensure they have some responsibility for the competence of doctors in small country hospitals that they generally serve.

I am not sure that I am convinced, doctor, I have to say, that that's a perfect solution, because then you are getting back to that conflict of interest issue where a doctor, who is in the position of medical superintendent, has to send someone out to the little hospital that's associated with the Base Hospital, the doctor in Roma has to send someone out to

Mitchell. How does that - that puts the medical superintendent in that situation where his duty to provide a service to the people of the small community conflicts with his duty to the whole system to-----?-- I think your point is valid. Perhaps the alternative is the Director of clinical training, I guess we should be looking at that. I suppose the point however is the Board processes can only ever be a very broad approach. At some stage somebody has to be able to personally distinguish between, for example, a graduate from, say, the United Kingdom who is perfectly well trained, capable, has done emergency medicine, experienced, is very capable, from somebody who may be from another environment, or may still be from the United Kingdom but has less experience and is less capable. An individual judgment at some stage needs to be made.

And that's the real problem. It is the problem that lawyers and policy makers face all the time, that you design systems to cover the worst case scenario, but that's usually an inconvenience to all the other cases which are the majority, and, as I have already mentioned this morning, what we've heard is there is some 15 hundred or 17 hundred foreign-trained doctors in the State, the vast majority of whom aren't a problem for anyone and make a huge contribution to the State. We need to be careful not to put impediments in their way?-- Indeed so, yes.

MR ANDREWS: Doctor, when a special purpose registrant such as Dr Patel is appointed to an Area of Need, it is for the specified position by which you mean the employment position, Senior Medical Officer, for example?-- Certainly.

In a general location, for instance as specified by the Director of Medical Services at the Bundaberg Base Hospital?-- Not - generally more specific than that. So, for example, it would be a Senior Medical Officer in surgery at the Bundaberg Hospital. There is a broader provision particularly for the junior doctors to cover the rural relieving type roles where that is delegated to the medical superintendents to do, but Senior Medical Officer would be generally more specific to the location.

In 2003 would it have been general knowledge among the administrators responsible for employment of clinical staff that a Special Purpose Registration for the position of SMO would have required a further application for registration if Dr Patel was to be promoted to Director of Surgery?-- It is difficult for me to judge because I have not been in a relationship with many of the people involved. But I would suspect that the tightening up of arrangements and the greater clarity of arrangements in recent times has been necessitated by perhaps a broad - sorry, a lack of clarity amongst medical superintendents about the requirements of these positions.

What has been done to clarify for medical superintendents, as you call them, their obligation to seek - to have their employee apply for further registration before promoting the employee?-- Mostly in the way of - where there have been

meetings of medical superintendents to discuss this issue broadly with them, but mostly through the clarity around the conditions placed on registrations, it has become clearer that as those conditions - as the Board has become, I suppose, more clear in terms of its conditions.

And those clarified conditions have been in place for a month or two, haven't they?-- I suppose the clarity has been increasing over the last year or two, we have been getting more consistent in the way we have been applying things, hence the documents that you have referred to this morning, being documents that we've been producing over the last probably six to 12 months to try and get some consistency in the processes.

You adverted paragraph 50 of your statement to the suggestion of the Medical Board of Queensland that overseas-trained doctors provide or have certificates of good standing provided by the relevant Boards in each jurisdiction in which they have practised?-- Yes.

And you regard that as less practical than a recommendation of your own?-- I just find that there probably is some practical impediments to that, and there are some evolving practical impediments that are occurring that we probably need to just think again without reducing in any way the risks associated with this, but I use the example of my own circumstance there, but there are other examples presented relatively recently where doctors, who have practised at some stage for probably relatively short times in some countries where there are less sophisticated structures, are finding it difficult to get certificates of good standing out of those countries. For example, a doctor who may have graduated in India who spent some time in, say, Zimbabwe, and who then has worked in the United Kingdom for several years finds that probably the only way of getting a certificate of good standing out of Zimbabwe is actually go there and try and obtain it, which is obviously somewhat difficult. So there are some practical impediments. The principle, of course, is that if somebody has practised in a previous location and there may well have been adverse incidents there, we do need to obviously try and identify that. So I think my suggestion there is perhaps there should be just a time limit on that. There may be some other ways of overcoming this dilemma.

The way you have expressed paragraphs 50 and 51 - paragraph 50 leaves me as a reader to infer that you are suggesting the applicant should be providing the certificate of good standing. The Medical Board of Queensland has recommended as a safety device that the certificates be supplied directly from the administrative body in the overseas country?-- Yes.

You don't quarrel with that?-- Oh, not at all, no.

At paragraph 51 you observe that for some time the competency of overseas-trained doctors has been identified by Queensland Health as an issue of concern. When do you recall it to have been identified by Queensland Health as such an issue?-- I recall discussions over - I have been in the position for two

and a half years. I think from my personal perspective - I was on the Medical Board as a result of being appointed this position. From almost the first meeting of the Medical Board, I detected considerable concern about how we could guarantee the qualifications and experience of people in the current system and I think - and certainly from there on there have been many discussions with many bodies and individuals including people who have been before this Commission.

Would it be fair to say that that concern has been well-known also within Queensland Health during the same period?-- Oh, I would think so, yes. Certainly I have had discussions within Queensland Health with various officers who have raised that concern with me personally.

D COMMISSIONER VIDER: Doctor, I think we have had evidence from the Medical Board that they intend to do some work on getting a better handle on the accreditation, if you like, of various courses so they can identify those who have not much relevance to a course in Australia as opposed to those from other countries that do have close association with the standards as the under graduate courses?-- It is-----

Or preregistration courses I should call them?-- Indeed so. In fact, I think that work is being undertaken by the Australian Medical Council so it is consistent across Australia.

Is it?-- Yes. To identify as you point - prior to the early 90s, of course, we automatically recognised graduates from countries that we had a traditional association with, such as the United Kingdom and London.

MR ANDREWS: Doctor, you first became aware of problems at the Bundaberg Hospital intensive care unit on the 17th of December 2004. Is it from this email that's now on the monitor that you were first appraised of these problems?-- Yes, that's correct.

I see that the email is written by Rebecca McMahon. She is in Brisbane or she was at the time, is that the case?-- Yes, that's right, yes.

And it is Rebecca McMahon's advice to Mr Leck that the issues of clinical practice and competence were raised rather than any official misconduct?-- Yes.

D COMMISSIONER EDWARDS: Could I ask, Rebecca McMahon's qualifications are medical or other?-- I would suspect other but I am not - I think she is an officer within the audit review - internal audit, we normally call it.

So it is not uncommon for people referring to this particular document who have no medical experience or qualifications to do this kind of report on an intensive care unit?-- They would not normally. I think what they - what she was seeking to do was - well, my understanding of what she did was that they were looking at it from the perspective of is there

official misconduct here, and having come to that conclusion, then felt they were - it was not an area on which they could provide any expert advice.

I see?-- So hence the advice to Peter Leck to refer it to my office.

Thank you. So that's how it came to your office as a result of this audit?-- Yes - well, I don't think they did any audit as such. I think they just looked at the material and said, "This is not material that we would give you."

Thank you?-- I think the email - a back copy of the email was sent to me, from my memory.

MR ANDREWS: Was there any sense of urgency conveyed to you orally by anyone about the situation in Bundaberg?-- I don't recall talking to anybody at that stage. My memory, imperfect as it is, is that I saw this email at some stage, whether it was that day or days later - I don't get to check my e-mails on a daily basis - and took the step of printing it out as a memoir for when - if I received a call from Mr Leck.

You received no copy of the letter of complaint from Ms Toni Hoffman, just the e-mail?-- At that stage, yes. From memory I didn't receive any other material.

You attach at GF9 e-mail correspondence between Mr Leck and Dr John Scott. You don't say when you were provided with it. Would it have been likely to have been at the time or some time later?-- I don't recall that correspondence at the time. I think that was provided to me some time later.

I'm curious - you will see I've highlighted the words "in the new environment of QH". Are you able to interpret what the writer meant by that?-- As he refers to Dr Mark Waters and Dr John Wakefield, I assume he's referring to the structural changes that occurred some time last year when the department previously had two divisions and it was restructured to five directorates, with the development of particularly areas around patient safety and clinical standards, the introduction of those new areas under the direction of Dr Waters, John Wakefield looks after the patient safety centre. So that would be my interpretation of that. This is particularly the date - which I suspect is January - 20th of January, is it?

Yes?-- Or the 13th - the dates are around the wrong way.

The 13th of January seems to be the date of the lower e-mail?-- My memory of the changes was that it's the middle of last year. I'm sorry, I'm hazy as to the exact date.

As one goes down the page one sees that Mr Leck has suggested to Dr John Scott that, "My met super is keen not to have a professorial boffin from a tertiary hospital undertake the review for fear they may not relate to the real world demands of surgery in regional areas." Is that a reasonable proposition?-- I think there's a reasonable point there, and one that we like to be careful about in some of these investigations, that if you obviously appoint somebody who has a very tertiary view of the world and may lack experience in small rural locations, the limitations of small rural locations may not be as obvious to them. The way, usually, of dealing with that, of course, is to mix people in a team who have that realism.

COMMISSIONER: Doctor, I think it's appropriate to disregard words like "boffin" that might have been written in the heat of the moment when no-one expected this e-mail to be sent by anyone else?-- Sure.

But dealing with the principle of it, if this is being examined as a question of clinical standards, surely clinical standards in Bundaberg shouldn't be any less than clinical standards in Brisbane?-- Oh, indeed so. Obviously the limitations of services, say in Bundaberg - or more particularly in small country towns with isolation et cetera - there will be those limitations that are realistic, but I think you're correct. I mean, you do need to have the boffin, if we use the word, that - it's the person who is expert in the area to determine what those standards should be.

Obviously it's useful then to have either that person or somebody else to then interpret those standards, or the application of those standards, or the limitations on achieving those standards that might occur in smaller towns.

For example, we heard evidence over the last couple of days from Dr Peter Cook, and I think you might have been in the courtroom when he was finishing his evidence?-- Yes.

I'm not suggesting for a moment that anyone would regard him as a boffin, but he's certainly at a very high level of expertise in relation to ICUs?-- Yes.

And I should have thought that if a manager of a country hospital wants a review of whether the ICU standards are acceptable, it's that sort of person you want to come and give you advice, not someone who is familiar only with poor standards in other country hospitals?-- Oh, indeed so. But I suppose the point is just to ensure that that is balanced in terms of the limitations that may apply.

Yes.

MR ANDREWS: By the time this e-mail was written by Mr Leck, one sees at the bottom of the monitor that Mr Leck writes that he was becoming increasingly anxious about the need for a swift review process. Was that anxiety communicated to you?-- My memory is that the first day back from my leave I had a conversation with Peter Leck, and he was concerned that he was - that this was an increasing issue for him, and that he needed some assistance as soon as possible. My memory is that he then forwarded material to me.

Did Mr Leck explain to you why he was anxious? I'm wondering whether he, for instance, alerted you to the fact that he was concerned with the competence of the doctor or the concerns of staff?-- My memory of the conversations was that he was certainly concerned that the issue would become an issue of public concern, but I think he also - the impression I got from the conversation - or remember from the conversation was that he was also concerned that he really just didn't know whether there was a clinical issue at stake here or not.

And it's appropriate for a person in Mr Leck's position to concern himself with whether this would be - become a matter for public concern, because in Queensland Health's system its administrators are obliged, are they not, duty bound to consider whether Queensland Health's reputation might be tarnished by events?-- Oh, I think so. I think that would be normal and good management.

Within GF10 is a large bundle of material. You don't make clear, doctor, whether you received all of that material at once. I suspect some of it is dated at times after you commenced your review at Bundaberg, although I'm checking on that. When did you go to Bundaberg?-- It was early February. The dates - may I refer to - reconfirm the date, but I think it was about the 13th of February.

Thank you. Within GF10-----

MR CHOWDHURY: I think the evidence will be it was 14 and 15 February that Dr FitzGerald went to Bundaberg.

WITNESS: Thank you. My memory is we drove up on the Sunday night, which is probably the 13th, and had the interviews on the 14th and 15th.

MR ANDREWS: Within GF10, the very first document is a memo to you from Mr Leck, the second page of which I'll put up on the monitor. It's a memo dated the 19th of January 2005. It alerts you that Dr Patel did not intend to extend his contract when it expired on 31 March 2005. Was that of any significance to you in determining what kind of investigation you would do?-- I'm not sure in terms of what - not sure the linkage in terms of what kind. It was of - I do recall it was important, I think, in terms of the timing of the investigation, of trying to achieve that investigation before he left, because - can I say it worries me at times where we don't progress investigations because people depart, that there is unfinished business, and as a result, when these people come back there is no evidence base to avoid - or to manage the issues that were of concern before. But in terms of the type of investigation, I don't know - I certainly don't sense that that had an impact, except to say that we needed to try and do it before he left.

Thank you. Another file note is within that bundle, and it is dated the 17th of December 2004. I can see from the second page of it - which isn't on the monitor at the moment, that there was a suggestion that this would be CC'd to Gerry FitzGerald. I wonder, were you provided with a copy of this document before you attended at Bundaberg?-- I certainly don't remember reading that document before attending Bundaberg, but whether it was attached to the bundle of information we received from Peter Leck or not, I'm not sure.

Within it you will see there's a statement that the district needed to handle this carefully, as Dr Patel was of great benefit to the district and they would hate to lose his services as a result of this complaint. Did anyone explain to you what Dr Patel's benefits were to the district?-- Yes, he was - certainly the officers in the district felt that he was a significant benefit in terms of that he was very diligent, he worked hard, he attended and had been reducing the waiting times for non-urgent surgery quite significantly, that he was very keen to teach students and other staff, and he - particularly junior staff and students who were attending there, and that he'd really been, I suppose, very hard working, in their view, and had really helped them in terms of reducing waiting times for people for elective surgery.

A reduction in waiting times for elective surgery has a financial benefit for a hospital, does it not?-- That's my understanding, although I must admit I'm as yet ignorant of these detailed financial arrangements for hospitals.

COMMISSIONER: The suggestion we've heard is that according to the system of weighted separations, in broad terms the complexity of the operation combined with the underlying health of the patient - including a patient's age and medical condition - lead to the hospital getting more money in accordance with the system of weighted separations as compared with either a simpler procedure or the same procedure performed on a patient in better underlying health. Is that consistent with your understanding?-- Well, that's - I've certainly heard that. At present I don't know the facts of how the hospitals are funded.

Yes?-- What I thought happened was that they had a budget which was, on historical grounds, worked around a certain workload. That budget didn't vary in any significant way depending on the nature or complexity or the mix of that work, but I think what was - what I understood had happened was that there'd been special new initiatives around funding of elective surgery, and that as a result, if the hospital could undertake further elective surgery then it could access those funds. But I don't know whether that additional funding was varied in any way depending on the complexity of those cases.

In any event, with the passage that Mr Andrews had highlighted, no-one from Bundaberg Hospital or anyone else suggested to you that Dr Patel's value to the hospital was in monetary terms?-- No, nobody ever mentioned that. It was more about reducing waiting times.

Mr Boddice, it does trouble me a little that we've heard rather anecdotal evidence about this system rather than precise details. I wonder whether at some convenient time - and I realise you've got many other things on your plate, but at some convenient time you might be able to identify the documents and just give us a little bundle of what we need to know to understand the system without lengthy material.

MR BODDICE: We'll endeavour to have a short statement with the appropriate documentation annexed to it provided to the Commission.

COMMISSIONER: I don't think we'd even need a witness to explain it if the documents speak for themselves. It might also be useful to know what the truth is regarding Dr Patel's money-spinning endeavours at the Bundaberg Hospital, how much money was in fact received as a result of operations done by him. I don't know if anyone at Queensland Health has done that exercise, but you might see if again you can perhaps locate the documents or, if necessary, get a witness who can explain it.

MR BODDICE: Yes. We will again endeavour to do that and provide it to counsel assisting.

COMMISSIONER: I appreciate that. Thank you.

MR CHOWDHURY: Can I just raise a matter? The document that counsel assisting just put up, which is a minute, I don't have a copy of that. If I could just have a copy made for me over the break. I don't think my learned friend Mr Diehm's got a copy of it either.

MR ANDREWS: Neither does Mr Allen, it seems.

COMMISSIONER: Yes. If there are those or any similar deficiencies in your copies of the statement, perhaps Mr Scott can look after that over the lunch break, if you'd care to liaise with him.

MR CHOWDHURY: Thank you.

D COMMISSIONER EDWARDS: Talking about papers, I was wondering if Dr FitzGerald would be prepared to make available the papers he published in the medical journal to the Commission?-- Sorry, you're-----

You wrote a couple of papers for the medical journal to which you refer somewhere in your statement. I was wondering-----?-- Are they the ones in the recency of practice document?

Yes?-- I don't think they're mine.

COMMISSIONER: That's a different Dr FitzGerald.

MR ANDREWS: I think so. Interestingly, spelt the same way.

COMMISSIONER: Even capitalised the same way?-- That's right, sir.

D COMMISSIONER EDWARDS: That's what confused me. Thanks. Don't worry.

MR ANDREWS: That was an M FitzGerald, as I recall.

D COMMISSIONER EDWARDS: You are more diligent than I am, Mr Andrews.

MR ANDREWS: Doctor, when you went to Bundaberg, you had a pile of material that had been supplied. Were you able, from reading that material, to form a view about whether there was a dangerously incompetent surgeon practising at Bundaberg simply from the review of the material that had first been supplied to you?-- No, I wasn't. The information - I remember our reactions to that information was that, as I expressed yesterday, I was surprised that certain procedures were being performed there, but apart from that surprise, the information there that we had contained, obviously, concerns - issues of concern, but there - similar to the discussion we had about detailed assessment of patient outcomes, there's a lot more work needs to be done before you could identify whether those concerns actually constituted incompetence or whether they were in fact a reflection of other issues such as the complexity of patients et cetera.

COMMISSIONER: Well, without necessarily forming a view that there was a dangerously incompetent doctor at Bundaberg, was there enough to tell you that dangerous practices were going on at Bundaberg?-- I think what - my memory of the time was that having seen this I thought we did need to have a look at this. Ordinarily I would arrange for somebody else to undertake these sort of investigations and reviews and report through me, but in this case, because, I think, of the concerns raised by Peter Leck in our discussions over the phone, and also the information presented, I thought this was probably a complex situation that may need perhaps - not so much technical judgment, but perhaps more - if I say political, the policy and the interaction of people, and judgment about those issues as well as the management of evidence, shall we call it, but certainly data about outcomes et cetera. So I remember being struck by - as I said, the surprise about the sort of procedures, and also that there seemed to be a lot of issues, not only of a clinical nature, but of an interpersonal nature which caused some concern. I mean, I do remember noting that there'd been only a limited number of those very complex cases, but still, it did raise concern with me.

Yes.

MR ANDREWS: Doctor, as I understand things, the improvements that have occurred in recent years would be such as to give the public a good degree of comfort that if, hypothetically, Dr Patel applied for registration as an Area of Need SMO for Bundaberg Base Hospital today, that the first gatekeeper safeguard would be that a Certificate of Good Standing - not from Dr Patel, but from the United States, from Oregon or from New York - would have to be supplied, and if-----

COMMISSIONER: Well, not have to be supplied, would be obtained directly from that registration authority?-- That's correct.

MR ANDREWS: Directly from that authority?-- Yes, that's correct.

And that would prevent what has happened in Dr Patel's case. It would prevent the last page of the document from being concealed?-- Yes.

That would have revealed that disciplinary proceedings had been brought against him, and indeed that there had been restrictions on his right to practise?-- That's correct.

The second safeguard is that conditions would have been imposed upon Dr Patel that - on the assumption that he was registered - that he must be supervised?-- Yes, that's correct. If we - there's a slight difference, I suppose, in that if we were aware and had that information about his United States experience, then serious consideration, I suspect, would have been given to not registering him, obviously. But if they weren't quite so serious then they

would be taken into consideration in terms of the conditions, as well as the conditions that you mentioned about supervision.

COMMISSIONER: And quite possibly conditions about the types of operations that he'd be allowed to perform and so on?-- Yes, certainly. I mean, if that - from my vague memory of the conditions that have been applied, it was about complex anal surgery that he'd been undertaking. As a general rule the Board will apply conditions that another Board has applied in addition to applying its own conditions regarding supervision.

D COMMISSIONER EDWARDS: And those conditions are reviewed at a period of time whether they're being fulfilled or not?-- Yes, they are. Part - I mean, certainly there's no inspectorate as such to go out-----

No?-- But part of the linkage between these conditions and the supervisory arrangements is to ensure that the supervisor provides comments about the clinical competence of a person, and also the fulfilment of any conditions that apply.

D COMMISSIONER VIDER: Could you comment on the scope of practice within which a surgeon in a hospital like Bundaberg would act, presuming that their registration was current - and let's say they even had - they were a deemed specialist or they were able to do surgery at certain levels. I've been a bit amazed, I must admit, at the scope of procedures that Dr Patel undertook, but would that be at all the norm in a hospital the size of Bundaberg? For example, Dr Miach gave evidence that when he first came in contact with Dr Patel and asked him what he could do, he said, "Everything", and there's a range of clinical activities to support that. Like, he did amputations, he went into the thorax, as well as doing general surgery. Would that be a range of things? I'm mindful that I'm coming out of an environment that's now used to highly specialised procedures, and I'm looking at generally an orthopaedic surgeon or a vascular surgeon even doing amputations because of the need to be so careful with the way they fashion the stump?-- I think if we go back, of course, 20 years ago, then there really was the concept of a general surgeon who used to do general - almost anything, and I mean, I was at Ipswich Hospital where the general surgeons there did a full range of surgery because there wasn't the level of super specialisation that we would now be used to. In many respects my observation is that Dr Patel really did probably similar things - a similar range of procedures that may well have been done in many provincial cities 20 years ago by the general surgeon. I think - I certainly don't have any information or experience that there is anybody else around Queensland who is that, shall we say, broad in their operational experience or operational scope of practice. There's certainly no limits placed in terms of legal limits, but it is the - as I mentioned yesterday, the credentialling and clinical privileges process that should get that level of clarification. I suppose it's the linkage that provincial hospitals is difficult, because it depends very much on the capability of that individual surgeon. I think Bundaberg is a

case in point where the previous director, I think, was a vascular surgeon, so he was doing vascular surgery there that you wouldn't - I mean, if asked to look at that circumstance I may have expressed surprise that that level of vascular surgery was being done at Bundaberg until brought to the fact that he was a vascular surgeon - a trained vascular surgeon. That's probably more acceptable.

COMMISSIONER: Dr FitzGerald, I wanted to follow up Sir Llew's question about monitoring supervision of compliance with Medical Board requirements. As I mentioned this morning in response to Mr Diehm's concerns, we do hear things from people we meet in the street and friends and so on, and one story I've been told relates to the federal body - the federal advisory body relevant to the deemed specialisation system, where a deemed specialist from overseas can get a provider number and therefore provide specialist services in Queensland. As I understand it, in general terms there is an advisory body with representatives of the various medical colleges that assists the Health Insurance Commission, I think it is, to operate that system of deemed specialisation, and that - I'm not talking about something that happened recently, but some years ago - four or five years ago a number of representatives of the colleges resigned from that body because they were sick of the fact that they would put in place quite rigorous requirements that a deemed specialist had to be under the supervision of a member of the college, had to attend the college lectures, had to go through the college examinations and had to work towards getting Australian qualifications, but they would put in place those regulations, and Queensland Health would blithely ignore them and would employ the deemed specialist as if he or she were any other specialist. Are you aware of that sort of problem?-- I'm not aware of the federal structural arrangements around it, except to say that I thought it was the colleges themselves that dealt with their own applications. So, for example, somebody who sought to be a deemed specialist in a surgery would be - that application would be referred to the College of Surgeons, and the College of Surgeons would make that determination. Going to the latter part of your point though, once those determinations were provided to the Medical Board in Queensland - certainly since I've been there, that would be automatically included as conditions on their registration for a deemed specialist.

Yes. The criticism wasn't one directed to the Medical Board. The criticism was that Queensland Health then employs the deemed specialist and disregards any conditions attached to the deemed specialisation?-- Well, certainly the Medical Board isn't in a position to check - to inspect and check, except at the time of renewal, in which case the report that was expected from the supervisor should attend to the issues of conditions that have been applied.

COMMISSIONER: Mr Andrews, I see-----

D COMMISSIONER EDWARDS: I just have - slightly off the subject, but related to your position, in years gone by in

this jurisdiction and in other jurisdictions, the Chief Medical Officer or Director General - from a medical point of view - of Health was in fact the chair of the Medical Board in those states, and in fact traditionally in this state for many, many years. Whilst it's difficult to ask you this in your difficult position - because it's a political decision made through the Act - do you have a view that there is advantage in having the Director General/Chief Medical Officer - as I said, it applied many years ago, and is still applied in some other states - as the chair of a Medical Board? If you feel you would not like to answer, I understand?-- I'm happy to respond. The - I mean, I think there's - perhaps through a different direction, to say that I think the intent of the Medical Board is that it is of professional self-regulation. I think there are great strengths, therefore, in the chair of the Medical Board being seen to come from the profession directly and not through a government official. I think there is, however - one which we talked, I think, yesterday about - the personal dilemma that I confront of serving government purposes one day and registering the next because of my, I suppose, enthusiasm as part of the Medical Board to help out by chairing the Registration Advisory Committee. I think if the position of Chief Health Officer - which, in effect, I think is Chief Medical Officer - the role is distinct from some other states where it has the public health role, hence the Chief Health Officer is probably relevant there. I think that position, were it to have its own - a degree of statutory independence more than it currently has - at present the position is created, but the role is not defined in the current legislation except in certain elements of other pieces of the legislation - I think then there wouldn't be a conflict in terms of that person being part of the Board to ensure that the professional direction set by the Chief Medical Officer/Chief Health Officer was consistent where the Board was going. But I really feel it's probably stronger actually having the chair seen to be a member of the profession, and often from private practice.

D COMMISSIONER EDWARDS: I share that view. I just wanted to know-----

COMMISSIONER: Just going back to the questions Mr Andrews was asking you, we have seen the fact that in mid-December of last year it was brought to your attention that there were these problems in Bundaberg and your initial reaction was, as you've told us, surprise and I think you might have even used the word "alarm" at the level of operations going on in Bundaberg. I feel obliged to ask you the question did it occur to you, and if not why didn't it occur to you, to put a stop to those operations then and there?-- Well, if I may clarify the timing, I think in December all I got was that e-mail.

Yes?-- So prior to January I had no real information of what was going on at all.

Yes?-- And in January, I suppose it didn't - it didn't come to my - I suppose I didn't sort of consider that we needed to do anything precipitously. I mean, I think the point is valid in retrospect it may well have been that we should have done something more urgently. I know when I visited Bundaberg and had discussions and got a clearer picture of what was going on, including some idea of the number of these cases and when they were being dealt with, I did obtain a commitment before leaving that those operations would cease in Bundaberg both from Dr Patel and from the Medical Superintendent.

Would it be fair to say that since that thought didn't occur to you in January when you first became aware of the problem, that it would therefore be difficult to criticise someone like Mr Leck or Dr Keating for not doing the same thing?-- Look, I think that's fair. It is - they were in a difficult situation. It would have been difficult for them to have moved on that sort of situation at the time.

Particularly when they were waiting to have an official review from head office as it were?-- Yes, indeed so.

Is that a convenient time, Mr Andrews?

MR ANDREWS: Mr Devlin has a housekeeping matter to raise.

COMMISSIONER: Oh, yes, Mr Devlin.

MR DEVLIN: Commissioner, something arising out of Dr Charles Nankivell's evidence earlier in the week I feel should be dealt with today so it is somewhere close by in the record.

COMMISSIONER: Yes.

MR DEVLIN: Dr Nankivell's letter that he received from the Medical Board Exhibit 215 which dealt with excessive work hours.

COMMISSIONER: Yes.

MR DEVLIN: I have since received a copy of correspondence which is self-explanatory and I'll seek to tender it. It's a letter dated the 23rd of March 2005 from Dr Mary Cohn, the Chairperson of the Medical Board, to Dr Buckland referring to

his correspondence and the long and the short of it is that the health department has made an appropriation available in the financial year just started to conduct an independent development of a safe work hours policy. So, indeed, from the date - it would appear that from the date of the letter written to Dr Nankivell, which was in the September of 2004, the board did reassess its role in that respect and the letter reveals - well, it points to health - Q Health making available to the Medical Board an appropriation of in excess of $200,000 that commences that independent development of that policy.

COMMISSIONER: Thank you for bringing that to our attention because it has been causing me a lot of concern and I have to say surprise that the matter hadn't been addressed but I'm delighted to see it has been, but the letter from Dr Cohn to Dr Buckland of the 23rd of March 2005 will be Exhibit 229.

ADMITTED AND MARKED "EXHIBIT 229"

MR DEVLIN: Thank you. I can probably turn up Dr Buckland's letter of the 9th March so that the Commission understands how it came about.

COMMISSIONER: Look, I think this tell us - flicking through it briefly, I think this tell us all we need to know.

MR DEVLIN: You would have noticed that the objects of the relevant Acts leave room for such a study to occur so it is probably some comfort to the Commission to know it was initiated.

COMMISSIONER: Thank you. I was also going to inquire, Mr Andrews, how much longer do you expect to be with Dr FitzGerald in evidence-in-chief?

MR ANDREWS: Twenty minutes.

COMMISSIONER: Mr Boddice?

MR BODDICE: At the moment, probably 10 minutes and any further evidence-in-chief.

COMMISSIONER: I wonder whether I can ask counsel for the other parties over lunch to consider a couple of things. Firstly, if there's any prospect of finishing Dr FitzGerald this afternoon, he's got an important new job and that would obviously be desirable?-- Thank you.

If not, then you might care to discuss amongst yourselves the order in which he is cross-examined. I have in mind that some people who are here now possibly may not be with us in a couple of weeks' time depending on what happens in the Supreme Court, so may wish to put off their cross-examination until

the week after next because we won't be able to hear from Dr FitzGerald next week. It may be that people feel it's important for their own client's interests to cover particular subjects whilst it's fresh in the public mind. So I would appreciate it very much if you could discuss amongst yourselves any preferred order of cross-examination. Would I be right in thinking that there is a risk at least that we won't finish Dr FitzGerald this afternoon?

MR DEVLIN: I wouldn't assume that. I have very few questions myself.

COMMISSIONER: Mr Diehm?

MR DIEHM: My present guesstimate would be about 20 minutes for me, Commissioner.

COMMISSIONER: Mr Chowdhury?

MR CHOWDHURY: About 10 minutes from me.

COMMISSIONER: Mr Allen?

MR ALLEN: I would have thought about half an hour.

MR HARPER: Quite minimal as well.

COMMISSIONER: Let's do our best to finish this afternoon if we can. Does anyone mind if we have a slightly abbreviated lunch break, for example come back at 2.15? Is that satisfactory. Thank you, Dr FitzGerald.

THE COMMISSION ADJOURNED AT 1.08 P.M. TILL 2.15 P.M.

THE COMMISSION RESUMED AT 2.20 P.M.

GERALD JOSEPH FITZGERALD, CONTINUING EXAMINATION-IN-CHIEF:

MR DEVLIN: Commissioner, may I add to Exhibit 229 by tendering a letter from Dr Steve Buckland which is referred to. It is the letter of the 9th of March. In short, the initiative from Q Health appears to have been triggered by the case involving Dr Doneman.

COMMISSIONER: Doctor?

MR DEVLIN: Doneman.

COMMISSIONER: Right. Yes. Thank you so much. The letter of the 9th of March 2005 from Dr Steve Buckland to Mr Jim

O'Dempsey will be added to and form part of Exhibit 229. Yes, Mr Andrews.

MR ANDREWS: Doctor, there are, as I count them, five improvements to the system that have already taken place and perhaps two more in prospect that would prevent a Dr Patel situation from arising in the future. I'd like you to confirm them for me. The first is that a certificate of good standing will not be obtained from the applicant for registration. It will be obtained from the relevant body overseas. The second is that the Medical Board now is insisting that there be appropriate supervision, which is something that did not happen in Dr Patel's case?-- That's correct.

The third is that by June of 2005 the clinical services capability framework is now to be applied in all regional hospitals which would have the effect that there would be no oesophagectomies, no Whipple's procedures in a hospital such as Bundaberg?-- It was implemented as of 2004, July 2004, but would become - there was a one year, I think, time to get up to scratch.

Yes, one year time to get up to scratch so that from July of 2005, one would not expect that in any small regional hospital with a level 1 ICU that there would ever be a Whipple procedure conducted?-- Certainly.

Nor would there be an oesophagectomy conducted?-- I would not expect those to occur, no.

Next, because of the Medical Board's insistence upon supervision, I would expect that there will no longer be promotion of an SMO to the position of Director of Medical Services with the effect that the person would be unsupervised.

MR BODDICE: A Director of Surgery I think, Commissioner.

MR ANDREWS: A Director of Surgery I intended, I'm grateful. And so, a Dr Patel, if he were appointed to Bundaberg tomorrow, would not find himself as Director of Surgery the day after?-- We would certainly not expect that to happen.

The next thing I don't believe has been discussed yet and that's privileging and credentialing?-- Mmm-hmm.

You would expect that - is it the case now that someone such as Dr Patel would be recognised by the administration at any regional hospital as requiring privileging and credentialing or has that not yet been fixed?-- I'm not sure of what instructions have gone out in that regard but I would certainly anticipate that there would be a heightened sense of awareness by the hospital administration to ensure that everybody was credentialed and privileged.

Would it be sensible for Queensland Health to alert the administration in each of its regional hospitals that the privileging and credentialing of unknown quantities such as an

overseas trained doctor should be done as soon as possible?-- It would be sensible and I think I'll need to ensure that it is done.

And for the future, you're anticipating that there will soon be testing of the cognitive skills of applicants for registration?-- That's correct.

By tests administered over the Internet?-- Initially. Supported by interviews and, in certain circumstances, skill testing in a laboratory, yes.

Yes. You're anticipating then that some time in the future there'll also be - you called it or someone wrote of it as psychomotor skills testing?-- Yes.

You and Mrs Jenkins visited Bundaberg on the 14th and 15th, so your statement-----?-- That's correct.

-----advises. The methodology you used for investigation was to collect the personal impressions of issues of concern and not to collect evidence for any particular disciplinary process?-- That's correct.

Why did you elect to make that kind of inquiry as opposed to I suppose the more detailed variety?-- Because it's the nature of clinical audit. The process of clinical audit is intended to be non-judgmental or non-threatening to ensure that people do participate in clinical audit. So the processes we tend to use are not processes which would seek to find guilt but, rather, to seek to identify issues of concern so that those issues can be addressed in the interests of quality improvement.

You prepared a confidential audit report and had it completed by the 24th of March 2005?-- Can I accept the date from you. I'm not sure of the dates so I presume so.

I've deduced that from paragraph 72 of your statement?-- Certainly.

Would you look, please, at this copy of a confidential audit report and tell me if it is identical with the version you've produced by that date?-- It certainly appears to be. It's-----

It doesn't appear to be exhibited to your statement and for that reason I tender that document?-- If I may comment, there is one page that is an attachment to the version that I have which contains some data at the rear that doesn't appear to be on that version.

May I inspect your version, please?-- Yes, certainly.

May I tender your version instead of the other?-- You may.

COMMISSIONER: Exhibit 230 will be the Clinical Audit of General Surgical Services Bundaberg Base Hospital.

ADMITTED AND MARKED "EXHIBIT 230"

COMMISSIONER: Yes, Mr Andrews.

MR ANDREWS: Within that audit, I see at page 3 that you collected data from facilities at Mount Isa, Mackay, Rockhampton, Gladstone, Hervey Bay, Maryborough, Redcliffe, Caboolture, Ipswich, QEII, Logan and Redland for comparison. They were each public hospitals?-- Yes, they were all public hospitals.

And that was to enable you to do some benchmarking comparisons between the data you gathered at Bundaberg to see how that hospital's results compared with other hospitals?-- That's correct, and if you'd note that the hospitals were selected to be hospitals of equivalence rather than a large metropolitan hospital.

From page 4 of that report you have a section headed "Interpretation of These Data". Is it right to conclude that where you wrote, "There appear to be a number of areas worthy of further in-depth statistical analysis", and you then nominate six dot points?-- Certainly.

But you recommended that because the number of episodes identified in each of those six dot points seemed to be high?-- That's correct, there was - the adverse incident rates in those areas seemed to be higher than we would have expected.

The first of the dot points is the number of episodes with a T81ICD-10 code complication of procedure not elsewhere classified. Does that mean that there are a number of classified complications but this one falls between the cracks?-- I think it's the "other" category.

Other, yes. The next relates to misadventures to patients during surgical and medical care?-- Yes.

That seemed to be too high statistically, did it?-- Certainly on our examination of the data, compared to the group of hospitals.

And the number of surgical or medical procedures which caused an abnormal reaction in a patient without any mention of misadventure was too high?-- Yes.

COMMISSIONER: That's more than one in four patients with an abnormal reaction. Seems extraordinary?-- Sorry, could I-----

Sorry, I was looking at the appendix at the end, 28 point - sorry, that's more than one in four adverse episodes, not one in four patients?-- Yes, I don't have that page on

this version unfortunately.

MR ANDREWS: I'll put it up on the screen because there aren't many in the room who have it. Are you referring, Doctor, to the last page, the appendix to your report?-- That's right. That's the page that's missing from the version you've just given me.

COMMISSIONER: So you examined 408 surgical episodes and at the bottom of the page, if we can move it up I guess, 28.9 per cent involves surgical/medical procedures as cause of abnormal reaction. Is that 28.9 per cent of adverse outcomes or 28.9 per cent of all patients?-- I think the number, if you look at the first column, is the number of patients I think with complications, if we could just check the heading on that. The number of episodes with complications, so it's actually 28.9 per cent of the 400 cases-----

Yes?-- -----had that indicated in their data. As you can see on the right-hand side, the benchmarking group, that figure was 12.7 per cent. So it's two to three times - two and a half or two and a third times higher than that.

And it just seems phenomenal that more than a quarter of all patients would have an abnormal reaction from surgical or medical procedures?-- Bearing in mind they may be very minor reactions such as, you know, an abnormal scar or a minor wound infection or something. So I would - I imagine the majority of those are relatively minor complications.

D COMMISSIONER EDWARDS: An allergy to plaster or something?-- Absolutely, yes.

D COMMISSIONER VIDER: Dr FitzGerald, did you pick that information up from the medical records?-- No.

Or did you pick up that information from the staff?-- No, this was picked up from data that's held - I think this is the Health Information Centre data or it may be the ACHS data. I'm not sure the source of that, I'm sorry.

COMMISSIONER: So this is data that already existed prior to your visit?-- Yes, it just has to be retrieved from some data source.

Is it data then that should have been readily available to people like the Director of Medical Services and the regional manager?-- I think we - we obtained the - some data from the Bundaberg Hospital as we left. So they were retrieving and recording certain bits of the data. I certainly can't recall which bits they had and which we had to retrieve from the Health Information Centre and the ACHS. I know what they had was the ACHS adverse incident data and we sought to retrieve the benchmarking data from ACH - the Australian Council of Health Care Standards itself. The Health Information Centre, which also collects data off the admission discharge records, also has some complication data on it.

If you ignore for the moment the benchmarking data, because I know you went to some effort to get that data by obtaining it with reference to several other hospitals?-- Yes.

If you just review what that table tells you about Bundaberg, is that something that would have caused you a concern if you didn't have the benchmarking figures to compare it with?-- I'm not sure that I would be as familiar with the complication rates to know that without comparing that data. I mean, obviously when you look at a figure such as Y83-84 which you mentioned before, you would intuitively think that that's a high rate. What I'm not aware of is the detail of what's actually captured in that by the people who actually record the coders if you like, medical record coders. I suspect they're recording relatively minor complications in that package.

You look at T81.2, accidental puncture and laceration during a procedure. I would have assumed that intuitively, 4.2 per cent, one in 25 patients, would immediately strike you as an excessive figure for accidental-----?-- Yes, it would seem high, bearing in mind though the numbers are still relatively small in terms of 17 events.

Yes?-- But I suppose my intuitive reaction, that would seem high, although it depends - I mean, I know that they are doing a lot of these procedures by laparoscopic means at present and I just am not aware of the usual complications rate or wasn't until seeing this sort of benchmarking data that we see here.

I guess what I want to know is whether these are the sort of statistics that should have begun to ring alarm bells before you got there?-- I think that would certainly - I mean, intuitively to me, they would seem a cause for concern at least and - but at least to start further investigation as to exactly what's been captured in those areas.

Yes?-- And what the nature of those complications are.

Yes. I see in your report one of your principal concerns, this is on page 11 - I'm sorry, I'm referring to the wrong page but somewhere you made the point that it was of concern that the systems had failed, that these problems hadn't been picked up sooner?-- Yes, that's right. Both the systems of credentialing clinical privileges, which would have dealt with in a proactive sense with the management of Dr Patel. Secondly, obviously, the quality and safety systems which would be monitored - which should ordinarily be monitoring closely this sort of data and advising when there appears to be adverse trends and in fact doing the benchmarking that we've done by collecting comparative data from - that is, that should be readily available. And then the third aspect of that comment was in regard to the management once concerns were raised, that there didn't appear to be a response that dealt with the issue.

I suppose what I have to ask you, Doctor, is whether the failure to detect these problems was a systems failure in the

sense that the systems weren't in place to pick them up or whether it was human failure?-- My suspicion is that it was largely systems failure.

Yes?-- There were committees in place but they didn't seem to detect or dealt with the issues of concern that had been raised. I know that some of the staff there, particularly some of the nursing staff, did have some data and that data has caused concern but for some reason that hadn't converted into action in terms of dealing with it.

My untutored view, Doctor, would be when you start getting complaints, and we've already received evidence about complaints being made not only by Ms Hoffman but, for example, by Dr Miach and others within the hospital to the local administration over the months, more than six months preceding your visit in March, that's when you start looking at these figures and trying to see if something's going wrong. Surely that's right, isn't it?-- I would think so. I mean, I think as a general rule, when you receive complaints you should ensure that there is some substance to the complaints before doing anything else with them and I think that's about collecting data and collecting information from whatever sources.

It appears that it wasn't a hugely onerous task for you to gather the relevant data?-- It wasn't personally onerous because I had the advantage of Mrs Jenkins to do considerable work in obtaining them but I do know she had some difficulties obtaining them, but it wasn't impossible by any means.

I certainly don't want to put words in your mouth, is it possible that you're being generous when you say it was merely a systems failure rather than a matter of human error?-- It is possible but I suppose it's - the approach that one would ordinarily take in a clinical audit is to look for the system issue and perhaps again, perhaps it's the doctor in me but I tend to think that there is - there aren't bad people trying to do bad things but rather people working in the systems that constrain them.

Yes?-- And so it's certainly - I that the general view or the general approach we ordinarily take. I think people try to do the best within the limitations that confront them.

I'm pleased to hear you say that.

D COMMISSIONER VIDER: Doctor, can I just ask you, this information before us now would lead me to the observation that if there had been a more active morbidity and mortality committee that was seriously able to, you know, review at case level, some of this might have been avoided, but that M&M committee has to be robust?-- Indeed.

I think we spoke yesterday there may be advantages in smaller regions about the public and private system working together?-- Yes, yes.

And having one committee if you like, or to give it more robustness-----?-- Yes.

-----in that area. And the other thing is, we've heard evidence of the number of committees and, certainly, it would seem to me that there are adequate numbers in the committee to the point that I would say that there is duplication for ACHS requirements and for Queensland Health requirements to the point of saying one system, and I would suggest the ACHS, which is nationwide, use that as the framework in which you operate and go with that one because you can't spend all day going to committees. I think what happens then, the committee meetings become an end in themselves?-- I'd agree with you. I think a good management principle is to collect data once for all purposes and do it properly and make sure the data is sound and I think the observation I would share is that we seem to have incredible amounts of data being collected across the system but because it's duplicated and confusing, people probably don't take the next step to deal with it spend the time trying to analyse why the data is inconsistent.

MR ANDREWS: Doctor, looking at those figures, the bottom figure, that is the Y83-84, you mention that some of the procedures may have been quite minor, that is some of the abnormal reactions might have been quite minor?-- Yes.

That's likely to be the case with each of the comparative figures, too, is it not?-- Oh, quite right, yes.

With respect to the figures that you were able to compare with Bundaberg's figures, were such figures acceptable to the administrators at Bundaberg? That is, if an administrator looked at Bundaberg's figures and found, for instance, that nearly 29 per cent of all surgical episodes caused an abnormal reaction in the patient without mention of misadventure, would the administrator have been obliged to rely only on intuition or would there have been some benchmark that was accessible to the administrator for comparison?-- I actually don't know the answer to that question but I don't think we exerted any particular effort in terms of having to sort of use any sort of force to get the data, so I assume they would be available, but I really don't know.

On a Queensland Health intranet, or where would you have found it?-- No, you would have to actually go to the system that collects the data or the people who collect and are custodians of the data who requested, but I don't know if that information is readily available at this stage.

Would it be useful for those who monitor these things to have made available to them periodically data which is of the kind you use for comparison purposes?-- I think it would be. I would also bring to your attention there was an exercise last year called the Measured Quality data, which was produced, and I just remembered, as you started speaking, that it did have benchmarking data but I am not sure of the nature or intent of that, but it may be some further useful information that could be provided to the Commission.

D COMMISSIONER EDWARDS: I didn't catch the name?-- It was called the Measured Quality Project, so it had data that was collected as a result of a particular project, to collect the data, and that data was made available back to hospitals, but, as I say, it is some time since I have seen the document, scrutinised its exact contents, but it may be of interest.

Thank you.

MR ANDREWS: Doctor, the next page of your report - I beg your pardon, at page 5 and following of your clinical audit report, there are a number of opportunities for improvement that you have reported upon. I will put my own copy on the screen. First opportunity for improvement "reviewing staff retention strategies". Would that be intending to include - trying to encourage staff specialists to continue their services as VMOs or otherwise?-- Indeed so, yes.

The implementation of the service capability framework, would that be exhorting the administrators to consult the document

that had been produced to them in mid-2004 to ensure that they weren't doing surgery that was too complex for the hospital?-- Yes, that's the intent of that.

"The development of an orientation program on the Australian health care system", would that be particularly apt for an overseas-trained doctor who was practising for the first time in Australia in a regional hospital?-- Yes, that's correct.

Would you turn the page, if there are no more - oh, thank you. "Develop a process of clinical audit for evacuation of patient care." Do you mean that there wasn't a process of clinical audit at the hospital that you regarded as adequate?-- What we did discover is that Dr Patel had been undertaking audit but of his own patients in his own controlled environment. What was not there was the sense of independence, which is paramount to audit, independent scrutiny, and I think it was developing that independence scrutiny that we considered important.

COMMISSIONER: Doctor, we've had this canvassed with a number of witnesses during the week, and whilst I am certainly not biased in favour of central control of anything, it strikes me that auditing is one thing where there should be a world best practice model that Queensland Health can choose and then make that mandatory for every hospital in the state?-- Sure. I think so. But the system of audit needs to be a tiered approach.

Yes?-- Obviously you can't centrally audit every case, but you can put in place a system whereby there is audit at a local level, at the unit level initially, at the hospital level for cases that reach a certain threshold, ranging through to a State level for cases that reach that threshold. Part of that process, for example, is we have quality councils that are set up in my office that, for example, do individually scrutinise every death - every neonatal death, because there are so few of them, they can be done at a statewide level. So it needs to be a tiered approach under a consistent model.

It is really the model I was referring to. It does seem candidly surprising that this is left to each hospital to reinvent the wheel and develop their own practice?-- Yes. There was some work again done as part of the quality improvement projects, which finished last year, for two or three years preceding that, which is where the quality unit in my office came out of. It was a project to develop clinical audit guidelines and standards. They were developed and issued last year and as part of that process - part of that improvement we established the office in my office to support the quality councils as well as to undertake high level audits such as we have seen here today.

For example, a number of our witnesses this week have spoken about software packages that can be used to facilitate clinical audit once it was packaged, identified - it was called Otago. I am sure there are many others as well?--

Yes.

That strikes me as the sort of thing where Queensland Health would be more than capable of determining what is the best system and instituting that Statewide rather than each hospital choosing their own?-- Oh, I would agree and the value of that, of course, then is the data produced out of those systems can be rolled up to a Statewide level relatively easily.

And you can get benchmarks with other hospitals?-- Yes.

There are all sorts of advantages?-- Yes.

D COMMISSIONER VIDER: I think ACHS does it also. They have a framework and they will give you national benchmarking?-- Indeed, yes.

MR ANDREWS: On page 6 you deal initially with the credentialing process. I do want you to clarify: is there or has there been any directive to the administrators of public hospitals that credentialing must be undertaken as soon as possible for overseas-trained doctors?-- Subsequent to these events, do you mean?

Yes?-- Not that I am aware of, but that doesn't mean - I would not necessarily have been aware of it.

With respect to the credentialing process, it is correct, is it not, that one does not need, for credentialing and privileging, persons necessarily to be nominated by a college; they can be specialists from the area who would be apt to credential someone such as Dr Patel?-- I don't - I don't know that the standard requires the college representative, I think it just requires people who have the ability to do so.

COMMISSIONER: Doctor, we have been told there is a credentialing committee I think for the Fraser coast area. Do you know anything about that? Is that a-----?-- Only that I have been told the same thing. I don't know the details of that, I am sorry.

You don't know when that came into existence?-- No.

Or how Dr Patel slipped through the net?-- No, not really. Except - sorry, it was raised in the Mattiuissi report.

Yes.

D COMMISSIONER EDWARDS: And you feel there are systems in place within the Medical Board and elsewhere to stop Dr Patels slipping through the net in the future?-- I think the registration processes now would - well, I think they would stop Dr Patel slipping through. Obviously it is always difficult, for somebody who is openly fraudulent, to detect that if they are very skilful at it.

COMMISSIONER: But it certainly helps to have checks and

balances?-- It is.

So if you have got a best practice model at the Medical Board and the best practice model at the hospital level credentialing and privileges committee, then there is double the chance of picking up the fraudster?-- Indeed so, yes.

MR ANDREWS: Indeed, if there is a credentialing and privileges committee, the fraudster can still be put to good use, couldn't he, doing surgery limited to particular types?-- Well, that's correct, yes. I mean, I think the issue with Dr Patel - certainly the feedback we got from the staff up there was - from his colleagues up there that certainly parts of surgery he seemed okay on, it is just he took on things he shouldn't be taking on.

Doctor, is it correct that one can, in this respect, distinguish between a small regional hospital with, for instance, only two staff surgeons and a major metropolitan hospital, that in a small regional hospital a surgeon who is occasionally practising outside his area of competence might not be picked up, his transgressions might not be observed, but in a major metropolitan hospital it is very much more likely that his poor technique, his lack of competence, will be observed by a registrar, reported to the surgeon in the next theatre the next day, and there is a likelihood that other specialists will consult with their colleague and ensure that his inadequacies are either retrained or that he's directed so as not to persist with that kind of surgery?-- I think that's absolutely true. And I would emphasise the issue about the registrars, the advantage in metropolitan hospital is they are probably fairly experienced staff themselves who have a clear understanding of what should be done. Whereas in Bundaberg, of course, the registrars, principal house officers were, in effect, fairly junior themselves.

So an overseas-trained doctor such as Dr Patel, had he been directed, for instance, to the Princess Alexandra Hospital or the Royal Brisbane Hospital, may well have been able to make a positive contribution without danger to the public because he'd have been better reviewed by his peers?-- That's very true and limited in his scope of practice.

With respect to the Area of Need and appointments to a particular position, such as SMO, you have advised us that if one were to be - well, promoted to Director of Surgery, there ought really to be another application to the Medical Board of Queensland for registration for that position. Can you say whether there should have been another application for Dr Patel to have been appointed to the University of Queensland to a teaching position?-- I don't think there would necessarily have needed to be for that. There is a category, which is not Area of Need, for medical teaching which would have covered that, but there are many members of staff who are registered, whether they're special-purpose registrants, or general registrants, or special registrants, who obviously undertake other duties at the university. Mostly those are non-paid clinical attachments or adjunct

appointments. I understand in this case, though, there was a financial arrangement, although it was through the hospital, rather than directly. So they, in effect, paid the hospital to employ him for the university time. So I think it probably wouldn't have necessitated a reapplication because, in effect, he remained the Director of Surgery, which was his principal appointment. Had that been approved, it may not have been necessary to obtain a separate approval for the university attachment.

COMMISSIONER: Indeed, doctor, I suspect, from my reading of the Medical Act, that one doesn't have to be a registered medical practitioner to teach medicine at the university, one would expect most medical teachers are registered medical practitioners but it would be quite conceivable for an overseas doctor to come to the University of Queensland to teach medicine as long as that teaching didn't involve clinical sessions, as long as it was pure lecturing there would be no need to be registered?-- Of course, because many of the people who lecture medical students aren't in fact doctors. They may have Australian qualifications. Teachers in anatomy, et cetera, probably have a science background as opposed to a medical background.

Yes.

MR ANDREWS: You met with Dr Keating and Mr Leck on the 14th of February when they advised you that they had their credentials and clinical privileges committee and they told you why that committee had not considered Dr Patel?-- Yes.

And they told you it was because the Royal Australian College of Surgeons wouldn't nominate a member to sit on the committee. Did you determine - well, did you disabuse them of the notion that they needed a nominee of the college?-- We certainly didn't have that discussion at the time.

COMMISSIONER: Did it surprise you that people in their position would have been under that misapprehension?-- I probably was not at that stage aware myself of how the credentials and clinical privileges committees were established, and I suppose when I - when provided with that information, I assumed that they couldn't get a surgeon to sit on the committee, rather than that the college wouldn't support. I since understood that other hospitals have had similar difficulties getting nominees officially through the college, but the college feels once it is approached then it has some indemnity responsibilities for the individuals concerned. I would have thought most, however, of the clinical privileges committee are structured by local surgeons or local specialists.

Yes.

MR ANDREWS: Doctor, is there any doubt that in 2003, when it was determined that Dr Patel had not gone through a process of credentialing and privileging, is there any doubt that the administrator at the hospital ought then to have approached

surgeons in Bundaberg to ask them if they would participate in that process?-- I would have thought that that's the way it would ordinarily be done.

On the 14th - as I look at paragraph 75 of your statement, it seems that on the 14th of February you were informed, you say, by Peter Leck and Darren Keating, that there were no patient complaints or adverse incidents about Dr Patel. I would like you to try to recall which of those gentlemen informed you of that, whether they were both present at the time?-- I really can't recall whether they were both present at the time or which, but I do recall sort of the question being asked specifically. I think it may have been Mr Jenkins that asked the question were there any complaints. I do recall, I think, the answer specifically because I think the answer indicated there actually had been complaints against other surgeons in the place but not against Dr Patel.

And so you are not able to say whether that information came from Mr Leck or whether it came from Dr Keating?-- No, I am sorry, I really don't recall.

Some time - well-----

COMMISSIONER: Sorry, Mr Andrews, at the time of that conversation, had you already spoken with Dr Miach or did you only see Dr Miach later?-- I am sorry, I really don't recall the order on the day. We saw Dr Miach - I remember speaking to Mr Leck I think early in the day, Dr Miach some time during the morning. I think the issue there was really about patient complaints as opposed to complaints from staff, of course.

I see.

MR ANDREWS: Well-----

COMMISSIONER: It does say "patient complaints or adverse incidents" but I assume that's a reference to a formal adverse incident report?-- Yes, that's correct.

MR ANDREWS: Well, you were on the 15th of April provided by Mr Dan Bergin a folder of documents which are now attachment 19 to your statement, and I notice within them seem to be complaints from Annette Webb to Mr Leck, from Peter Dalgliesh to Mr Leck and to the Director of Medical Services, and from Gwyneth Roach to the Director of Medical Services. Did you take up with them the fact that there - that you had been given contrary information two months earlier?-- No, I didn't.

When you received your document from Dr Keating, which is attachment 22, I see that it includes a peritoneal dialysis catheter placements 2003 schedule relating to six patients-----

COMMISSIONER: I think, according to the statement number 22, was provided by Dr Miach rather than Dr Keating.

MR ANDREWS: Thank you, Commissioner. I was mistaken.

COMMISSIONER: It was a very long week, Mr Andrews.

MR ANDREWS: I intended indeed to say Dr Miach. When you were provided with that document by Dr Miach, can you recall whether Dr Miach was more effusive? Did he tell you anything about it or did he simply hand it to you for you to draw your own conclusions?-- Oh, no, he did - he told us that certainly one of his concerns, as supported by this document, was that he had - he had asked him to undertake a number of these procedures when he first came to Bundaberg, and that he'd noted that he'd had consistent failures in completing them, and as a result, therefore, he'd refused to send more patients to him.

And did you inform the Commissioner a moment ago what day you saw Dr Miach? Will have been either the 14th or 15th of February, I assume?-- Yes.

COMMISSIONER: I think you said you can't recall the order in which you saw him as compared with, for example, Mr Leck or Dr Keating?-- That's correct. I don't know - we do have a schedule of meeting somewhere. I am not sure if it is attached or not.

MR ANDREWS: And I gather you don't-----?-- Sorry, if I could add I think most of the meetings were on the 14th. So I believe there was just some final - I think the next day was largely involved with our trip to Hervey Bay - Maryborough and Hervey Bay on a related case - alternate case.

Doctor, did you put, that is did you ask Mr Leck or Dr Keating to comment upon the information that you obtained from Dr Miach?-- No, I didn't.

Or to comment upon any other person's information that had been given to you about Dr Patel's performance?-- I don't think we did at that stage because we were really just getting our heads around it.

COMMISSIONER: Doctor, from your experience - and I realise it is not your answer of specialisation - the insertion of these catheters isn't at the highest extreme of surgical complexity? Is that a fair comment?-- I really don't know what's involved. I have not personally seen one done.

All right?-- But I know of similar procedures which I wouldn't have thought were terribly complicated procedures.

Can I ask - perhaps it isn't a fair question, and I am sure someone will stop me or stop you answering if it isn't, but if you were a Director of Medical Services and you had your director of medicine telling you that your head of surgery had a 100 per cent complication rate in the insertion of catheters, how would you react to that sort of information?-- I would assume he didn't know how to do them. And I suppose the concern obviously with Dr Patel is that his fearlessness

was he obviously didn't know how to do this procedure, but did it anyway, without saying, as most normal practitioners would, "I am not experienced in this area."

And surely it is, but a small cognitive step from arriving at that conclusion to saying, "Well, we should take a close look at everything else he is doing because if he's doing this relatively simple procedure and getting it consistently wrong and continuing to do it, then what else is he doing wrong?"?-- Certainly should spark a degree of alert as to what's going on - what else he's doing, yes.

D COMMISSIONER EDWARDS: Is it fair to say that hospitals really do spread the word around when things are going wrong, and, therefore, it probably would have been known by a lot of people that there are a lot of incidents occurring?-- That's certainly our expectation, but could I suggest, Sir Llew, that perhaps that's an expectation, from our experience in hospitals where today things, particularly in hospitals such as this with the number of overseas-trained doctors and their degree of anxiety about their employment, et cetera, that things are different. There is no doubt, and certainly our intuitive part of the reaction of some of my experienced colleagues was intuitively we were surprised from our experience in hospitals of the past, the people would have been talking very quickly, the word would have gone around very quickly, so I suspect part of the reason is the - a change in nature of hospitals particularly the number of junior staff, and people who aren't used to the Australian culture.

COMMISSIONER: Doctor, you are familiar, of course, with the physical layout of the Bundaberg Hospital. It would be pretty hard to pick up any of the corridor gossip from the executive offices unless you actually left your office and went into the clinical parts of the hospital?-- Yes, that's true, if you stayed in there, but, I mean, obviously people come to there as well, I would have thought that - most experienced managers, I am sure you are aware, have ways of tapping into what's going on in the hospital that aren't necessarily reliant on the formal communications.

Yes. And that's often the best way to find out what's actually happening?-- Indeed so, yes.

MR ANDREWS: Doctor, at paragraph 84, you explain that you weren't in a position to release your report for certain reasons. You - can you tell me was it your decision that it would be inappropriate to release your report made independently or was it a decision communicated to you the report shouldn't be released?-- There were obviously statements, as people would be aware of, by other people about the release of the report. However, at that stage the - there were no specific instructions to me not to release the report. It was my advice in return to the Director-General and to the Minister that as a general - as a general principle, clinical audit reports should not be publicly released. It is - it places at risk the nature of the clinical audit process which

is intended to be focussed on quality improvement, not on disciplinary issues, and disciplinary issues can arise, certainly from the public disclosure of information, can be taken out of context. So the approach that I took when I returned to Bundaberg was to make that publicly available and, as I have indicated in there, to say this I wasn't trying to hide anything and that people - if representatives of various bodies wish to look at the report - and I had offered it, for example, to the Nurses' Union and to others to look at the report, to see that we weren't disguising anything, but as a general principle I - it is not good form, if I could say so, to have clinical audit reports publicly released.

COMMISSIONER: Doctor, I accept entirely what you say about clinical audits, given the very nature of the process and the need to maintain trust and confidence between the people supplying information and those conducting the audit, but this really touches upon one of the underlying problems that we've observed over a couple of months of evidence now, this culture of concealing adverse news, and we have instances like the orthopaedic report at Bundaberg, the Emergency Department report in relation to Rockhampton, the report prepared by Dr Lennox in relation to overseas trained doctors. Is there some difficulty with the proposition that the taxpayers who pay for the health system in this state, and the members of the public who utilise public hospitals, are actually entitled to know that there is a problem in the hospital rather than having it gather dust in a filing cabinet in Charlotte Street?-- I'm sure there's no problem to that, and in fact certain justification, as you indicated. On the other side of it though, of course, is there is a concern about the ability to manage problems that may occur that may have some - many aspects of confidentiality - that are confidential, either to the patients, obviously, in terms of their clinical records et cetera, but also to staff members who have made comment or may need to go through disciplinary processes et cetera. I suppose in health services we have drummed into us from our very early days concepts of confidentiality, and I suppose we tend to err in favour of trying to manage those sorts of issues without disclosing people to public ridicule or public notice.

Doctor, this comment isn't aimed at you, because I know you're not a bureaucrat at heart, but that does strike me as the bureaucratic response, when it would be a very simple matter to de-identify and arrange reports in such a way that they're available for release so that the taxpayers and the users of our hospitals could know of the problem and, more importantly, so that the public could apply political pressure to ensure that things are fixed up?-- Sure. I mean, there are, obviously, issues of concern that are raised in public arenas - for example, the coroners identify issues and can de-identify them, et cetera, and publish those sorts of things. It just is difficult, I would suspect, in small country towns to de-identify anything because everybody knows everybody. It's difficult.

If I can give you an example - and we're expecting to hear some evidence about this concerning a dentist at the Gold Coast. A Dr Naidoo, who raised issues about a dentist who is referred to on the Gold Coast as Dr Pain because of the agony that he caused to his patients, repeatedly raised the matter through the appropriate channels and got nowhere, in the final resort went to the newspapers, and of course it's then Dr Naidoo, the whistleblower, who gets the sack rather than Dr Pain. That's within the last fortnight. When do we stop this system of shooting the messenger and hiding the evidence rather than putting it out in public so that things can be done about these problems?-- I think we need to do so, obviously. I mean, I certainly would believe that we need to protect people who are making reasonable points in terms of

concerns being raised, and that they shouldn't obviously be dealt with in any disciplinary sense. I obviously don't know the details of Mr Naidoo - or Dr Naidoo on the coast.

Mr Andrews, you know the statements that have been obtained. Is that a fair summary of the matter? Perhaps you could elaborate on it.

MR ANDREWS: That's a fair summary, Commissioner, yes.

D COMMISSIONER EDWARDS: Dr FitzGerald, would it therefore be better for consideration to be given to a system within the department provided to the Director General or Minister by so many days after receipt of a report on those actions so that, if necessary, it could be made public - or certainly the response as to activities to try to rectify a difficult situation can certainly be set by that date?-- Yes, I think that would be fair-----

It seems to me that there is a potential that reports, as the Commissioner is indicating, I think indirectly or directly, lie in cupboards and nobody really wants to deal with the problem?-- Yes.

I'm just wondering if we should consider the possibility of such reports, by legislation or regulation, must have a formal response from the department and the officers concerned within a set period of time?-- Even if there were issues that couldn't be raised publicly because they would identify and adversely affect people, there is, I think, scope for checks and balances to be put in place. It may be through a body such as the Health Rights Commission or some similar statutory independent body who has to be informed and is therefore responsible to ensure that these matters are followed up if, for whatever reason, they cannot or should not be disclosed publicly.

COMMISSIONER: Indeed, doctor, again at the risk of embarrassing you because of the present hat you're wearing, if we were to recommend that the office of the Chief Health Officer be separated from the Department and made entirely autonomous, that may be the sort of office which should receive copies of all these reports and be in a position to say to Queensland Health, "What have you done about this report? And if you don't do something about it, we're going to not leak it, we're going to make it public so that you will have to answer it."?-- Indeed so, and what happens - for example, the Chief Medical Officer in the United Kingdom produces a report to parliament each year, so their public accountability and public disclosure in a de-identified way could be - undertake a very formalised process and give the responsibility of reporting on events that aren't being treated in a more timely fashion than perhaps an annual report as well.

Well, if I could ask you for a moment to take off your hat as Deputy Director General and go back to your other hat, is that something you would favour for the Chief Medical Officer's

role?-- I think that's probably where the-----

I'm sorry, Chief Health Officer?-- Chief Health Officer. I think that's where that position is probably tending to go to some extent, but without the legislative back-up and the authority in the current legislation. But I would agree. I think that's probably a good position - a good value for that position.

Mr Andrews, we might just have a 10 minute comfort stop, if that's convenient. It will only be 10 minutes.

MR ANDREWS: Thank you, Commissioner.

THE COMMISSION ADJOURNED AT 3.22 P.M.

THE COMMISSION RESUMED AT 3.36 P.M.

GERARD JOSEPH FITZGERALD, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Andrews?

MR ANDREWS: The topic that was the subject of discussion before the break was the release of reports for public scrutiny. You have given an answer in the witness box orally that the release of clinical audits was something that just really isn't done. I inferred that's because they are supposed to be to do with quality, not blame?-- Yes.

And if published there's a risk that you won't get as free an exchange of information?-- That's correct, yes.

Within your written statement you expressed a different reason, and that was that the report contained information which could identify either patients or informants. Now, that's not really the reason, is it? When one looks at this particular report that's been drawn by you and distinguishes it, for instance, from the Fraser Coast report which is in evidence, your report conceals every patient's name and conceals any informant so that no sleuth could identify either. Indeed the topic - the primary topic of the report, which is really about Dr Patel - the only references to him are positive ones?-- That's right.

COMMISSIONER: I think perhaps, Mr Andrews, you're being a little unfair because, for example, it does identify that Dr Miach was the source of information which could be regarded as critical of Dr Patel. So there is some force in the proposition that informants might be less forthcoming if a report like this were published. I'm not saying that Dr Miach

wouldn't have told you that, but it's conceivable that other informants would be less robust than Dr Miach in their willingness to provide information if they knew it was going to be linked to them?-- And if I may, I suppose the point I was making in the statement was that as a rule they are the reasons why I wouldn't like to - at least as a rule. They may not particularly apply to this particular case.

Doctor, on this subject, we've heard a lot of concern from clinicians, both nurses and doctors, about what is referred to as the Code of Conduct - or as some of them affectionately know it, the Code of Silence - and there is a perception, rightly or wrongly, amongst people at the coalface of the medical system that that is used as a bludgeon to prevent them raising concerns with, for example, members of parliament, or indeed the media. You mention in your report the need to reinforce the Code of Conduct for the sake of protecting patient confidentiality and matters of that nature, which I'm sure everyone would accept. It's on page 12 of the report, paragraph 4. "Code of Conduct - all staff are aware of their obligations. For example, confidentiality of patient information, having respect for people, treating people with dignity." No-one would disagree with that. But are you familiar with this perception that it's used as a bludgeon to prevent whistleblowers from raising their concerns with people like parliamentarians and the media?-- I'm certainly familiar with the perception. I don't have any personal evidence either way in that regard. I would indicate, of course, the Code of Conduct is a public sector-wide Code of Conduct.

Yes?-- There is requirement in our system of government, I suppose, to respect certain things about the way we behave. If I may also just address the issue that you mention in my report, while reinforcing it generally, I have to say that that specific reference was in regard to concerns that were raised by many of the nursing staff that Dr Patel had been particularly loud in his manner and was often discussing individual patients loudly in the corridor, and the intent of that was really to reinforce to Dr Patel the importance of being discreet in what he said and how he said it.

Doctor, on the evidence we've received to date - of course we haven't reached the end of the road yet - I'm left in little doubt that this whole sorry saga at Bundaberg would not have come to light if it were not for the courage of people like Toni Hoffman and their willingness to speak to people like Rob Messenger, and that leads me to think that whatever the Code of Conduct says, whether within Queensland Health or within the entire public sector, we need to rethink that and to allow scope for whistleblowers, having properly exhausted appropriate avenues of redress within the current scheme of management, as a last resort to go to parliamentarians or even the media if problems aren't being addressed?-- Yes.

Do you have any views about that?-- No, except to say that I was personally admiring of Toni Hoffman's persistence, and told her so when we went to Bundaberg after the report was - I mean, there are people who at times have not been able to have

matters dealt with. They have to be brave, and are brave, and I think they deserve our respect and acknowledgment. How that can be dealt with structurally or legislatively, I'm not sure, but there needs to be a mechanism whereby people can, as a last resort - I would obviously be concerned - I'm sure we all would be - of people who use it as the first point of call.

Yes, of course?-- That there needs to be checks and balances so that - because, you know, obviously that can cause quite considerable distress if people have made no attempt to resolve the issues through the appropriate mechanisms.

And indeed there still has to be protection of patient confidentiality and issues of that nature?-- Indeed so, yes.

Thank you, Mr Andrews.

MR ANDREWS: Doctor, there have been a number of discussion papers that have been published by the Commissioners - six in number. I wonder whether you've had the opportunity to consider them?-- I have, yes.

There are some aspects of them I'd invite you to comment upon?-- I may have them here.

Not all of them indeed, but within the first discussion paper at paragraphs 5.1 and 5.2 there's mention of an argument that there are substantial benefits to be obtained through autonomous administration of regional public hospitals which would include the reduction in the bureaucratic hierarchy involved in the present four-tiered system of hospital, district, zone and statewide administration, and in particular that that would ensure that decisions affecting the local community are made at local level?-- Mmm hmm.

Would you care to comment upon that proposition?-- I think there is considerable value in returning some degree of decision making, and certainly engagement of both the community and the professionals in the decisions around service delivery. I certainly worked at Ipswich Hospital during the board days. There were certain advantages to that system, particularly around decision making. You could actually get decisions made at a certain time. However, there were also enormous constraints around that system. In fact it was a system which operated in what one might call the McDonald's mode, that, "Yes, you may run your hospital, but you run it according to these set of instructions. You employ people according to this level et cetera. You have the McDonald's outlet where we want it and it's the right shape and design." The second side of that, of course, is that it did limit to some extent the ability to manage the resources at a regional level and to concentrate resources where they need to be. I think what's different about now to then is the increasing complexity of medicine and the specialisation and concentration of resources. I think there's a lot of value - and if I may relate my personal experience with the Ambulance Service to say that we retained local advisory committees from the community that we managed very closely and supported very

closely, and they were enormously valuable in terms of providing local advice. I would think - at the other extreme, of course, is the statewide system where decisions all end up at a very centralised location. I would argue, perhaps, that there is an intermediate correct model - or good model which is something based around areas that are reasonably self-sufficient in terms of their capacity to provide the full range of medical services, that that could be the management or organisational unit, preferably with some form of engagement in terms of its management - a board, a council of some form - and that a number of those would constitute the state. I suspect there needs to be some form of central body, and I notice in the discussion papers there's discussion about the trusts - the British trusts, and I think a model such as that would be - would certainly support the sort of concepts we're talking about. What they also have is strategic trusts, which are the central bodies that tend to support the policy making, the standards development et cetera. I think there is a model in there that I think would be quite useful. How that's organised and what the legislative base for that is, I don't know. The only other point I would make is that I think whatever happens, the legislation should really specify the relative roles and responsibilities of key players. I think what has occurred most recently is that the medical superintendent has become really an officer of the district manager, who in turn is an officer of the zonal manager and the state manager. I think what we've seen is the breakdown of the checks and balances that we would have expected, and I think whatever we do, if we can define in that the responsibilities - the independent and individual responsibilities that key players such as the Director of Nursing or Director of Medical Services would have to report directly to the governing body rather than being within the complete direction of the district manager. So I think there is a model that would work in that regard.

COMMISSIONER: Similarly, the current legislative framework provides for district councils, but gives them no real authority or power whatsoever, and it frankly seems a bit pointless to have them if they can't do anything?-- I think that's correct, and I've spoken to some members of district councils and I think they would share that sense of frustration, that they really don't have any authority to do anything. But it can be - I mean, even advisory - community advisory bodies managed well, supported well and listened to, can be very useful management adjuncts.

Yes.

D COMMISSIONER EDWARDS: One of the suggestions in the conversation that has been referred to in early day - relative to medical practitioners - indicated to us that there was grave concern about the mode of the operation of, say, a local board, a community board, that the biggest concern was the blow-out of budgeting, because if you are going to give control, you really give some control also to budgets, and also the standard relative to medical practice and so forth would be disintegrated into a large number of different -

rather than the overall policy of being able to implement it as it is now, and that was a big price that may have to be paid for local control, local involvement and local activities. Have you a view on that?-- I think - I mean, in a purist sense that can be overcome using, if I may, the McDonald's model, that there could be in fact a contract with the area health service which is for the funding of services in that area, and the terms of that contract could be spelt out in very clear terms around the standards that are required, the control of budget and where it should go and how it should be controlled et cetera. The problem, I suppose, at the end of all that decision-making step is the penalty should things not occur properly, and probably the only weakness of any sort of governance system which involves a community board is that the worst penalty is being dismissed from the board, which is certainly a source of public concern, but not necessarily a major penalty in itself.

It was also indicated to us - to me particularly, that two of the areas that would suffer under such a system - that has suffered under the present system - is the input of nursing professionalism and activities and the importance of theirs in the overall run of the system, and the medical input, and it's all been downgraded by the emphasis on administration. Could you give us a view and your feeling on that?-- That's been information that's provided to me as well, and I suppose to some extent observations of things that have happened around the state.

I think the solution, if there is such, is to strengthen the role of the Director of Nursing, and the Director of Nursing-----

Within the hospitals?-- Within - well, within whatever the administrative unit.

Or within the system?-- Within the system generally. So if there was such a thing as an area health service that had a Director of Medical Services, that person would have defined responsibilities and at the subunit level, when it gets down to an individual hospital or a health unit, then that Medical Superintendent would also have personal and professional responsibilities, particularly around the quality and safety, as with the Director of Nursing around the quality and safety of nursing capacity, and they could be given the capacity to report directly to the board if required. So I think there are ways of addressing it but I think the concern has been raised as well that there has been a disengagement of professionals in the health care system and hence the cause of considerable tension amongst people.

COMMISSIONER: But going back to the funding point that you raise, I guess one of the apparent attractions of regionalisation is the regions deciding their own funding priorities. So to take an extreme and perhaps unfair example, regions might prefer to spend more money on medical services than donating a million dollars to the Broncos as Queensland Health did last year. Those sort of funding priorities can be decided on a local basis responding to the needs and enthusiasms of the community?-- Mmm. That's certainly true and - but, again, you could put frameworks around - I mean, there are frameworks around how departments should use their funds. There are guidelines through the Financial Administration Audit Act which would be similarly restricting on local groups, but it certainly would give them the flexibility to say that in an environment such as a rural environment, it may be more useful to put efforts and energies into community health rather than building large institutions. I suppose my only concern is if you make the history - the areas too small, then you do start to get the diseconomies that occur as a result of that and the dangers of thinking that they have to replicate all the services in that area, where some services should only be provided on a statewide basis; indeed, some probably on a national basis.

Perhaps I should say I don't think anyone disagrees with the proposition that there are many services that are provided from the central office of Queensland Health that would have to remain centralised, things like rural and indigenous health services and the breast screening campaign-----?-- Sure.

-----and the health promotional advertising campaigns and that sort of thing - all of that would obviously have to be done statewide. But even when it comes to things like local medical services, it strikes me that if the people of Dalby, to take an example at random, realised that there is only so many dollars available for them to spend on medical services,

they decide that they want more palliative care or more gynaecological and obstetric care and maybe the cardiac patients will have to go to Toowoomba, they decide those priorities rather than having them dictated from Brisbane?-- I think that's correct and they can decide those priorities on local need.

Yes?-- And the particular geography of the locality.

Yes?-- The danger of that though is the desire sometimes for local communities to have everything there and not only is that not practical but in the current environment it is not just deliverable. And so, that's the challenge - there is some rate I'm sure which says the units are large enough to have that networking occur and build the services that are required but still responsive to the local needs.

I guess the other attraction, just thinking out loud, is that when you have centralised control, there really is no check or balance; your Director of Medical Services is the servant of the District Manager, the District Manager is the servant of the Zone Manager, the Zone Manager is the servant of Charlotte Street and there really is only one decision-making corridor?-- Yes.

Whereas if you have decentralisation, then if something is going wrong in a regional hospital, you've got someone outside the decision-making loop on a statewide basis that can come and look at it and say, "No, this is where you went wrong"?-- Yes.

At the moment there's just no scope to do that because the blame flows with the decision making?-- That's right. I think there could be a matrix of reporting lines. Obviously there is still a need for accountability but outside of that system, I suppose we - again we're used to a situation where there was the Director-General of Health and Medical Services who had clear - who was very clear Medical Superintendents could talk to him directly.

Yes?-- And that position has now changed fundamentally but it could be a model where Medical Superintendents had the right on professional matters to go directly to, for example, the chief health officer, the chief medical officer and I think, similarly, there could be a situation with nurses where Directors of Nursing could have a right to go directly to the state's chief nurse to discuss professional concerns that they are not being able to resolve locally.

Looking at it from the other side of it, from the viewpoint of the practising clinician that the complaint that we hear, and a number of witnesses have mentioned this in evidence, is that there is no transparency in the decision-making process. Dr Miach at Bundaberg has this great idea to participate in a national kidney foundation event?-- Mmm.

He raises that very properly with Dr Keating, who passes it up to Mr Leck, who passes it up to the Zone Manager and it just

sort of gets lost in the mess and the haze of the administration and six months, probably after the event has come and gone in any event, the message comes back, "No, you're not to do that." No-one knows who made the decision. No-one knows why the decision is made. No-one knows whether some fine-tuning of the proposal might have led to it being accepted?-- Yes.

There's just no opportunity for a face-to-face discussion?-- Yes. I think that's - and I think that's so. I think the advantage of having some form of decision-making body such as the board is that if it meets on the second Tuesday of each month, you know that's when decisions are made.

Yes?-- So there can be clarity and transparency about the timing and processing of decisions. But I think the other element of that, certainly I'm getting the sense since holding discussions since early week, that there has been quite considerable centralisation of even relatively routine decision making, which of course drowns the central people as well. They can't possibly deal with that sort of diversity. And so, the system again has let everybody down in that, really, it should be quite clear that most decisions are made by the local administration of the hospital whatever that is and they should be empowered to do so.

I think back, for example, to the evidence we heard from Dr Huxley, which is six or eight weeks ago now, and she was telling us how the department had under review for a couple of years the criteria for areas of need?-- Mmm-hmm.

And that was under consideration by a division, I can't recall its name. It was workforce innovation or something like that. They had been doing it for two years and they only had 30 people available to do it?-- Mmm.

That's what strikes me as bureaucratic gridlock. As soon as the problem is identified and it's given to your office, then within a week you're able to put in place a new system without having lots of committees to review it and lots of memos flying everywhere. What Queensland Health needs more than anything else is decision makers rather than committees and reviewers and memo writers?-- Also - I think you're correct but I would also add that it is part of the system issue in that if a decision - let's say the case you highlighted, which was about attendance at conference, or whatever it was - I'm sorry, I missed the detail - but if that gets up to a central person, they rightly start considering about its implications statewide and they get more and more confused and complicated around something which if decided locally, those matters would never be taken into consideration and need never be taken into consideration.

Yes?-- It's a local decision about local issues. So I think the current structure actually just disempowers decision making as a whole and I really would argue that if we can - if we are going to fix it, then we need to be very clear of what decisions can be made at whatever the local level is and just

make that very clear and allow people to do that, bearing in mind they'll get some wrong and we probably have to be tolerant enough to expect that sometimes those decisions will be wrong and we need to be supportive and caring about them when they do and understanding and guiding, and hopefully to getting them to not make wrong decisions too often. But it certainly - that, I think, is probably the solution, and being just more tolerant I think as a community that decision making should get out to where it should be made, not centralised.

It's a funny thing, Doctor, but my experience of life has told me that even a wrong decision is better than none at all and that seems to be what's happening in so many areas of Queensland Health's operation throughout the state. It's-----?-- Yes.

You know, the choice is, "Do we let this doctor go to this conference or don't we?" Having the right decision or the wrong decision is better than people being left in limbo?-- I think that's correct. And the other one I'd add to your proposition is that there's the right time to make a decision too. The judgment of management is to know when that time is.

Mr Andrews.

D COMMISSIONER EDWARDS: Could I just ask one other, sorry, Commissioner. It's been suggested in discussions and in some information provided to us that the Medicare agreement may in fact restrict a lot of the potential adventures that a health department like Queensland or New South Wales may want to engage in and there are rigid rules of the policy of the Medicare agreement that prevent those innovative programs that could cut costs and yet provide essential and better services in many regions. Just in a couple of moments, do you have a view on that agreement and is it as restrictive as it's made out?-- I really haven't read the latest version or had access to the latest version of the Medicare agreement. I did read one some generations previously that seemed to be a simple document, that didn't seem as restrictive in those certain areas. I perhaps put it to you perhaps it is our health care system as a whole and the various funding arrangements, maybe that's the essence of the point, which does restrict those sorts of things. So, for example, if we seek to move services out of hospitals into the community, then we move them out of direct state funding into federal funding arrangements; that's where the complexity runs.

Thank you.

COMMISSIONER: And, similarly, if - to take up something that we were canvassing the other day with Mr Nankivell I think it was, in Victoria there seems to be this tendency to offer positions for Australian trained specialists on the basis that they'll work a three-day week and have a three-day income and be able to provide services to the public as private specialists the other two days a week?-- Mmm-hmm.

Dr Nankivell raises the concern, well, that specialist then

has to pay for rooms and-----?-- Sure.

-----insurance and so on. As I understand it though, there are practical difficulties with the Medicare agreement and elsewhere that would prevent Queensland Health saying to a doctor, "Come and live in Bundaberg. We'll give you three days a week work in our surgery and pay you for three days a week work and you can see private patients in your room at Bundaberg Hospital." That can't be done for some reason. That doctor has to have private rooms somewhere else in the town?-- I certainly don't know about the details of those - of the - or legal restrictions around that but could I say to you that if we could achieve that outcome, that obviously it would be a more sensible and resilient outcome for rural areas and not dissimilar to where we have traditionally been.

Yes?-- Certainly places that Sir Llew and I'd be familiar with at Ipswich, the place was run by a combination of one or two staff people but mostly visiting medical officers, who provided incredible support to the hospital.

If you go to the smaller country hospitals you've got a GP Medical Superintendent who is the only doctor and is also the town GP?-- Indeed so. Yes.

D COMMISSIONER VIDER: Dr FitzGerald, one could also mount an argument for greater decentralisation than what we've got at the moment that would be enhanced by clear role definition-----?-- Yes.

-----of the local hospital or health services that are provided in that local area. If we were able to define it, that local population would also know what level of service is going to be provided locally, what they may have to go out of their local area to receive?-- Yes.

The complexity of services will demand for some of they will have to be transported elsewhere as they do now but they could be more - they could be better informed, and if they were better informed, they would know what expectations they have of local services that would be delivered to them. And I might suggest that such a service could also appear to be, and be, much more transparent than what it is at the moment and could break down a lot of the barriers that do seem to be perceived about information not being freely flowing in either direction?-- Yes, I think you're right. I think probably the point of what you're raising is that perhaps we should put more effort on ensuring we have good primary care at a local level-----

And I think we have to be absolutely certain whatever we do, we have got to have patient centred models to a degree?-- Indeed.

And so that everything flows out from that, so we don't want to end up then with divisions. You have got clinical argy-bargy then going on between this group and that group?-- Yes.

Because the only reason they're all there is for the patients?-- I concur, yes.

COMMISSIONER: Mr Andrews.

MR ANDREWS: Doctor, you mentioned that you complimented Toni Hoffman on her courage for bringing these matters to the attention of authorities?-- Certainly.

Should I infer that you expect that medical and nursing staff have a perception generally in Queensland public hospitals that if they raise problems, that they might face some kind of disadvantage?-- I've heard that allegation many times from a number of people. I have no personal sense of how widespread or how consistent it is. I suppose the concern I had or the - my personal reaction to what had happened in Bundaberg was that regardless of what the impediments or what had happened or what the perceptions were, is that, certainly, Tony had been quite persistent, and I think the terms were bravely persistent, which is necessary, you know, when sometimes you must doubt yourself as to whether you're really running the right course. So I'm not sure that I can easily generalise I think what I observed and felt had happened there on a personal sense for the people who'd raised the original complaints to what's happening generally across the state.

Within Queensland Health budgets are an essential evil. Is there for those who administer them a contractual three strikes rule, somebody's told me about? Is it the case that some District Managers are the on - on a contractual guillotine, that if after three failures to meet budget, they'll find that their services are terminated?-- I'm not aware of the contractual arrangements at the moment with the District Managers themselves.

Is it the case that or are you aware of whether it's the case that persons who control budgets in regional hospitals are the subject of approval if they meet the budgets and disapproval if they fail to meet them?-- Oh, I'm sure that's true. I'm sure failure to meet budget - I'm sure it's not just a factor that applies at district hospitals but across the state, I'm assuming the same pressure is on the Director-General.

And it's likely that promotional opportunities are enhanced if a District Manager continues to meet budgets or, indeed, to outperform budget targets?-- I would expect that to be so, yes.

D COMMISSIONER EDWARDS: That would also apply to the education department I guess as well?-- I expect so.

Having tight control, and all departments are expected to meet budgets?-- Indeed, that is true.

But I guess Mr Andrews raised the issue: do you think, therefore, there should be far more flexibility in the role of local hospital, districts and so forth in the distribution of

the overall budget rather than specific, as I understand it, almost brought down the number of biros that can be bought?-- I think there should be more flexibility but if I could take your point one step further as to say that I think what's more important is to have a balanced approach to the performance management which clearly indicates includes factors beside budget as being of equal importance. I can envisage a situation where a hospital confronted with a - say, a sudden pandemic would understandably go over budget but with very rational and reasonable reasons of the number of patients to be treated, et cetera. So I would think a generally balanced score approach where obviously finance is one of those areas but there are also areas such as safety and quality patient outcomes in terms of quality of service, et cetera, but also such issues as the community's satisfaction, meeting the needs of the community, and the staff satisfaction, who provide the service in the first place, and I think the department has over the last 12 months attempted to introduce such an arrangement through a program called ISAP, which I now forget what that stands for, but that program has been an attempt to take a more balanced approach rather than just a finance approach.

COMMISSIONER: I think, to take up Sir Llew's example, the difference between Health on one hand and Education or Police on any other department is you're dealing with matters of life and death and that's where there has to be some sensible flexibility. Do you have any views as to whether this system of funding hospitals based on historical budgets needs to be re-considered because it has certainly attracted some criticism in the evidence we've got?-- I can only comment in principle I suppose because, again, my experience with the ambulance in terms of budget management is we did have to go back to taws occasionally and just look at the needs of the community and the resources that were required and then try and get the appropriate level of resources there and I'm sure the same apply to hospital services. It would be an enormously complex exercise I expect to go back to taws and start from the ground up.

MR ANDREWS: Doctor, visiting medical officers, there would be a budgetary disincentive for administrator to shift from staff specialist to visiting medical officers if those visiting officers were in fact more productive than the staff specialists, in the sense that greater productivity can mean greater expense to the hospital?-- Oh, that would be a fair point. I think, however, most people - most of the medical administrator - hospital administrators - I suppose one of the arguments behind what appears to have been a trend from visiting medical officers to staff people is that they feel they are indeed more productive because they tend to be there for longer hours and be available for the emergencies, et cetera, so - but your point about budgetary impact, there would be, I think, a disincentive to increasing the turn-through of patients if that would have an effect on the budget.

I have nothing further for Dr Fitzgerald.

COMMISSIONER: Has there been such a discussion, as I suggested, who is to go first?

MR ALLEN: Can I confess to wanting to revise my estimate from 30 minutes upwards, and I have spoken to my learned friends and I understand that both my learned friend Mr Diehm and Mr Chowdhury would prefer not to cross-examine today.

COMMISSIONER: Yes.

MR ALLEN: Given that we won't finish, I am in the Commission's hands as to whether I cross-examine at a later date as well.

COMMISSIONER: Well, can I ask this, being brutally frank, is there anyone who feels that if they started their cross-examination they would finish this afternoon - feels confident, I should say? No? Well, Mr Boddice, you might continue till 4.30 with any additional evidence-in-chief.

MR BODDICE: Thank you.

COMMISSIONER: Unfortunately, Dr Fitzgerald, you will have to come back on another occasion.

EXAMINATION-IN-CHIEF:

MR BODDICE: Thank you, Dr Fitzgerald. Earlier in your evidence, you spoke about the public sector now having the service capability - the clinical services capability framework. Is that the document you were referring to?-- That's the print version of the document, yes.

And in the forward to that document, there is reference to the

document replacing the guide to the role delineation of health services for the public sector, and also a services capability framework for private health facilities otherwise. Were they the two earlier documents that you were referring to that there had been an earlier system and this, in effect, replaced it?-- Yes.

And applied the private system to the public sector?-- That's correct, that those two documents were essentially amalgamated into one.

Have you helpfully provided me with copies of those earlier documents as well?-- Yes, I have.

Commissioner, I tender perhaps as a bundle those documents.

COMMISSIONER: Yes, exhibit 231.

ADMITTED AND MARKED "EXHIBIT 231"

COMMISSIONER: Bundle of documents described by the witness consisting of the Clinical Services Capability Framework, The guide to the Role Delineation of Health Services, and the Guidelines for Clinical Services in Private Health Facilities.

MR BODDICE: Thank you. And, Dr FitzGerald, you said that the clinical services framework document, which now applies to the public hospitals, commenced from July last year?-- Yes.

With a one year period for it to take effect?-- That's my understanding, yes.

And is it an ancillary part to that also the credentialing and privileging type system to ensure that doctors also are credentialed appropriately within the public hospitals?-- It is a complimentary part of the regime, I suppose the clinical - what we call the clinical government's regime. It has been issued in separate documents, that's all.

COMMISSIONER: I am very sorry, Mr Boddice, to interrupt. Dr FitzGerald, as you may or may not be aware, it has been our practice for all exhibits to be published, including on the Commission of Inquiry website. Not having been through these documents, I just wonder whether there is any information which they contain which may be commercial in confidence to the private hospitals or anything that would cause embarrassment if it were published?-- Not that I am aware of. Certainly the current document is on the Department's website.

Right, okay, thank you.

MR BODDICE: So there is a credentialing policy throughout Queensland that Queensland Health has introduced?-- Yes, there is a document that was issued a year or two ago, I

think.

And that is to work to have the doctors - the medical staff credentialed in accordance with that policy?-- That's correct.

There was some questions asked yesterday of one of the witnesses who was a principal house officer. Is it intended that they be credentialed?-- No, not generally. The credentials and clinical privileges generally applies to the senior medical staff. Junior medical staff and middle - what we call middle grade staff, which is the PHOs and the registrars, work under the supervision and direction of a specialist or a Senior Medical Officer, so they work in the areas to which they are credentialed.

The second area, doctor, is that you spoke yesterday - you used the term a medical manager?-- Yes.

And today you have been speaking about the need for perhaps in legislation for there to be specification as to what are the respective roles?-- Yes.

Could you comment, do you see there is in today's world definitely a need for a medical manager in hospitals?-- I think there is. The practice of medicine has become increasingly complex and the regulatory regimes around medical practice have become increasingly complex. The roles of the medical Superintendent or Director of Medical Services at a hospital have become very complex in terms of not only the resource management of the medical staff and ensuring there are sufficient medical staff appropriately trained and guided and educated, et cetera, but also in terms of dealing with the various regulatory regimes that are required to be met. For example, the requirements of the Coroners Act are met, et cetera, dealing with patient complaints, ensuring that they are dealt with professionally. And also, of course, having responsibilities around the whole safety and quality agenda to ensure those mechanisms are in place. I think there is a number of those sorts of areas which I - although the relevant college is called the College of Medical Administrators, I tend to think it is not just a matter of administration, it is actually more a matter of management, management of medical resources, and I think that does require some expertise. Again, the tradition was that the surgeon at the hospital would do the management in whatever spare time they had, and I think in 20 years later it is too hard for that. I think we do need some people who are appropriately trained in that area, and that's, I think, the formation of the college - the Royal Australian College of Medical Administrators was formed with that intention, to train people appropriately in medical management, medical administration.

But the suggestion you were making, as I understood it, was that to overcome, in effect, that concern, that may niche with some people that the Medical Superintendent, or the equivalent, or what was the Medical Superintendent is under the control of the District Manager, that you could have a

setting out of what are the respective roles of these people, the medical manager, the Medical Superintendent, the Director of Nursing?-- Yes.

So it is clear that they do have certain management responsibilities, if I can call it that?-- Yes.

In respective roles?-- Yes, that's what I think would be a way, I think, of ensuring there are checks and balances in the system, and particularly the issues relating to the safety and quality of patient care are individually and personally responsible - the district - the medical manager, medical administration person would be more responsible for that.

Doctor, you were asked some questions in relation to your involvement in the clinical audit up at Bundaberg Hospital?-- Certainly.

And you set out in your statement and you were taken to e-mails that you had received. The first email you were taken to is GF8 which is the email that came from Rebecca McMahon of the 17th of December 2004?-- Yes.

Did you, shortly after receipt of that email, go on holidays?-- Yes. I am not quite sure when I saw the email but it was sent on the 17th. That was obviously the week leading up to Christmas. I was due to go on holidays as of Christmas and intended to do so. Except, of course, Boxing Day certain events happened in south-east Asia. So I spent that week in work trying to organise some responses in terms of Queensland's response to that event.

And you were part of that process of arranging for the support to go over there and deal with that disaster?-- Yes. We started and I did have two weeks' leave. Dr Scott relieves me when I am on holidays, so he was tied up between Christmas and New Year, so when he came back I went on holidays for two weeks.

Yes?-- Obviously the actual team didn't go till some time later, so by the time I came back it was still very much a significant issue.

I wanted to ask you about GF9. You have raised the point of Dr Scott. If we look at GF9, which is the combined email, you will see in the bottom half of it, which is the email from Peter Leck to obviously John Scott, John Scott was in your role at that stage, was he?-- As well as the role of General Manager Health Services, yes.

You will see there is a reference to the fact that you have been away on leave?-- Yes.

So, as you understood it, whilst you were on leave, Mr Leck, if he had these queries about what was happening with your office coming up to look at matters, would, in fact, contact Dr Scott?-- Yes, that would be right.

And then Dr Scott appropriately discussed the matter with you when you came back from holidays. You will see there is a reference - sorry, no, that's Mr Leck obviously had spoken to you when you got back from holidays?-- Yes.

And then GF10 appears to indicate that he spoke to you on the 17th of January. Do you see that at the start of the memo?-- Yes, that's correct.

And then you received on the 20th of January what appears to be copies of various documents, including Ms Hoffman's original letter of 22nd of October 2004?-- That letter was certainly included. Can I apologise in saying that our housekeeping let us down, which is why that bundle of material is altogether. Some of it was obtained at the time and some of it was obtained when we went to Bundaberg but we were unable to subsequently divorce out what was obtained at the time.

Earlier in evidence, when you said you didn't have Ms Hoffman's letter, you were referring to when you got the initial email on the 17th of December, whenever you may have looked at it. That's all you had initially?-- That's correct, yes.

But before you went to Bundaberg you had been provided with Ms Hoffman's letter?-- Yes, that's correct.

COMMISSIONER: Mr Boddice, how much longer are you likely to be with Dr FitzGerald?

MR BODDICE: Five minutes.

COMMISSIONER: Let's finish then.

MR BODDICE: You also, in respect of that, said that prior to leaving Bundaberg you had obtained an undertaking from the management there that oesophagectomies and such procedures would not be performed again at Bundaberg?-- Yes, that's correct. In fact, the management offered that.

They offered that. I was going to ask you because there has been some earlier evidence. Were you told that in fact the manager had - the management had already put that in place?-- Yes, that was my understanding.

All right. Finally you - sorry, finally on that point after leaving Bundaberg-----

COMMISSIONER: You had me excited for a moment, Mr Boddice.

MR BODDICE: Just ahead of myself. After leaving Bundaberg, did you then contact the Medical Board informally, Mr O'Dempsey, and discuss that you had some concerns?-- I did. Upon return - and I did speak to Mr O'Dempsey - I can't recall whether that was by telephone or in person, to be honest, now - but I did indicate to him that I had some concerns - we had some significant concerns about Dr Patel.

He indicated at that stage that he had applied for reregistration which would be an opportunity for us - for the Medical Board to address any of these concerns that might be being held. And we agreed that we would in fact not consider his application till such time as I had some further information and considered the matter in some detail.

So whilst you still had to complete your report, you were aware that (1) the management had taken steps to prevent such operations from occurring in Bundaberg?-- Yes.

Even though your report was not completed?-- That's right.

You also were aware that the Medical Board was deferring consideration of any renewal pending your report?-- That's correct.

And then when you completed your report did you formally write to the Medical Board in relation to your concerns?-- That's correct, yes.

That letter appears?-- Yes.

Finally, this afternoon I think it was, doctor, you referred to the clinical audit standards that have been put in place by Queensland Health in recent times?-- There was a document which is a guideline - sorry, I forget the name of it, but it was - effectively guidelines, clinical audit, that was developed as a project and those guidelines were issued around the State.

Is that intended to have a Statewide effect so that there is some consistency in terms of the clinical audit process?-- That was the intention of that document, yes.

And that hospital would then adopt a consistent approach in the future?-- Yes.

Yes.

COMMISSIONER: Is that computer based, or is that - don't the guidelines specify the technology to be used?-- No, I - they more specify the approach to be used.

Yes?-- The document, of course, is on the website available.

Is the audit system based on some computerised storage and retrieval of data or doesn't the guideline specify it one way or another?-- No, it more is the approach to doing clinical audit rather than "Here is a tool in terms of collecting information."

Yes.

MR BODDICE: But it is to set down some standards that should be followed by the core of the hospitals throughout Queensland in undertaking that process?-- That's correct.

Those are the only matters.

COMMISSIONER: Thank you, Mr Boddice. Doctor, I am sorry we're going to have to ask you to come back and I will ask counsel assisting to arrange a time that suits your convenience. It won't be next week but within the three weeks after that?-- Thank you, Commissioner.

Ladies and gentlemen, I have been reminded that this courtroom is going to be used on Monday morning for the swearing-in of the new Magistrate. That's taking place at 9.15. It is expected to be finished at 9.45 so we will resume at 10 o'clock, if that suits everyone's convenience, and we have to finish on Monday by around lunchtime because a number of us have planes to catch to Townsville. Who are we expecting on Monday?

MR ATKINSON: On Monday just two witnesses, which will fit neatly with that timetable, Commissioner. The first is Dr Martin Strahan, and the second is a Mr Tathem. Mr Tathem, Commissioner, you may remember, is one of the people who took the ethical awareness seminar.

COMMISSIONER: Yes, yes.

MR ATKINSON: So he is a relatively short witness and Dr Strahan is a relatively short-winded sort of person.

COMMISSIONER: Just before I rise, can I thank everyone for assistance in what has been a very long and, I believe, very productive week of evidence. Look forward to seeing you all on Monday.

THE COMMISSION ADJOURNED AT 4.33 P.M. TILL 10.00 A.M. ON MONDAY, 1ST OF AUGUST 2005