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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 01/08/2005

..DAY 31

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

THE COMMISSION RESUMED AT 10.06 A.M.

COMMISSIONER: Mr Morzone?

MR MORZONE: I call Thomas Martin Strahan.

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

COMMISSIONER: Thank you, Ms Gallagher.

THOMAS MARTIN STRAHAN, SWORN AND EXAMINED:

COMMISSIONER: Dr Strahan, please make yourself comfortable. Do you have any objection that your evidence be video-recorded or photographed?-- No, I don't.

Thank you.

MR MORZONE: Doctor, your full name is Thomas Martin Strahan?-- That's correct.

Your business address is at the Bundaberg Specialist Centre, 102 Woondooma Street, Bundaberg; is that right?-- That's right.

And you are a general physician with a special interest in gastroenterology?-- That's correct.

You practise at the centre that I mention?-- Mmm.

And you are a visiting medical officer at the Bundaberg Base Hospital?-- That's right.

You have attached to your statement a full curriculum vitae; is that correct?-- That's right.

We see from that that you are a Fellow of the Royal Australian College of Physicians?-- Yes.

A fellow of the American College of Preventative Medicine?-- Yes.

And a fellow of the Australasian Faculty of Public Health Medicine?-- Yes.

In your statement, there's one correction to be made and that occurs in paragraph number 15 where you make reference to a patient by the number of P170 in the Woodruff Analysis. That should be a reference to P220 and the words "in the Woodruff Analysis" should be deleted. Save for that correction, are the facts contained in your statement true and correct to the

best of your knowledge and belief?-- Yes, I believe they are.

COMMISSIONER: Sorry, Mr Morzone, I think you said paragraph 15. It is 16, isn't it?

MR MORZONE: It is.

COMMISSIONER: The third sentence, how should that read now?

MR MORZONE: It should simply read "given the number P220".

COMMISSIONER: "P220".

MR MORZONE: It is a Commission number rather than a Woodruff number.

COMMISSIONER: Splendid.

MR MORZONE: Can I also perhaps indicate to the parties, if it please Mr Commissioner, an earlier statement was circulated to the parties of Dr Strahan. Dr Strahan has added one further paragraph in the latest edition which is the paragraph 8, but in all other respects, if remains unchanged, in case parties are trying to decipher what changes were made and which were not.

COMMISSIONER: All right. And that also explains the confusion with the paragraph numbering.

MR MORZONE: It does.

MR CHOWDHURY: Can I raise a matter on that? I have obviously obtained instructions on Dr Strahan's original statement. Before I cross-examine, if I reach that today, I would like an opportunity to get some instructions on that new paragraph.

COMMISSIONER: Of course, yes. The statement of Dr Strahan will be Exhibit 232.

ADMITTED AND MARKED "EXHIBIT 232"

MR MORZONE: Thank you, Commissioner. Dr Strahan, in 1993, you refer to having taken up a locum position at the Bundaberg Base Hospital and then soon after becoming the Director of Medicine, and you remained in that position, am I correct, until the year 2000?-- That's correct, until Peter Miach came.

Okay. During that period, was work at the Bundaberg Hospital your sole source of practice?-- Yes, I enjoyed my work at the Bundaberg Base Hospital during that period. We had several new specialists recruited to the hospital, several new services were commenced, and there was a positive sentiment generally amongst the staff and we felt that we were improving

our services and adding new additional services during that time.

COMMISSIONER: Doctor, we have heard many comments about the quality of surgery performed at the hospital in the late 1990s and early part of the present decade, essentially before Dr Patel came to Bundaberg. I guess as a bit of an outsider to the surgical section to the hospital, you would be in a good position to get an independent view as to the quality of surgery performed there?-- My view was that the Surgical Department functioned very well during that period. We had Dr Anderson and Dr Nankivell working together for most of that period. They were very dedicated, productive surgeons. Dr Anderson particularly has a very high energy level and he would probably do 140 per cent of the workload of an average surgeon. His lists were long. He would do 10 or 12 endoscopies on a list when an average surgeon might do eight, and it was an enormous workload. The Surgical Department had a lot of patients in the hospital, and all the time surgical patients were flowing into the medical ward, and I was always on their case to get their patients out of my ward and there was some rivalry between the medical and the surgical ward in a very congenial way, and we were - you know, the Surgical Department was very productive and very busy and new things were being done, and the development of the training program for the junior staff with rotating Registrars from Royal Brisbane Hospital had a positive impact on the hospital and Dr Thiele's vascular support was very positive and we felt we were one of the premier surgical units in rural Queensland.

As the Director of the Medical Ward, I imagine there would be times when you would be referring your patients for surgery in the Surgical Department. Did you ever have any reluctance to refer your patients for surgery in Bundaberg rather than, for example, sending them to Brisbane?-- No, we didn't have any reluctance at all, and we were communicating frequently. We would attend - the surgeons usually came to the medical meeting every Monday lunchtime, and we would be discussing medical cases, and they would give their input. There was a Thursday morning X-ray meeting where the surgeons and physicians would attend together and we would debate backwards and forwards appropriate management for various patients, and so we had a lot of communication and we would often ask surgeons for opinions, and if they felt they weren't able to help, they would say, "Look, we know this fellow down in Brisbane, you should go down and see that guy. I can't handle that myself." So, we never had any concern that they might be wanting to do more than they - than was appropriate.

We have also heard evidence expressing the view most recently from Dr Fitzgerald on Friday that very complex procedures like oesophagectomies and Whipple's procedures were just too complex for the facilities that existed at Bundaberg. What was the attitude of procedures of that complexity whilst you were at the hospital?-- I think early on there may have been one or two procedures of that type that were done at Bundaberg, but I don't have any specific recollection of that or any specific recollection that the outcome was adverse, but

I think, you know, towards the latter part of that period, we were more inclined to refer them to Brisbane because of additional treatment modalities - sometimes people would be offered radiotherapy or chemotherapy before embarking on that type of surgery, and we were aware that the optimum outcome would be achieved by referral to a centre that could offer those additional treatments.

Was there also a concern in relation to surgeries of that seriousness regarding the facilities at Bundaberg; for example, the ICU and other facilities being adequate to deal with these sorts of patients?-- Yeah, it wasn't something that was in our consciousness during the 1990s. You know, we didn't have conflict with ICU about, you know - that I remember - about overloading them or undertaking things they felt uncomfortable with.

Doctor, you will have to understand I have got no medical background at all, so I have to ask what may be very trite questions of you, but I get the impression from a lot of the evidence we have heard that medical practice has changed enormously over the last few decades, and whereas a general surgeon in a rural hospital might do virtually anything 20 or 30 years ago, there's a tendency today to refer patients to the tertiary hospitals in Brisbane where there's a likelihood that if additional specialisation is required, it would be available; for instance, a vascular surgeon or gastroenterologist or whatever other form of specialisation may be needed. Is that a fair assessment?-- That's very correct, and that would happen more frequently with every year. Opposed to that view is the fact that patients have a very high preference to be treated in their home town if possible and very often patients would say, "Can't you do it here in Bundaberg?"

D COMMISSIONER VIDER: Can I ask a question? During that period you were talking about, were there support services - I'm thinking in particular of radiology - I understand there's no resident radiologist at the Bundaberg Base Hospital now. Has there ever been a radiologist at the Bundaberg Base Hospital?-- In my memory, there's not - going back 12 years, we have never had a full-time radiologist at the hospital. During the early part of my period there, we did have a radiologist in practice - private radiology practice that would assign a half of a full-time equivalent radiologist to the hospital, so every day there was a radiologist in residence there, and we would get CAT-scan reports within 24 hours, you know, often the same day, and there was somebody in the hospital we could go and talk to and they would attend regular X-ray meetings and that level of service has greatly deteriorated in recent years.

What about pathology services?-- We do have a pathology service in the hospital. Much of the pathology is done within the hospital laboratory, but some of it is sent outside. At one stage we recruited a pathologist for a brief period towards the end of Brian Thiele's tenure, but when Brian left, it was deemed that we didn't need a pathologist and that

person was sort of not encouraged to stay, but the level of pathology service has deteriorated in recent years, and I have difficulty - there's two main difficulties: one is the turn-around time for histopathology is slower now, and I have to wait for over a week to get a bone marrow result back very often, and we have somebody sitting in hospital and we don't know how to manage them, so we are waiting on this report and they are just sitting in the bed day after day while we are waiting on a report to come back; and the second difficulty is that it used to be that nurses assigned to the night shift, one of their tasks was to file all the pathology results in the charts, so that when we are doing medical rounds the next morning, I have all the pathology results there, and now that's considered not to be a nursing task, and it doesn't get done, and I'm often doing ward rounds and I can't get any pathology results, and we are asking - well, "What's the haemoglobin?", and they say it is available on the computer, but you have to leave the patient and go down to the nurse's station and sit down at a computer, and I've never - I don't have computer access there because you are required to do a half-day orientation to do the computer and I have never had the time to spend half a day - they won't give you a password unless you do their course, so I'm dependent on the junior staff to obtain these results, and - so, it's a very frustrating experience doing a ward round when you can't get pathology results and you can't get radiology results and I say, "Show me the X-ray and I'll look at it myself.", and half the time the X-rays are unavailable because they are somewhere getting reported on by the radiologist.

D COMMISSIONER EDWARDS: How long did you say that you think that's been going on?-- I think it has just been a gradually progressive process over the past five years or so.

COMMISSIONER: Doctor, you mentioned in answer to Deputy Commissioner Vider's question that radiology has deteriorated. Can you expand on the way it has deteriorated and the implications that has for you?-- I think there's two aspects to it: one is the turn-around time of the report. We have people with CAT-scan reports that don't become available for sometimes seven to 10 days and while most of the clinicians have some experience in reading X-rays, we would all struggle a little bit more to interpret a CAT-scan, particularly the older clinicians who didn't grow up with CAT-scan interpretation in their training days. So, it's a significant detriment to our clinical activity not being able to have those reports in a timely manner, and there are several circumstances where patients are being disadvantaged by the late production of these reports, and I think there were several circumstances in Dr Patel's practice that was disadvantaged by not having timely radiology reports. The other aspect to the radiology reporting issue is that whereas before we might have one or two radiologists who would do all the reporting, the reporting now tends to be sent sometimes out of town or conducted by locums, so you don't get a feel for how the radiologist tends to report. Some radiologists are very conservative and they detail everything. Some, you might think, are a little less detailed in their response, and

you might have more questions that you might want to ask them, but, you know, there might be eight different radiologists reporting on the films here and names popping up all the time of people you don't know, people you haven't met, and you are not confident of what their skills are. So, it is very different to how it used to be.

Can I take it from what you have been saying there are adequate radiology and pathology services in Bundaberg, they are just not available at the hospital?-- The private sector is very different. Every CAT-scan I get is - if I order it during the day, I have a report at 6 o'clock that night when I'm doing rounds. Pathology is excellent. I get reports the same day or the next day. A bone marrow I get within 24 hours. There's a marked distinction between the quality and the timeliness of radiology and pathology reports between the private and public sector.

This is probably a bit out of left field, doctor, but I'm going to ask it anyway: I've noticed just in my own experience that a number of the private hospitals now have co-location facilities for radiology and pathology. As a matter for the future, do you see any merit - when you have got a town like Bundaberg which has adequate private radiology and pathology - in arranging some sort of co-location arrangement so they can be on site and, to put it bluntly, so that public patients can have the same standard of care as private patients?-- I'm sympathetic to that view and I would be supportive of that. To some extent the radiology service is provided by the private practitioners in the town, but I don't understand - it seems as though priority is given to their private work in contrast to their public commitment and I don't understand what the incentives are that allow them to provide a - you know, a five hour turn-around for X-rays in private but a seven day turn-around for public. I don't understand what's happening there. But, you know-----

You and I both might suspect that it has something to do with money, though?-- That would seem likely.

MR MORZONE: You made mention of Dr Thiele during the time between 1994 and about 1999 or 2000. He was at that time the Director of Medical Services; is that correct?-- Mmm.

And you make mention in paragraph 4 to yourself, Dr Anderson and Dr Thiele having a good regard for each other and working well together?-- Mmm.

Without necessarily personalising it to any particular person, what were the skills that the Director of Medical Services exhibited that made it easy to work together?-- Dr Thiele had an academic background and he had a sensitivity to the application of clinical knowledge. He was a clinician who was actively working at the time. He had experience working as a consultant, and so he knew the pressures that would be applied to consultants, and we felt that he understood the consultants and were sympathetic to the pressures that we had to work under, because he, himself, was a consultant or had worked as

a consultant. I guess when Brian came, he was an older doctor and so he had worked in prestigious institutions and it was easy to relate to him and to have confidence in his clinical and interpersonal skills. Brian was also - had grown up in the town and had a wide social network in the town and he had - you know, it was very evident that his primary interest was in providing a good service to the community. He had a community linkage and loyalty, and we all felt confident that if he made a decision, he was doing it in the interests of the community, not in the interests of, you know, the corporate Queensland Health, and sometimes there would be - not always, of course, but sometimes there would be a conflict in that Queensland Health would have a requirement that we felt that was impractical or unable to be implemented, and Brian was of the view that he would say, "Oh, well, you know, we are going to do what's in the best interests locally.", so sometimes we would thumb our nose at Head Office and get on and do the job as we felt we should.

You make mention of him having introduced an Ethics Committee. That subsequently fell into disuse; is that right?-- Which was that?

An Ethics Committee?-- Ethics Committee.

Did Dr Thiele introduce an Ethics Committee?-- One of the main reasons for introducing the Ethics Committee was that we had an active research program going for a few years there, and we had a requirement in order to implement the research, we had to have an Ethics Committee, and while that research was ongoing, then the Ethics Committee had a reason to be there and a function to perform, and later on, that level of research fell off and wasn't continued, and so the reason for having the Ethics Committee fell away, I think. I think, too, that some of the later medical directors felt that the complexity of having an Ethics Committee had increased. There was some new guidelines, I think, on ethics committees that made the whole task somewhat more complex than we originally thought it was, so that may have been a contributing factor as to why the Ethics Committee discontinued.

COMMISSIONER: Doctor, can I take you back, for a moment, to paragraph 3 of your statement, where you mentioned when you were Medical Director, you worked five sessions per week at the hospital. So, you were - throughout your time as director in the Medical Department, you were actually a VMO rather than a-----?-- That's correct.

-----staff doctor. It has been suggested to us by a number of witnesses that that sort of flexibility is a good way of attracting the best medical people to a place like Rockhampton so that you can have a steady, if not generous income from your time at the hospital and also the opportunity to work outside the hospital, and that it also increases your experience and variety of patients and therefore allows you to maintain your clinical skills at the highest peak. Do you have any views about that?-- I think there's a prejudice against VMOs acting as clinical directors. I think that the

hospitals prefer to have a staff director. I think they are more compliant with hospital protocols and procedures and - but my view is that it should be taken on a case-by-case basis, and I think, you know, the best person available should be recruited to that role. You know, the person most suited to that role could be given that role. I don't think there's a good reason why a VMO can't do the role, and I think that in any mix of clinicians in a particular area, there will be someone who has, you know, an interest or a bent to administration who can fulfil that role, and whether that person is a staff employee or a VMO, I think it is less relevant to the personal skills that they would bring to the task.

For example, in the evidence we have heard to date, when Dr Anderson left the hospital, he expressed a willingness to continue seeing patients as a VMO. Certainly with the benefit of hindsight, the people of Bundaberg would have been much better off with Dr Anderson as Director of Surgery than Dr Patel, but without taking into account the benefit of hindsight, it does seem to me, at least, to be very beneficial to have an experienced Australian-trained specialist in that position, albeit part-time, rather than an unknown quantity from overseas?-- I would agree with that.

MR MORZONE: In your position as the Director of Medicine and as a Visiting Medical Officer, did you find you could still supervise junior doctors adequately, and including overseas trained doctors?-- Well, I was in the hospital every day and I did ward rounds every morning during that period, and I probably had as much contact or more contact with the junior doctors than many staff, directors, would have in their role, because most often a staff - a clinical director would be doing clinics in the afternoon or doing - involved in meetings or research activity. So, you know, I don't think there was a disadvantage in that respect.

Now, whilst we're dealing with your position as a Visiting Medical Officer, you continued as a Visiting Medical Officer after you left the hospital as Director of Medicine; is that right?-- Yes, I did. I had a break out of the job for about six or nine months at one stage, but I've continued on since then.

How have you found the hospital in terms of encouraging you or aiding you to remain as a Visiting Medical Officer?-- I think they have been happy for me to do it. They are particularly interested in reducing the burden on the after-hours roster, which is a big issue in a provincial hospital where there's a shortage of specialists, and my contribution has been to - you know, participate in the one in four roster. So certainly the hospital's been encouraging of that.

You make mention also in paragraph 5 to the District Manager at the time, the golden era time, if I could call it that, being Barry Marshall.

COMMISSIONER: Bob.

WITNESS: Yes. Initially in my first-----

COMMISSIONER: Bruce.

MR MORZONE: Bruce?-- In my first draft of this document I referred to him as Barry Marshall but that - his name's Bruce-----

Sorry?-- -----as has been corrected.

And you state there that you recall he also had very good interpersonal skills. Again, without necessarily personalising it to particular individuals, what sort of skills are you referring to there and why were they good for the assistance-----?-- I think in the course of my work there I would have talked to him once or twice a week and it just seemed we kept running in to each other, not that I was hanging out at his office but he would circulate in areas where we were working, and we would meet him in the hallways, we would see him on the ward, there would be meetings that we would meet him at, and he just had a very congenial personality and was interested in what we were doing and was available, and - you know, if I had an issue I always felt that I could contact him and discuss it with him.

COMMISSIONER: Do you happen to know whether Mr Marshall has a background in medicine or administration?-- No, he was a career administrator and he originated in Victoria and he was recruited to Queensland to the job of District Manager and then he served here for a period of some three or four years, and then a more senior promotion was offered to him back in Victoria.

MR MORZONE: Before we also leave the era up to 1999, Dr Miach has given evidence of during his period as Director of Medicine having set up the Baxter Program?-- Yes.

And surgery involving the insertion of pericatheters being sent outside the hospital. During your time as Director of Medical Services, what was the-----?-- Well, during my time Brian Thiele was working at the hospital and he was available to do those procedures and - so, we didn't have any of the issues with difficulty with vascular access because of Brian's involvement in that.

Paragraphs 6 and 7, you refer to the position of Hospital Manager becoming vacant. You state that your recollection is you waited for the job to be advertised and it didn't, so far as you can recall, is that right, and then Mr Leck was appointed.

COMMISSIONER: The record might show that Dr Strahan nodded his head.

MR MORZONE: Thank you.

COMMISSIONER: Sorry, doctor, it is just that everything here gets recorded and if you don't give a verbal-----?-- Yes.

-----answer it doesn't get taken down?-- Okay. Okay. Yes, that's correct. We were - as staff do, we were all speculating on, you know, who might get the job, you know, who amongst our colleagues might be offered this position or who might apply for it, and while we were speculating about it, all of a sudden an announcement's made that Mr Leck has the job.

And-----?-- So I was quite clear in my memory that it was never advertised.

To be fair to Mr Leck, from your description Mr Marshall and of course Dr Thiele, they would be very hard acts to follow?-- Of course.

Mr Marshall, again from your description, would have had a large following around the hospital?-- Yes.

And I guess it would have been difficult for anyone to try and fill his shoes, particularly when they were unknown to the local staff at the hospital?-- That's correct.

D COMMISSIONER VIDER: Doctor, you were not alone in imagining

that this position would be advertised?-- Oh, it was a topic of morning tea conversations and corridor conversations, you know, who would get the top job in the hospital, and it was talked about widely.

So the fact that someone was simply appointed to the position and you were notified as to who the new person would be, that would represent a change, perhaps, in policy from Queensland Health, certainly a change-----?-- It was outside of our expectations at the time.

Yes.

MR MORZONE: When Mr Leck arrived, you state in paragraph 7 that there was - he pushed for the officers of various directors to be relocated, and you refer to Dr Thiele's resistance, but comparing before and after in terms of where they were located, can you shortly outline the difference?-- There is a group of offices where the clinical directors are located, and Brian had his office located in that area and it meant that - you know, every time he walked in and out of his office he would walk past our offices and if we had a question we would just go next door, and it was easy proximity and easy communication, and the nursing situation was the same, that the Director of Nursing office was located with the Assistant Directors of Nursing, and so there was a new arrangement made, and I don't know whether it was Peter Leck's instigation or whether he had advice from head office that's how they wanted it done, but the directors of all of those areas were enclaved in their own area and removed from the previous proximity that they had to their staff.

COMMISSIONER: Dr Strahan, we had the opportunity a couple of weeks ago to visit the hospital and my observation was that what is now the executive area is quite remote from the clinical parts of the hospital, you are behind glass doors, I assume for air-conditioning purposes, you've got to go out through the doors, across a substantial open space, down a set of stairs, into quite a long corridor, I would have thought 2 or 3 00 metres really to the other end of the building, and then you have to take the lift to whatever clinical floor you are planning to visit. It really is quite seriously dislocated from the rest of the clinical operations of the hospital. Was that the same in your time?-- That was introduced, I think, in the late 1990, perhaps 2000, 2001, about that time that that change occurred, and it just meant that the proximity and access that we had was greatly diminished, and we just wouldn't encounter the executives in our clinical work to any near the extent we did previously.

Was that the context in which Dr Thiele was arguing in favour of staying with the other clinicians?-- Yes, he refused to move.

Yes?-- And I don't think it was immediately the office was moved, but at some later stage the Director of Medical Services was taken into the inner sanctum.

Doctor, I'm probably jumping ahead, but one of the views that has been urged on us throughout the course of this inquiry is that whilst everyone accepts that a hospital needs a manager to cover a whole range of administrative and managerial and bureaucratic functions, that the ultimate decision-maker in a hospital should be a clinician rather than someone with a managerial background. Do you have any views on that subject?-- I think that's a common - a common sentiment expressed by doctors, that the medical responsibilities have been usurped by administrators, and I used to have that view. I have had some involvement in hospital administration and I'm not entirely wedded to that view now. I think that doctors are sometimes prone in their enthusiasm to provide good clinical services to neglect the economic responsibilities that attach to that role, but I certainly think probably dependent on this one too far and the doctors have been disenfranchised from control over issues that they should have control over.

An alternative view that's been put to us already by Dr Thiele is that there should at the very least be a position such as Medical Chief of Staff or Nursing Chief of Staff who was a practising clinician who has the role of mentor, figurehead, final Court of Appeal, and so on, for the clinical staff, so that if there is a clinical decision, then the chain of command is through clinical people rather than through administrative people?-- I think that Dr Thiele's very familiar with the American model, having worked there for 17 years, and this is a common American model which is based on a private hospital structure where the medical staff aren't employees, they are VMOs, if you like, they have private practice arrangements, and I think that's a model that works well in that environment. I certainly think that there needs to be some attention to addressing the issue of - you know, having a senior clinical person, and whether have having a Chief of Staff is the best model, I'm not certain.

To cut to the chase, with what we have heard in evidence so far, one of the things that I find of concern and, indeed, quite alarming is that when the problems with Dr Patel arose, he was, in effect, the highest - he was the apex of the clinical decision-making as far as surgery was concerned, and was whilst Dr Miach was in a sense his equivalent, there was no-one higher than Dr Patel who was a practising clinician, and that's the sort of situation where it struck me that it would be beneficial if junior doctors and, for that matter, ward nurses and subordinate nurses have someone higher up the tree that they can speak to who is himself or herself a clinician, rather than having to resort to the administrative management of the hospital?-- I think that's true. Dr Patel was in a very strong position and whether an alternative administrative model would have been better or - you know, perhaps the argument could be made that he should never have just been put in that position. You know, I'm not sure the existing model is faulty. You know, if he hadn't been put in that position, then obviously the problems wouldn't have arisen.

D COMMISSIONER EDWARDS: Or if there would have been more clinical supervision of his outcomes?-- I have difficulty hearing, I'm sorry.

Sorry. Would it be that if there would have been more assessments of his clinical outcomes that would have prevented the recurrence of these problems?-- Yes. I have said in my statement later that I think Patel - Patel's performance at the hospital suffered from the lack of peer review and collegial support and somebody to direct him in an appropriate clinical manner, and I think if he'd - if he had gone to a larger clinical institution he - you know, we probably - he wouldn't have been allowed to undertake some of the surgery that he was proposing to do, he would have been subject to more effective audits and, you know, I think that - you know, the outcome may have been very different if he was in a different environment.

COMMISSIONER: But being candid about it, doctor, it didn't need to be a larger institution, if he'd been practising at one of the private hospitals in Bundaberg he would have been subject to a much more rigorous auditing process and even accreditation possess before he started?-- To some extent he would have, but - you know, the strongest audit in the private sector is the referring general practitioner.

Yes?-- And there is no way that he would have been - you know - he would have been able to do it. I think the anaesthetists in the private sector are all - by and large Australian trained, and I have often heard from the anaesthetist that some surgeon was proposing to do something and they just weren't going to let him do it and they weren't going to give the anaesthetic for that procedure. But as you are aware, in recent years almost all of the anaesthetic staff at Bundaberg Base Hospital are foreign trained or have been overseas medical people. They are almost all on a salary employment basis. There's only one VMO anaesthetists that I'm aware of, and these people weren't in a position to - you know, act with clinical confidence and provide a steadying hand on a surgeon to the extent they do in the private sector.

Doctor, you have touched on one of the keys to all of the problems we have been looking at. There's been a lot of debate as to whether overseas trained doctors have the same level of skill and competence as Australian trained doctors, and we have been told, and I have no doubt, that there are some 1500 or 1700 overseas trained doctors in Queensland, the vast majority of whom are highly competent. The real problem, as it strikes me, is not merely a matter of skill and competence, but having the authority in a personal sense to make the decisions, and if we have someone who is in Australia on a temporary resident visa who is compelled to work for Queensland Health who has no opportunity to work for any other employer, who has nowhere else to go, that person is going to have a lot of difficulty in saying, "I'm not doing this anaesthetic for this patient for Dr Patel because I don't agree that the operation should be performed."?-- Absolutely. I agree with that, and - you know, it's not just a situation

of foreign medical graduates coming to Australia. I was a foreign medical graduate when I worked in California for three years.

Yes?-- The culture and social dislocation that one feels is enormously significant and - you know, I felt like a fish out of water, and there were things happening every day that I wasn't, you know, familiar with and I would have been at a very tentative position there to have been critical of anything that was happening in that - in the institutions in which I worked. And I think that doctors coming to Australia have the same cultural and social challenges that influence how they work and - you know, the confidence that they work with. It's something that I think - you know, a few years can - they can put it behind them, but I think in the early stages they are very disadvantaged in terms of knowing what should be done and what's appropriate and the community expectations of what - you know, what is the community willing to accept or what's appropriate in a particular community. I think many of them just don't understand those issues.

And that's why, doctor, I am very partial to the suggestion of having a Chief of Staff or a Senior Clinician or Chairman, or whatever you call the position, so that, to take an example of Bundaberg, if Dr Berens, as the anaesthetist, has a problem with an operation that Dr Patel is about to perform, he doesn't have to put his own career or his own position on the line, he can go and see a Dr Thiele or a Dr Anderson or a Dr Strahan and say, "I have got a problem with what's going on here. Can you take a look at it and confirm to me that I shouldn't be too worried about it?", so that there is at least a senior Australian trained clinician at a high decision-making position within the hospital, so that anyone who has a problem, from the most junior medical student to overseas trained doctors, to even Australian trained doctor who feel they are out of their field of specialisation, can go and raise the matter informally?-- I think that's a very important role and I think ideally it would be filled by having an Australian trained head of - as a clinical director of that particular department. I mean, if there had have been an Australian head of Anaesthetic Department, Dr Berens would have had access to that person and that would have been within their area of expertise to advise him on that. But having, you know, another person above that - you know, that may be of great benefit also.

I guess that also leads me to ask the question, and for obvious reasons I want to make it clear that in asking this I'm not in any sense criticising Dr Keating, but I do wonder the merit of having someone who is not a practising clinician who is although medically qualified performing an entirely administrative job as Director of Medical Services. We have heard that when Dr Thiele had that position he spent 40 per cent or so of his time as a practising clinician. Do you have any views about that?-- I think that the increasing complexity of a level of hospital makes increasing demands on Director of Medical Services, and I think a hospital that's employing 20 or 30 consultants, whether VMOs or staff, would

benefit from a Director of Medical Services who'd had consultant experience and was able to relate to those senior staff in a - on a level of having had personal experience and with - perhaps sort of an equal, carrying an equal weight of clinical experience and response - and authority, and I think that for smaller hospitals, having someone with a general practice background may be appropriate, but I think as the hospital become more complex and - I think certainly as - consultants, I think, have greater respect for a clinical opinion from another consultant or someone with a consultant background.

And to be fair to the holder of the position, it's almost a matter of self-confidence, that if you have never been a clinician yourself or have never been a consultant yourself it must be very difficult to say to your Director of Surgery, the Director of your medical department, "I'm concerned about what's going on in the department."?-- I think that's a significant issue in the circumstance.

D COMMISSIONER VIDER: Doctor, would you see in the future in a place, say, the size of Bundaberg, that you could increase the robustness of the auditing processes if you had a combined community between the public and private sector, or it's not so much a combination of the public and private sector but it's a forum that's increased by a number of matters, they both gather around the table?-- That happens a little bit now.

Yes?-- Peter Miach, for example, is involved in the clinical audit at one of the private hospitals and we have asked him to come in and take that role as an outsider to the hospital, and I know that the surgeons have some clinical meetings now which involves public and private surgeons, although I don't think Patel ever participated in that. That's the sort of a voluntary thing that they engage in. So, there may be merit in that.

Yes.

COMMISSIONER: Mr Morzone?

MR MORZONE: Thank you, Commissioner. In paragraph 9 you mention that the appointment of Dr Wakefield had caused you some concerns. Do I understand from that paragraph not because of him personally but again because of the comments that you just made to the Commissioner about his limited experience and background; is that correct?-- Dr Wakefield worked for two or three years as a Junior House Officer at the Bundaberg Base Hospital and then he was appointed as a medical superintendent at Gin Gin Hospital, which at the time was a one doctor hospital, and he did a very good job, he was a very good general practitioner, a very good clinician, he was highly regarded by the community and by his colleagues. We were just a little bit surprised, though, that he was given the job of Director of Medical Services where, you know, the responsibilities and the role that he was filling would have been very different to his previous experience. But it should

be said that the job was advertised for two years, I think, before that appointment was made and I think that they had repeated interviews, and I understand at one point they did appoint a specialist from Adelaide, I think, to the role but then he pulled out and, so - and the staff were agitating to have a Director of Medical Services appointed and we wrote a letter to the Minister asking that a permanent appointment be put in that position, so I suppose the hospital - you know, had to do the best they could.

Subsequent to his appointment and the appointment of Mr Leck, you have referred in paragraph 10 to there being a number of clinicians leaving the hospital and you had a view that they could have been better managed and they may have stayed otherwise, and you have exhibited to your statement letters which you wrote, first of all to an AMAQ newsletter and then also to the local paper. So you must have felt quite strongly about that issue; is that right?-- Yes. Well, I felt that we had a very effectively clinical team there that was being dismantled and I did have strong views about it and at the time I was an officer, initially secretary, and later president of the local medical association, so I felt some responsibility to agitate about those issues.

When you say the term "dismantle", do you mean was there some deliberate attempt, did you feel, to remove-----?-- No, no, I think that we had junior medical administration who had been off to Brisbane with conferences and had received correspondence from head office that told them, you know, this is the way things should be and this was how - you know, we have to have everything done according to the letter of the law, and I think there were several unique circumstances in Bundaberg where things - you know, weren't being done according to the literal letter of the law but the overall outcome was very good, and - you know, criticisms have been made of Dr Anderson and how he did his work at the hospital, but I think that should have been put against the fact that there was - he was - you know, he was 140 per cent productive as compared with any replacement that you might find of him, that the standard of his work was excellent, and that - you know, he had pressures on him to be engaged and involved in other clinical work and - you know, it seemed like the administration was nit-picking and placing great emphasis on minor issues and ignoring the - you know, the overall impact that his work was making. And there were several clinicians in this area, there was - the Director of Psychiatry at the time was Dr Marsh May. There'd been administrative changes made in his area, so that he felt he was unable to continue. There were reports being made about the Director of Obstetrics and Gynaecology that I felt were unfair and we successfully defended that situation, and the Director of Pathology had been recently and was told that his services were no longer required, and so it just seemed that all - all around us - you know, the people we'd relied on for so many years who had - who are so hard to attract to a rural environment were being discarded without due consideration, I felt.

D COMMISSIONER EDWARDS: And added to that, you felt that you weren't being heard as well and other specialists weren't being heard?-- That was highlighted in correspondence to the local newspaper, that, you know, we were concerned that these people were leaving, that this was a year later that two of the replacements of Dr Anderson had resigned, and you know, the response from Queensland Health was that they hadn't resigned, they were just going to work in another hospital, and, you know, we felt that the story wasn't being told and that, you know, Marsh May, the Director of Psychiatry, he actually wanted to leave and, you know, he'd been there for 20 years and his family was located there and he had a long history of association but he just decided one day that he wanted to go somewhere else and those of us who knew him and talked to him knew that wasn't the case and we felt that, you know, the story should be told so the issues could be addressed.

COMMISSIONER: I see in paragraph 10 you state that Dr Wakefield threatened to take legal action against you in relation to the letter?-- Yes, he did, he took offence to that article in the AMAQ.

Do you recall what part of it he identified as offensive to himself?-- He felt that as the Director of Medical Services or he may have even been Acting Medical Director, but to say that five of eight clinical directors would have been leaving would have reflected in a negative on his management.

D COMMISSIONER EDWARDS: But it was a fact?-- Yes.

COMMISSIONER: I assume that no such legal action took place?-- No, he must have received appropriate advice.

MR MORZONE: You also said that shortly after publishing the articles and the letters, there was a meeting where the health minister attended; is that right?-- Yeah, I think that may have been the very same day or the next day.

And you say that that encounter as well as the encounter with the response to your letters left you with the impression that senior management at Queensland Health were not interested in responding substantially to criticism; can you expand on that?-- The Minister did most of the talking at the meeting and the other corporate health executives sort of left the running to her. I think she thought that I was trying to make a political statement, that I was trying to be negative about her performance as Minister and that wasn't my intention at all, I was focussed on the problems we had in our hospital and I was drawing them to her attention, and when we would get press releases from Queensland Health that gave the impression that, you know, everything was okay and there's no problem and these people are leaving of their own regard, that the - I didn't go seeking out the press to disabuse them of that notion, they would ring me up and say, "Well, what's your response to that?", and I would say, "Well, that's just completely untrue and the real story is this.", and the press - the local press are inclined to accept our viewpoint and so

they tended to give their headlines according to the advice that we gave them and not according to Queensland Health and I think the Minister at that time was very frustrated by it.

COMMISSIONER: But doctor, it's the same story again and again, isn't it, you try for years through the right channels to get something fixed and no-one listens to you and then when you go to the press, you're slammed as being unhelpful and uncooperative and making things difficult and so on; there just isn't a solution, is there?-- That's true.

Were you subject to one of those employment agreements that carried with it the code of conduct that said that you weren't to talk about problems with anyone outside Queensland Health?-- At one point of time there was circulated a document that required us to sign, and I don't know whether it was specifically a code of conduct but it had to do with media and our - and the deterring us from talking to the media, and this would have been perhaps in the late 1990s and I never signed that document and I kept expecting that I would get a phone call or a letter reprimand of advice about it but it never occurred. I do have a contract with Queensland Health and it may make reference to my media liabilities or responsibilities, but I can't remember that detail. I felt that I was, you know, my main interest was the welfare of the hospital and the local community and if that meant disagreeing with corporate health, then I was willing to do that.

Yes.

D COMMISSIONER VIDER: Was that document an absolute because you had another hat on, you had an AMA hat on?-- Yes. Look, I can't remember the details of the document.

Mmm?-- But nobody else would talk to the - if the media rang any other doctor in town, they'd always direct them to the local medical association president, that was the role-----

D COMMISSIONER EDWARDS: And that's not unusual?-- -----if I didn't say something, nobody else would.

And that process is not unusual throughout Queensland?-- No, I don't think so.

MR MORZONE: In paragraph 12 - or perhaps before we leave that, it's taken a number of inquiries like this one to sort of understand or realise the simple fact that staff ought to be encouraged to be open about concerns or criticisms within the hospital and be able to report them. Was it your view that prior to, say, the year 2000, that sort of culture was there, that there was an openness about reporting concerns or criticism or is it a matter that-----?-- There's been discussion about, you know, how best to process complaints, and, you know, having complaint bodies and so on. It's my view that the process of complaint is quite foreign to medical practitioners, and it's not a culture that doctors write letters of complaint, and I'm certainly, you know, I've heard reference to complaint forms - well, I've never seen a

complaint form and I've never filled one out. If I had a complaint I would talk to, you know, my line manager, you know, the Director of Medicine or the Medical Superintendent. I don't think that there's a culture of doctors writing - filling out forms of complaint and, you know, Brian Thiele used to get all sorts of complaints and he told me that he - when he got a complaint, he would ring the person up and talk to them about it, and that was just his approach to it and then, you know, if necessary, further steps would be taken, but he felt that 90 per cent of the complaints were best dealt with by talking to the person about it and he would encourage patients to talk to their treating clinicians and the complaints during that six year period were tended to be managed, you know, by trying to get the patient talking to the clinician concerned.

And in paragraph 12, you refer to there having been a change of culture within the hospital after the appointments of Mr Leck, Drs Wakefield and Keating, and I want you to expand on that change in a moment, but is one of the changes - did one of the changes relate to that openness of being able to express concerns or receiving feedback about concerns with confidence that you'd be taken seriously and not necessarily victimized in any particular way?-- Yeah, I think very much so. There was just more communication that would go on. There was more rubbing shoulders and I think that there was perhaps the personalities involved were sympathetic to each other and we had a common understanding of the difficulties each of us had to deal with and we were motivated by providing a good service. It would be wrong to say that there was a cavalier attitude to, you know, policy and process, but I think that it wasn't, you know, whenever we were confronted with a challenge our first question wasn't to ring up Queensland Health and ask for advice about what to do and we wouldn't get the policy book out and say, "Well, what are we allowed to do?" We would take the view well, the appropriate step is to solve it this way and so that's sort of how we functioned.

COMMISSIONER: So a lot easier to ask forgiveness after the event than seek permission before?-- We didn't have to do that too often. I mean, it wasn't irresponsible behaviour, we were - there were senior people involved who'd been doing their job for decades and they were willing to make decisions.

And you got the results?-- I beg your pardon?

You got the results at the hospital which is what really matters?-- Yes.

MR MORZONE: And subsequent to the appointments of those persons I've mentioned and bearing in mind others appointed them there, not necessarily their own fault in that regard, but what was it that changed in that respect?-- I think there was a - I don't think any of the administrators or clinicians at that time were particularly concerned about their careers. I don't think any of us were seeking promotion, I don't think any of us were seeking to calve out a niche in the big scheme

of things, we're all content with our role there and so we were somewhat indifferent to, you know, the processes required by Queensland Health, and I think the new team of people came along, they were career health administrators and they were seeking to be very compliant with head office, they were seeking to be very compliant with policy and I think they had an eye on, you know, advancement of their careers in health administration and I think that led people down a different pathway.

And you've mentioned in paragraph 13 that the different pathways was assisted by the other factor, that is, a new focus on waiting lists and the budgetary constraints with waiting lists; is that right?-- Yes. When I was searching for the article in the local news mail, as I was looking - the local hospital cuts out anything of interest to health and puts it in a scrapbook, and as I was looking through the scrapbook of media exposure, there was an article about waiting lists, and particularly during the period 2000 and 2001, you know, every week there was an issue about hospital waiting lists and I think it became an election issue at about that time about, you know, how the waiting lists could be shortened and there was really an extraordinary focus on this concept of waiting lists for elective surgery, almost to the exclusion of a lot of other things that the hospital did or had to deal with.

At the time Dr Patel arrived, what was your position at the hospital? Were you still there as Director of Medicine?-- I was Visiting Medical Officer in the Department of Medicine.

And during the first part of his tenure there, did you have much contact with Dr Patel?-- Very little. I would see him around the wards and Intensive Care Unit occasionally, but he didn't attend our clinical meetings as the previous surgeons were more likely to and my clinical contact with him was surprisingly little. I say "surprisingly" because often surgeons are hounding the physicians to get involved in the care of their patients and Patel did that rather infrequently.

There are two particular incidents that caused you to have some concern about Patel and you refer to them in paragraph 16 and onwards of your statement?-- Yes.

The first involved the patient P220?-- Yes.

And she was initially one of your patients; is that right?-- That's right.

And what had occurred with her?-- Her general practitioner referred her to me to have an endoscopy in the private sector because there was a well founded prevailing view that to get a gastroscopy in the public sector, there was a long wait, and she was an uninsured patient sent to the private hospital, she would have had to pay $500 out-of-pocket to have this procedure done but the GP felt that it needed to be done sooner rather than later, this lady was vomitting all of the time and not able to eat, and when I did an endoscopy, I found

she had an obstruction below the stomach between the first and second part of the small bowel, the duodenum, and I took biopsies from this area and then arranged for her to be admitted to hospital because she didn't have private hospital, she was referred to the Bundaberg Base Hospital with a letter asking that she be admitted to my medical unit. Do you want me to go on with that story?

Yes?-- I rang the hospital about 8 o'clock that night to find out what had happened to her and was advised that she'd been admitted to the surgical unit and I was a little concerned about that because that wasn't my intention and so I, on my way home from hospital that night about 9 o'clock I drove by the public hospital and went up to see her and found that she had been admitted to the surgical ward and Dr Patel was looking at her X-rays on the surgical ward and I was told - he told me that he felt that she had a perforation and that he intended to take her to theatre for surgery and that he'd called in the theatre staff to facilitate that. I asked him to show me the X-rays and he showed me a CAT scan, and when you do a CAT scan, the usual thing is to give the patient some oral contrast material where they swallow some oral contrast so that it outlines the stomach and then they also have an injection to give them intravenous contrast material, and he showed me - he put the scan up on the viewing box and said, "Now here's a line of dye in the retroperitoneal space indicating that the contrast material has leaked out of the stomach", and I had a look at this line of dye and I said, "That's not in the retroperitoneal space, that's a nephrogram and a pyelogram, you can see the kidney outline, and this streak of dye is the dye going down the ureter, and it was quite plain in my view and he had misinterpreted that X-ray thinking that it indicated dye in the retroperitoneal space, and I pointed that out to him and he conceded that, you know, it was an nephrogram, you couldn't do otherwise when you show the outline of the kidney it was quite obvious, but he said that he was going to take her to theatre anyway and because she had some pain in the abdomen he wanted to find out what was going on. My feeling was that it was all a bit precipitous and I wouldn't think a surgeon would normally be in so much of a hurry to take a patient to theatre in that circumstance, but I deferred to his surgical experience and-----

COMMISSIONER: Doctor, if I can interrupt you there just for a moment?-- Yep.

Accepting that you're not a surgeon yourself, are you able to say whether there was any valid surgical reason for operating on this lady after it was demonstrated that the initial diagnosis of the perforation was wrong?-- There's not another surgeon I know who would have operated on that lady that night and I didn't - I didn't think that there was a good indication to operate on that lady at that time, but I felt that, you know, at the time I didn't have a lot of concern about his surgical skill or - and he was a surgeon and he'd just examined the patient more recently than I had and he had the view and she should be operated on and I took the view well,

you know, sometimes you just can't convince surgeons.

But operate to do what, I mean?-- An exploratory laparotomy.

D COMMISSIONER EDWARDS: Thinking there was a perforation though?-- Yes.

Where in fact it turned out to be a carcinoma in the pancreas?-- Yes. But I think one of the thoughts I had at the time was he's called the theatre staff in so there's three or four nurses have been called out of their Friday night recreation into the hospital, the two - one or two orderlies have gone up there and turned all the lights on and, you know, the train has been set in motion and I think he felt it would be hard to ring up and say, "No, I've changed my mind, it's not a perforation after all", you know, I think that he'd started something in motion that he couldn't stop or wasn't willing to stop.

COMMISSIONER: Mr Morzone, would that be a convenient time to take the morning break?

MR MORZONE: Certainly, Mr Commissioner, yes.

COMMISSIONER: We'll rise for 10 or 15 minutes.

THE COMMISSION ADJOURNED AT 11.18 A.M.

THE COMMISSION RESUMED AT 11.43 A.M.

THOMAS MARTIN STRAHAN, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Morzone, I'm probably becoming oversensitive as a result of particular points that Mr Diehm raised on Friday morning, but can I mention that Deputy Commissioner Vider has recognised Dr Strahan's wife in the courtroom as someone who used to work as a nurse with her at the Holy Spirit Hospital, I think quite some years ago. I'm sure that doesn't cause anyone a problem, but I thought I should just place it on the record.

MR DIEHM: It doesn't cause me any concern, Commissioner.

MR CHOWDHURY: Nor me.

COMMISSIONER: Thank you.

MR MORZONE: Dr Strahan, over the break, you have had the opportunity to read through the medical records relating to the patient we were talking about before the break, and you have seen the CT Scan report which became available after the night that you examined the radiology images of the patient of Patel, and did the CT Scan report confirm your belief that there was no perforation?-- Yes, I believe it does. It comments that there's no free gas evident in the abdomen. I think that provides radiological support for saying there's no perforation. The report doesn't comment on the pyelogram, which I wouldn't expect it to because it is such an expected finding.

In your statement you have also referred to the patient having undergone a Whipple's procedure, and, in particular, in paragraph 18, you refer to that intention being made known, and then before the procedure or an intended procedure having taken place, the patient being sent home. Have you again had a look through the rest of the medical reports about that procedure, and is it the case that although there's mention of a possible Whipple's procedure occurring, the procedure, at least reported by Dr Patel as having been undertaken, was not a Whipple's procedure?-- That's correct. Dr Patel indicated to me that he intended to have the lady brought back to the hospital in three weeks time after that initial procedure for the purpose of having a Whipple's procedure. I understand, however, having looked at the chart, that at the time of surgery, he didn't proceed with the Whipple's procedure but he did what I call a gastric drainage procedure which is a palliative procedure, so he didn't, in fact, proceed with the Whipple's as he had intended to.

COMMISSIONER: Doctor, a Whipple's procedure is also called a pancreoduodenectomy, or something of that sort?-- That's why they call it a Whipple's.

But it is a very major operation?-- It certainly is, yes.

You have a discussion at some stage with Dr Keating. I see your attachment to - the last attachment to your statement is a note of a meeting which you had with Dr Keating in November of 2004 and Mr Leck was also at that meeting?-- Yes.

Did you express any opinions on that occasion as to the suitability of Bundaberg Base Hospital for doing procedures of that complexity?-- I believe I did, and I believe I had the view that it wasn't a procedure that was appropriate to be undertaken in Bundaberg.

Again, bearing in mind that you are not a surgeon, we have had comments already about the complexity of - sorry, I meant the other operation that was regularly performed, the oesophagectomy. Are you able to offer any comparison as to the degree of complexity of the two operations?-- I think they are both very complex and I think they would both exceed the type of surgery that would normally be undertaken in Bundaberg, certainly in recent years.

My concern is this: if it is the case that Mr Leck and Dr Keating were informed in November 2004 of your view that Whipple's operations should not be done in Bundaberg, would it logically follow from that that an operation like an oesophagectomy would also fall in that class of procedures that are too complex?-- I think at the time I had this conversation with Mr Leck and Mr Keating, I was of the view that Dr Patel shouldn't do vascular surgery, and that was on the basis of communication from Dr Miach to myself, and I was convinced that he shouldn't do vascular surgery. After this particular incident, I was convinced he shouldn't do Whipple's procedures, and sort of the list of things that I didn't think he was good at was growing. I hadn't had any personal experience with oesophagectomies and I wouldn't have expressed an opinion about that at that time.

Of course?-- Whether an inference should have been made at that time? Possibly.

Can I ask you perhaps a difficult question: had you been Medical Superintendent and a consultant was saying to you, "This man should not be doing Whipple's procedures at this hospital.", would you have viewed that as being advice confined to that one type of procedure or a reason to explore the range of other things that should or should not be done? If you don't think you can give an answer-----?-- It is too easy to say "yes". You know, I'm not sure. I think that - you know, with the growing list of difficulties that have been identified, I think it would have begged the opportunity to evaluate what surgery he was doing and perhaps drawing up a list of ones that he could do and couldn't do.

Yes.

MR MORZONE: In paragraph 19, you refer to "seeming too

devious" in having interfered with the transfer of a patient to Brisbane. Is that because at that time she was no longer your patient or-----?-- Yeah, it is just that - I think - I think if you have a concern about another doctor's practice, it is not a good habit to express those opinions to the patient directly, and I think it is more appropriate to express them to the surgeon concerned or perhaps to the - to their supervisors. I remember at the time contemplating, "Should I go into the ward and tell this lady, 'Don't come back in three weeks. Ask your local doctor to make another arrangement.'?", and the thought went through my head and I thought, "Well, you know, it is probably not appropriate."

COMMISSIONER: Sorry to ask you this so directly, doctor, but obviously it is important for us to know whether there's a causal connection between the procedure this lady had and her death. She ultimately didn't have the Whipple's procedure?-- That's correct. I only became aware of that this morning.

She did die. Are you able to say whether there was any connection between the treatment she received from Dr Patel and her ultimate death?-- I don't know the date of her death. My estimate at the time when I was thinking about it is that her life expectancy with that - with the malignancy that she had, given optimum treatment, may have been three to six months. In the absence of an operation, it would have been less than that, because she wasn't taking any adequate nutrition. I was told by one of the nursing staff that this particular lady had proceeded to a Whipple's procedure and had died soon after, and - but I hadn't reviewed the medical record.

Thank you, doctor.

MR MORZONE: Can I ask you then very briefly about the second incident, which you have set out in some detail on page 7 of your statement, paragraph 22 onwards. Yes, 22 onwards. In particular, in 23, you refer to a discussion with Dr Patel and can you briefly relate the substance of that conversation and your real concern which you express then in paragraph 24?-- Mmm.

And then perhaps your statement thereafter can speak for itself?-- We had a patient admitted to the Medical Ward with vomiting and bleeding and I think the initial presentation was vomiting - there wasn't initial concern about bleeding. We thought there might be a medical explanation for that in that she was having a drug reaction. She was on medication that could result in vomiting. We stopped that. Several days went by and she wasn't improving, and we then came to the conclusion that it wasn't related to the medication she was on, there must be some primary pathology causing this continued vomiting, and when I was doing a ward round on Friday morning, she hadn't had anything to eat for about a week. I was concerned about the period of time that had gone, and I felt that the next step would be to do a gastroscopy. I was aware that Patel was doing an endoscopy list that morning and even though I had concerns about procedures I felt he

wasn't competent to do, I thought he would be able to manage a gastroscopy, so I asked my junior staff to make contact with his staff to see if he could add a gastroscopy to his list that morning. This would be a relatively straightforward procedure that could be done in 10 or 15 minutes and surgeons are very often able to sort of add another case to the list in those circumstances. I understand that Dr Patel sent one of his junior staff out of theatre up to the ward to inform himself of the patient's circumstances and then report back to him, whereon we had a message come back to us that he was agreeable to doing a gastroscopy on Monday. I felt that that delay was too long under the circumstances, and I asked my junior staff to contact theatre to see if we could do it as an urgent case later that day, and I believe a time was arranged for about 1 o'clock to do a gastroscopy. I then got a message back that Dr Patel was very upset with that because we had asked him to do it and now we were making arrangements to do it, and so I rang him after he finished his list and talked to him on the phone and explained to him that we felt that there was an urgency that we do the gastroscopy and he was amenable to that suggestion and agreed to that. I did the gastroscopy and found that the patient had an obstruction in the second part of the duodenum again and it would bleed on contact, and so I had the view that this patient had a tumour in the same - very similar location to the previous patient. I felt that it was likely to be a secondary tumour, originating in either the gall bladder or the pancreas, and I felt that the patient would need to go to Brisbane for further investigation and treatment. I met Patel in the corridor leaving the theatre and he asked me what I found in this patient. I explained to him my findings, and he said, "Oh, well, that will be a primary tumour in the duodenum." I was a bit taken aback that he could be so certain, having not seen it himself, and he said, "The patient needs an operation to remove it, and I'll put the patient on the surgical ward, and I'll do it early next week.", and I felt a bit uncomfortable with his - you know, his confidence and, you know, the fact that he was wanting to sort of move in on my territory, but he's a very dominant character and he seemed 110 per cent confident of what he was describing, so I acquiesced to his advice and - but I was concerned about it - and then on the Monday or Tuesday I got a message that the patient had developed a chest infection, possibly aspirated, I guess, and would I be involved in her treatment to clear up the chest infection so that the patient could then be operated on, and having pondered the situation a bit, I thought, "Well, here's my chance. I'll transfer her to the Intensive Care Unit out of the Surgical Ward to create a greater distance between his control and my control.", and then I talked to the staff in the Intensive Care Unit and said, "I want to transfer this lady to Brisbane and I want her to be in the Intensive Care Unit so that I've got the capacity to do that.", and so we treated her chest infection for a few days, she was improving, and we discussed how we could transfer her to a surgical unit at Royal Brisbane. I was advised that there would be - it would be politically difficult for a medical unit to transfer a patient to a surgical unit without - because the surgical unit in Brisbane would ask what did our surgeons think of the

case. So, we devised a strategy where we would transfer her to the gastroenterology unit in Brisbane - from one medical unit to another medical unit - and then they would obviously conclude that the patient needed surgical involvement and they would be able to make that decision there. So, I was intimidated by Dr Patel, and I wasn't - I wasn't willing to confront him with the circumstances of this case. I joked to some of the staff that if I told him what I was going to do, he might hit me - not physically - but that was sort of the extent of concern I had about him - his behaviour - and so I discussed my plan with the Director of the Intensive Care Unit, the nurse in charge of the Intensive Care Unit, Toni Hoffman, and Dr Peter Miach, the Director of Medicine, and the interesting thing that I pondered at the time was that everybody agreed that this was a reasonable course of action. Normally it would be outrageous behaviour to put someone in intensive care who doesn't need to be there, but they all agreed that it was a reasonable thing to do, and when I talked with Dr Miach about it, he said, "That sounds all right, but I think you should inform Dr Keating." So, on the Friday morning, I contacted Dr Keating - I think I might have gone to his office - and I explained what we were doing, and the surprising thing to me was that he agreed that it was a reasonable thing to do, and he said, "Look, I'll contact Dr Patel and explain to him what we are doing.", and then he rang me a short time later and said, "I've talked with Dr Patel. He agrees that it is a reasonable thing to transfer the patient to Brisbane and there's no problem.", and that's what happened, and I don't know the outcome of the patient's progress from that point on.

Now, perhaps for completeness, can I show you an extract of a copy of the letter of Ms Hoffman dated the 22nd of October, which I think is TH37, from memory, to her Exhibit 4. At the bottom of page 2 or 3, there's a statement she attributes to you. In fairness, I should show you that, and my understanding is you don't have any disagreement with that statement; is that right? And you refer to speaking to her in paragraph 19, of your statement, from memory - I beg your pardon, paragraph 20; is that right? I just want to make sure that's clear on the record?-- Yes.

And I did say to you a moment ago that I wouldn't need to show you this, but perhaps for completeness, I should. There's a reference in the transcript to Dr Messenger having had a conversation with you and he records that conversation. Perhaps I might put the page number of the transcript on the record down there?-- They are fair representations of our conversation.

All right. For the record, that's transcript page 253, if it please Mr Commissioner. That's the evidence-in-chief.

COMMISSIONER: Thank you. Ms Gallagher?

MS GALLAGHER: Nothing, thank you, Commissioner.

COMMISSIONER: Mr Harper?

MR HARPER: Yes, thank you.

COMMISSIONER: Doctor, Mr Harper has some questions for you. He represents the Patients Group from Bundaberg.

CROSS-EXAMINATION:

MR HARPER: Doctor Strahan, I would like you to look at paragraph 15 of your statement where you talk about in the course of 2004, you generally became aware that Dr Patel had a reputation within the hospital of being personally abrasive, et cetera. Can I ask - you know lots of the staff, obviously, within the hospital? Yes?-- Yes.

You have worked with them for a long period of time?-- That's right.

They were colleagues?-- Yes.

Friends?-- Yes.

You knew Dr Miach quite well?-- Very well.

You knew Dr Carter quite well?-- Yes.

You knew Tony Hoffman in the first half of 2004?-- Yes.

Can I ask - the sentence where you refer - the next sentence, you say, "It was well known through the hospital that Patel and Peter Miach did not talk, but my understanding was that this was mostly related to the rough handling Patel had meted out to some of Dr Miach's junior doctors."?-- That's right.

I emphasise the word "mostly". Were there other concerns as well that you are aware of?-- I think Patel and Peter Miach had confrontations and there was a matter of talk around the hospital one morning when I came in that there had been a shouting match downstairs, that they had been yelling at each other, and we were all entertained by those sorts of stories. They carry a high priority for discussion amongst hospital staff, and there was a general acknowledgment that, you know, they had disagreements, and most of those - there was a couple of incidents like that, I believe, and they were related to Patel's interactions with junior medical staff, and Peter Miach felt a responsibility to defend them and to try and protect them and influence Patel not to react - not to have the conversations with them similar to his previous ones. When I say "mostly", I think Peter Miach didn't have a very high opinion of Patel's competence as a surgeon, obviously, and that may have - Peter Miach doesn't tolerate fools, and if he felt somebody was, you know, not doing their job properly, he would probably avoid them and not talk to them very much.

So, just going back to that then, you were aware that Dr Miach did not have any great respect for Dr-----?-- Very much, yes.

-----Patel's skills? Were you aware of Dr Miach's concerns about the audit of catheter placements?-- Yes, I was.

You were? You were aware of that in the first half of 2004?-- Yes, I think early in his period of employment there.

Okay. You were aware then that as a result of that and other matters with Dr Patel, Dr Miach had basically blackbanned Dr Patel from operating on his patients?-- Dr Patel had a conversation with me when he was - before he went on leave in early 2004 that he'd - I was to be the Acting Director of Medicine for four weeks for a period of time while he was away.

Sorry, Dr Miach?-- He told me that - Dr Miach was away.

Dr Miach had this conversation with you?-- Yes. He told me that he'd employed a locum nephrologist to act on his behalf in his absence and he told me the instructions he'd given to this locum was he wasn't to involve Dr Patel in the surgery of any of his patients.

So then it is fair to conclude that in addition to the concern about the treatment of the junior staff, one of the other major concerns which you were aware of was the clinical practice of Dr Patel?-- That's right.

Commissioner, I have nothing further.

COMMISSIONER: Thank you. Who wants to go next? Mr Allen?

MR ALLEN: I will go next. Thank you, Commissioner.

COMMISSIONER: Ms McMillan?

MS McMILLAN: I don't mind when I go.

COMMISSIONER: All right.

CROSS-EXAMINATION:

MR ALLEN: Doctor, John Allen for the Queensland Nursing Union. If I can ask you a few questions about this patient who was essentially hidden from Dr Patel so that she could be transferred to Brisbane, and you mentioned that those events occurred about a week or so before matters regarding Dr Patel became very public. One of the intensive care nurses, a Ms Karen Stumer, has identified that patient as being patient P48 on the list compiled by the QMU solicitors. Can I just ask you to have a look at this document and at P48 and see if you are able to agree that that's the person we are talking about?-- I'm not 100 per cent certain. It may well be.

Okay?-- If I had a look at the chart, I could confirm that.

All right. In any event, it was obviously only with the knowledge and cooperation of Dr Miach with Ms Hoffman and ultimately Dr Keating that those events could occur?-- That's right.

And the common opinion appeared to be that it was in the patient's interests that she be moved to Brisbane so that she not undergo the risk of surgery at the hands of Dr Patel?-- That's correct.

Okay?-- I think it was probably - it was almost like bringing it out in the open and - in terms of our concerns, and I don't know that - while each of us had individual concerns about various aspects of his management, this was sort of an incident that the nurses were able to observe collectively, that a large number of senior doctors were of this opinion, and my view is that this galvanised subsequent nursing initiatives.

Okay. But without that intervention, it seems there would have been a real risk that this patient may have undergone surgery at the hands of Dr Patel which may have even involved a Whipples procedure?-- Well, I don't think he could be anywhere near as confident, though, it was a primary tumour in the small bowel. That's a very rare condition and there would probably be one of those for every 10 tumours that are invading from nearby structures, and I was concerned that he may well have the intention of resecting a small intestinal tumour but the odds are when he got there he would find it would be more complex than that and he might head off and do a more major procedure that would lead to difficulties. That happens when a surgeon starts an operation thinking he's going to do a particular thing and then discovers things aren't the way he thought they were, and so one thing leads to another and he ends up doing a more major procedure than initially intended. That's what I felt in this case.

But even on Dr Patel's provisional diagnosis it would have been quite major surgery?-- It would have been major surgery

because of the location of where it was. If it was - had been in a lower location in the intestine it would have been well within the scope of a general surgeon to handle at Bundaberg, but in view of the location of where this tumour was, low - there was a very high risk that it would entail more than he intended.

Yes. Ms Stumer identifies these events as occurring on the 16th of March 2000. Would that be in accordance with your recollection as to about when they occurred?-- Where is that date in relation to when the incident was tabled in Parliament?

It was one week before?-- Yes. Then that would be right.

Okay. We have heard some evidence, indeed, there'd been an undertaking given by Dr Patel and Dr Keating to Dr Gerry FitzGerald, the Chief Medical Officer, concerning the scope of surgery to be undertaken by Dr Patel, and that had occurred some one month before that. Was that raised as a matter of discussion with you at all when you spoke to Dr Keating?-- No. I had no knowledge of that.

Apparently that may relate to an oesophagectomy?-- Yes.

And a Whipples procedures?-- I don't think staff were generally aware of that. I certainly wasn't. There wasn't - a memo was never circulated saying, you know, "Surgery in the hospital is going - from now on will be restricted to this.", and I never received in any advice of - you know, what surgery could and couldn't be done. So I don't know how widely that was known. It certainly wasn't knowledge that I had.

As far as you viewed the events of mid-March this year, if it had not been for the active intervention and cooperation of yourself, Dr Miach, and the nurses of the Intensive Care Unit, this patient would have undergone surgery by Dr Patel?-- I think that was certainly the intention. I have no doubt that would have proceeded.

All right. Now, just in relation to this patient, the Woodruff Report - you are aware of a report?-- Yes.

It deals with P48 at page 133 table 6 and the only description given - well, excuse me, table 6 is a table headed, "Patients where clinical management was considered reasonable". So it's one of those cases where Dr Patel was given the all-clear. The description given is, "Hyperemesis secondary to a duodenal tumour, multiple co-morbidities." That sounds accurate?-- Yes, it does.

"Appropriate transfer." Now, it's fair to say that when one reads that part of the report, the appropriate transfer had nothing to do with Dr Patel's clinical judgment, did it?-- No, it didn't.

No.

COMMISSIONER: And I take it, Mr Allen, you don't mean that as criticism of Dr Woodruff as the author of that report? Obviously there would have been nothing on the files, for obvious reasons, to show that the patient was being deliberately excluded from Dr Patel's tender mercies.

MR ALLEN: That's so. I suppose it's one of those instances that can demonstrate the limitations in undertaking a clinical audit based only on records, because you have been able to reveal - and so have certain nurses and Dr Miach - facts which put a - which provide the real picture as to what was happening?-- Yeah. The medical record obviously can't contain all of the transactions that occur in clinical management.

Now, you have agreed with my learned friend, Mr Morzone, that a description in the letter written by Toni Hoffman over conversation with yourself is a fair and accurate one?-- Yes.

That was a conversation, I suggest, which occurred about the day after the death of a patient, Mr Bramich; that's so?-- Yes, I believe so.

You actually came upon Ms Hoffman in her office. She was in tears?-- Yes, that's right.

And she had a detailed conversation with you about her concerns regarding Dr Patel?-- I believe she did.

And you told her that when you had difficulties like that that you would go and speak to Dr Thiele because he was something of a mentor?-- That's correct.

And you told Ms Hoffman that you would go away and talk to some other people before getting back to her?-- I did.

And a couple of days later you came back to her and said, "There is widespread concern, but no-one is willing to stick their neck out yet."?-- That sounds like something I'd say.

Do you recall who you consulted?-- I believe I talked to Dr Miach, Dr Anderson and Dr Thiele. I may have spoken to others but I'm not certain, and I think that - you know, the impression I gained was that they had concerns about his performance, that they were aware of specific areas where they - they had concerns about his surgical competence, but they didn't feel that the circumstances warranted - you know, a greater concerted approach or - because - I mean, whatever we did would have been to have - you know, we thought would have been accepted as a challenge by management, we would have been stepping into their territory, and I think there was a hesitancy to interfere with the hospital administration.

Okay. So, you didn't consider that it would be helpful to take a delegation to Dr Keating, for example, to express these widespread concerns?-- Well, I didn't want to go on my own. You know, the evidence that I had available to me at that time was a small part of the bigger picture obviously that we were

all becoming aware of now, and I think that was true for each of the others, and none of us, I don't think, were aware at that time of - you know, the extent of concerns that would have accumulated if all of these individual pieces or individual pictures had been put together. So individually none of us were - felt compelled to - you know, make a - you know, a formal confrontation with either Patel or with administration. I guess we were all a bit - we were all a bit sunburnt by the concept of taking concerns to administration, and I think that Peter Miach had conflict with administration that had gone back for quite a few months regarding issues of the rostering of junior medical staff and a whole list of issues that we felt, you know, administration couldn't or wouldn't deal with, and, you know, to raise another issue would be to invite, you know, more frustration on our part.

So, you felt that there was a very real likelihood that management wouldn't be responsive to such a concern?-- I think there was a sense of complaint fatigue, you know.

COMMISSIONER: Doctor, did you know from Dr Miach that he'd already raised concerns with management about the catheters?-- I was aware of that, yes. But that was sort of - that was cut and dried. You know, that was a problem that had been dealt with. We didn't dwell on it or contemplate that.

No?-- I was thinking about in terms of the complaint. I mean, there were other - there were other concerns that were active at the time and they had to do with resourcing in the medical services and the rostering of junior staff and issues like that that were the topic of our daily conversations.

I was thinking of it from a different viewpoint, that when Dr Miach went with his concerns about the catheters, it's easy to document and set it out and put in black and white-----?-- Yes.

-----your concerns?-- Yes.

And really what I seem to be hearing from you is that largely the concerns were rumour and innuendo and scuttlebutt with everybody knowing one or two specific instances but no-one has done the exercise of putting it altogether to make out a case?-- Yes.

MR ALLEN: Quite apart from any feeling that perhaps management mightn't be responsive to concerns in any event, was there any worry that management might be responsive in the sense of responding negatively?-- To the - to us as complainants?

Yes?-- No, we were fairly realists about that. We're not - the people I talked to are older people in their careers and, you know, if they got sacked tomorrow they wouldn't worry about that, and some of my colleagues are in private practice so there wasn't a sense that - you know, our careers would be jeopardised or - you know, we would be short of bread on the table.

It was really more of an assessment that there wasn't any point?-- Yes. We - I think we felt that there wasn't a sufficient case to mount at that time.

Okay. Look, just one final matter, it's not-----?-- The other point I'd like to add to that is that I also felt that it wasn't my primary responsibility to - you know, I would be seen as stepping outside of my area if I was to - I mean, this is - I'm not a clinical director, I'm not a Director of Medical Services, I'm just one of the VMOs, and I felt that I was sympathetic to Toni Hoffman's concerns, but I - you know, I wasn't - you know, a clinical policeman in the hospital.

You would have been credentialed and privileged in your capacity with the hospital through a process of credentialing and privileging?-- The history of credentialing at the Bundaberg Base Hospital, as far as I'm aware, was the responsibility of the Director of Medical Services pretty much for the first 10 years I was there, and I can't remember there being a formal committee that did that. It was usually the medical superintendent would look at the CV, he might discuss it with other colleagues, but I don't remember ever receiving correspondence from hospital administration to say I have been credentialed and so on. Up until about some time, perhaps in the last - might have been this year or six months ago, when the process of formal credentialing was introduced I was asked to be on the credentialing committee as a representative of the College of Physicians, in that area, and when I attended the committee at the stated time I was advised that there were, in fact, multiple committees and that the committee I was on was the Medical Paediatric Committee and that there would be another committee dealing with surgeons and another committee dealing with obstetrics and gynaecologists, and I don't have a feel for how many committees there were, but we only directed our attention to physicians and paediatricians at the Bundaberg and Hervey Bay Hospitals. It was - we had representation from the Harvey Bay Hospital at this meeting.

So you weren't aware of any formal process of that nature existing in 2003 or 2004?-- I'm not aware that there was a formal process prior to 2004.

Were you aware that Dr Patel hadn't been credentialed or privileged?-- Well, no more or less than any of the others.

Right. Okay. Look, just one final matter, in paragraph 8 of your statement-----?-- Yes.

-----you didn't have any personal involvement in any type of correspondence or negotiations that might have occurred between management and the union in that regard?-- No, I didn't.

Okay?-- This was an explanation that was - that was given.

By whom?-- By other staff, I think. I don't think it came from management at all.

Okay. Yes. And-----?-- There was no - there was no letter of explanation. We all gave up two days of our clinical practice to attend this meeting in a community setting and we talked and we talked and we talked, and then a week later we were told it wasn't going anywhere.

Okay. But as far as the details of any reasons behind that, you don't have first-hand knowledge?-- I don't, no.

Thank you.

COMMISSIONER: Ms McMillan?

CROSS-EXAMINATION:

MS McMILLAN: Many of the matters I have have been clarified now and I am indebted to my friend Mr Morzone with the chart.

Dr Strahan, as you know I represent the Medical Board. My name is McMillan. Just one matter I wanted to clarify in relation to P230. You indicated, I think, after having looked at your statement at paragraph 19, you indicated she died in the post-operative period. You indicated when you had revised your statement. After looking at the chart you were unclear when, in fact, she did die; is that correct?-- I had advice from nursing staff that this particular patient had died in the post-operative period.

Yes?-- And I was unaware that the patient had survived to leave hospital until I looked at the chart this morning. It seems in retrospect that we must have had a - the nurse who said this to me must have been referring to another patient and we had a crossed wire there.

In fact, does the record show that she was transferred to Biggenden Hospital; is that correct?-- Yes.

All right. And is that - why did you say you were unclear about when, in fact, she did die?-- I thought I knew when she died.

Yes?-- But the chart demonstrates that I didn't know.

Yes, all right. Thank you. Thank you, Mr Commissioner.

COMMISSIONER: Thank you. Mr Diehm?

MR DIEHM: Yes, thank you, Commissioner.

COMMISSIONER: Dr Strahan, Mr Diehm represents Dr Keating. He has some questions for you.

CROSS-EXAMINATION:

MR DIEHM: Doctor, you have participated, I gather, in an interview prior to giving your evidence in these proceedings with representatives of the CMC and as-----?-- That's correct.

-----well as the Commission?-- Yes.

Doctor, the Commission's made available to some of the parties - those who have requested it - transcripts from that interview. So I just want to ask you a couple of questions, if I may, about things that you may or may not have said during that interview process. The first of them concerns your meeting with Mr Leck and Dr Keating which at the time of your interview you had thought was a meeting that happened in late January or early February. You aware of what I'm speaking of?-- Yes, that's correct. That's what I told.

And you now realise that that was a meeting that seems to have taken place in November?-- I think I was reading a transcript where it was mentioned the proximity of that meeting to receipt of Toni Hoffman's letter and it seemed to suggest a period earlier than I'd remembered, and so I rang the secretary in the administration at Bundaberg Base Hospital and asked for her confirmation from the diary, what the date of that meeting was. She advised me that it had occurred on the 6th of November 2004, and I would accept now that that is the date that we did have the meeting.

Okay. And it's the meeting that resulted in the file note Dr Keating prepared that's annexed to your statement?-- I didn't hear that, I'm sorry?

COMMISSIONER: It's the meeting reflected in Dr Keating's file note that's attached to your statement?-- That's correct.

Yes?-- I agree with that as a record of the meeting.

MR DIEHM: Yes. In your interview, I suggest you told the investigators something additional about what was discussed at that meeting, and that was after you had made your reference as recorded in the file note to the patient who had undergone what you understood at that time to have been Whipples procedure?-- That's correct.

And with respect to what you told Mr Leck and Dr Keating about, it's, I suggest to you, said during this interview, "And I made the point to them that it wasn't - you know, a greatly damning sort of incident and the patient would have died anyway, and I didn't think the incident on its own - you know, warranted major concern. I didn't really talk to them. I had other concerns about Patel that I didn't really talk about at the time. I thought about maybe I should have said more but", and you were cut off at that point in time. Now,

forgive me, doctor, in reading that out to you I have skipped out a few ums and ahs and buts and other words that slip in, to the transcript at least, but in general effect is that what you told the interviewers?-- That's correct.

And you told them that because it's true?-- Of course.

You did tell Mr Leck and Dr Keating first - well, I should take this in several stages: you did tell Mr Leck and Dr Keating that you didn't think that this was a particularly damming sort of incident other that it warranted major concern-----

COMMISSIONER: I don't think it's necessary to go through it again, the doctor's already said that what you read out to him was what he told the CMC and that it was true.

MR DIEHM: Yes, thank you, Commissioner.

The next matter-----?-- Can I just enlarge on that point a little?

COMMISSIONER: Yes.

MR DIEHM: Yes?-- When I had the interview with Mr Leck and Darren Keating, they asked me a series of specific questions and said, "What do you know, individually, not hearsay, not anything else but what do you know about Patel's performance?", and I related to them this history and I said, "On the face of it, you know, as a single incident it wouldn't be, you know, necessarily of great concern, it doesn't sort of necessarily lay outside the range of what, you know, a normal surgeon might do of its own, and then the conversation didn't go very much further than that and I left and I remember as I was driving away from the hospital in my car thinking that I haven't really told them everything that I know or that I think about, they didn't really ask my opinion about him and they didn't really explore other areas of knowledge that I had about them, the questions were quite specific and I responded to them and I remember thinking later that they didn't really find out all that I know.

COMMISSIONER: And to be fair to them, you didn't push the information forward to them?-- No, I didn't, no.

MR DIEHM: Doctor, the file note that you've accepted as being an accurate record of the discussion starts with an introductory context by saying that Ms Toni Hoffman had made a number of allegations against Dr Patel, including some allegations about his clinical competence. It says you were asked to provide any comment in relation to these allegations because Miss Hoffman had named you as one doctor who shared similar concerns. Is that an accurate summary of the broad nature of the questions that was asked of you?-- You've tied me in a knot, Mr Diehm, because I've already said that I agree with that document and I've already said that I didn't feel that I had an opportunity or I didn't tell them everything that I knew about it.

Yes.

COMMISSIONER: I think to be fair, the knot isn't as tight as you might think because that's under a heading called

"Context" rather than purporting to be a verbatim account of what went on, but don't worry about getting tied in knots, all we want to hear about is your honest and best recollection of what went on?-- I had the feeling when I left the meeting that I wish I had said more. Whether I had opportunity to say more, I'm sure I did, but it - the situation didn't lend itself to it.

All right. Just so it's perfectly clear though, you don't blame either Mr Leck or Dr Keating-----?-- No, not at all.

-----for cutting you off?-- No, no.

Or preventing you from saying anything that you wanted to say?-- No, it wasn't inquisitorial.

No.

MR DIEHM: Thank you.

The next matter that I wanted to ask you about, doctor, arising out of your interview is where I suggest you explained to the interviewers that you were involved at a time in early 2004 in an audit of patient deaths in the Bundaberg Hospital; again, you need to speak your answer?-- Yes.

Thank you. Now, is it right to suppose that this was at a time that you were the Acting Director of Medicine?-- It would have been within that time period, but when we actually presented the audit, it would have been, I think by that time Dr Miach had come back.

All right. Well, what I suggest to you you said to the interviewers was, "There was one other issue I could tell you about is that on the medical service. We do" - perhaps that should be medical services - "we do an audit every three months and so - and it's rotated amongst the four physicians, so once a year I have to do something on an audit and we can pick up any subject we want to audit, and from January to March 2004, I did an audit on all deaths in the hospital and it was presented at our medical" - and the transcript is obscured, it just says "medical" and there was some other word, it wasn't picked up?-- "Medical meeting".

"On Monday, I think about March/April last year" - so that's 2004 - "so we went, we went down to medical records and we said we want all of the charts for all of the patients in this hospital for three months and so we had a stack of about 34, 35 charts." Now, I'll just pause there. Presumably there were more than 34 or 35 patients in hospital in that time, what was asked for was the patient charts for all of those patients who had died at that hospital; is that right?-- That's correct.

"And my PHO presented this report and there would be slides that remained on it, but the numbers as I remember it were there were about 34 deaths in the period, there was one obstetric death, there were about three or four ICU deaths,

there were two or three surgical deaths and there were about 26 medical deaths, and we looked through every chart and we didn't think that there was anything too untoward about it all at the time."?-- That's correct.

Now, when you say that's correct, correct both that you told the investigators that and what you told them is true?-- I certainly told the investigators that. I wish I could track down the particular overheads or slides that were made of that audit, but they're not available to me because the PHO who made them has left and taken his password with him, but that's how I remember it. Now, it may be that it was a two month period, it may have been a three month period, I think it was three months, and I thought it would have been intelligent if I'd inquired from the hospital how many deaths a year they have so that it would correspond to that period, you know, presumably on the basis of those numbers, the hospital has about 130 deaths a year, but that's as I remember it, those numbers.

All right?-- And I was impressed by how people end up on the medical ward before they die.

And doctor, the important thing from a point of view of the questions that I'm asking you is that your audit of all of these deaths, which included deaths from surgery, didn't reveal anything untoward as far as you could tell?-- No, that's correct.

Thank you. Doctor, you have mentioned in your evidence regarding credentialing and privileges that there was a committee that you were involved in that was established sometime earlier this year, maybe six months you said; was that during Dr Keating's administration?-- That's correct.

I want to ask you now about the circumstances surrounding the patient in March of this year, the one who you had concerns Dr Patel might end up performing a procedure on that would endanger the patient's life. You've explained for us in well and truly sufficient detail the development of your concerns and your involvement of other people in them as those concerns unfolded. I just want to concentrate upon your discussion with Dr Keating and make sure that there's no ambiguity firstly. When you spoke to Dr Keating, you didn't tell him, did you, that you had been engaged in - and I'll use this term without meaning anything improper on your part doctor, but in a conspiracy, as it were, with Miss Hoffman and Dr Miach and Dr Carter to keep this patient hidden from Dr Patel?

COMMISSIONER: Why don't we say a collaboration?

MR DIEHM: Yes, a collaboration, thank you, Commissioner?-- I can't remember.

I'll see if I can help you by putting the question in a positive context. What you told Dr Keating was about your clinical concerns for the patient and that you would be concerned if Dr Patel was to perform the operation because he

might end up performing an operation that was beyond himself and/or perhaps the hospital?-- Yes.

And without suggesting that there was absolutely nothing else discussed at all, that was really the thrust of your conversation with Dr Keating?-- I told them more than that. I said that my initial plan was to arrange for aerial ambulance transfer and once the patient was on the plane and had left Bundaberg, then I intended to advise Patel of what I had done, but I wasn't game to advise him before the patient had physically left the hospital and Patel - and Dr Keating said, "Well, you know, I think we can do better than that, I think I can ring him up and tell him and, you know, make sure that everything's okay." And I had - I rehearsed this joke a couple of times because I specifically remember telling Dr Keating that I thought that Dr Patel would hit me if I told him what I was about to do, so he knew that I wasn't willing to confront Dr Patel with this plan that I had.

Thank you?-- And that's why he offered to do it.

Thank you. Perhaps the point that I'm trying to clarify, doctor, is do you agree with my suggestion that Dr Keating was not at any time part of this collaboration to keep things hidden from Dr Patel?-- No, that's a fair comment.

Because the moment he was appraised of the clinical concerns that you had and the concerns about Dr Patel, he took a proactive stance in terms of dealing with Dr Patel directly?-- Certainly.

Thank you.

COMMISSIONER: And can you recall whether you mentioned to Dr Keating the fact, to use an even more neutral term, that you had the cooperation of Toni Hoffman and Peter Miach and I think also the Director of Anaesthetics, Dr Carter?-- I can't specifically remember whether I told him that. I'm inclined to think that I might have, but I don't know.

D COMMISSIONER VIDER: Doctor, what did you mean really then when you were talking about the fact that you were frightened about Dr Patel or you expressed the view that Dr Patel might hit you? You said previously that you didn't mean physically?-- Well, he had a reputation for, you know, standing in close proximity to people and talking to them in a loud voice and abrasive manner and I'd not encountered that from him previously, but I knew that it was his reputation that he was capable of doing that and I guess a lot of the staff there were - had reservations about confronting Patel.

You weren't inferring that he would hit you clinically by taking the patient to theatre as we've heard that he seemed to be able to do very swiftly?-- I felt that if I told him what my plan was, that he would somehow make it difficult for me, that he would interfere or take the matter out of my hands or.

MR DIEHM: Thank you, Deputy Commissioner.

Doctor, just for completeness, my suggestion to you is that Dr Keating - I'm sorry, my suggestion to you is that you did not tell Dr Keating about, as you describe it in paragraph 27 of your statement, this ruse between the senior people to keep that patient hidden from Dr Patel. I take it your answer is that you can't recall, you're not sure?-- That's correct.

Thank you?-- I could comment on that though, that in earlier transcript when you were talking to Toni Hoffman, you made the statement to her that on page 1491, day 14, "Now the other thing I want to ask you about Dr Strahan is concerning this patient it appears had been hidden in ICU, Dr Strahan I suggest to you, had in fact spoken to Dr Patel about this patient and told Dr Patel of his plans to have the patient transferred to Brisbane for surgery.", and that's a statement that you made to Toni Hoffman which I regard as incorrect.

I think I've been cross-examined, Mr Commissioner.

COMMISSIONER: No, but it's a valid point, if that's part of your case you should be putting it to the witness, and if it's not part of your case, no doubt you'll withdraw it at some stage.

MR DIEHM: Yes, I'll need to look back at it.

COMMISSIONER: Yes, of course.

MR DIEHM: Doctor, with respect to an earlier part of your statement, specifically paragraphs 12 and 13, where you talk about the role of Dr Keating as Director of Medical Services, firstly in paragraph 12, you express the view that, "Dr Keating was simply inexperienced in the role of medical administration necessary for the Bundaberg Hospital.", and you then go on to say that you "think that to some extent he was intimidated by specialists". Now, firstly, is your view about Dr Keating being insufficiently experienced for that job based upon his clinical background?-- What I understood of his clinical background, that's correct.

What did you understand about his clinical background?-- That Dr Keating undertook a residency at Royal Melbourne Hospital for a period of two or three years where he would have been a junior - an intern and then a junior resident medical officer; that he then undertook a period of time in the Army and during that time he worked in the emergency department of Townsville Hospital; that he then spent a period of time in East Timor as a medical officer and that he was then appointed to Medical Superintendent of a remote hospital in Western Australia, and my view is that during all of those appointments, he would have been in a relatively junior medical position, that he has never worked as a consultant in any of those roles, he would have had limited exposure to managing medical staff in a large complex setting, and on the basis of that understanding of his previous medical training, I felt that he would have encountered many medical situations in Bundaberg that he was not experienced with.

COMMISSIONER: Doctor, we might be having some trouble with the microphone. I wonder if the Court attendant can just twist it down a little bit so that it's not straight at mouth level or sit back, yes. Thank you.

MR DIEHM: And doctor, where you say that you think that to some extent Dr Keating was intimidated by specialists, what makes you say that?-- Because he didn't approach us in the sense that I never saw him on the ward, I never saw him in the Intensive Care Unit, he never attended the medical meetings, he didn't engage in casual conversation, he seemed to stay away from us and you had the impression that he was bunkered down, that all we did was complain and he wanted to stay away from us in case he encountered further complaints.

Now, such things are your impression, of course?-- Of course.

You can't say what was in fact in Dr Keating's mind? Again, you need to speak your answer?-- I beg your pardon?

You need to speak your answer; were you agreeing with my question?-- I missed the question, I'm sorry?

All right. These matters that you've mentioned about your supposition that he was intimidated by specialists are matters indeed just that, that you have supposed, you don't know what was actually in Dr Keating's mind?-- It's the most charitable interpretation I can make of his behaviour.

Which committee meetings are you speaking of when you say that Dr Keating did not-----?-- I mentioned meetings meaning medical meetings.

I'm sorry, medical meetings; yes?-- There's a Monday medical case conference and it has been the pattern for that meeting to be attended by a broad range of specialists; the Director of Obstetrics would often attend; the Director of Surgery would often attend; the Director of Intensive Care Unit would invariably attend, so not only was it a medical meeting but it encompassed, you know, virtually all of the junior medical staff in addition to many of the senior staff and, you know, I don't think Dr Keating attended that meeting more than once or twice that I can remember.

How frequently did you attend?-- It was every week.

And you generally attended every week?-- Yes, I did.

Commissioner, matters of impression of this kind are of course difficult to respond to fully.

COMMISSIONER: Of course, Mr Diehm, and I accept that you have performed your duty in putting an appropriate challenge to those aspects of the testimony. I don't frankly see how you could take that much further and you would certainly waste a lot of time trying.

MR DIEHM: Yes, thank you Commissioner, that's precisely what I was concerned about. Commissioner, in those circumstances, I don't have anything further. Thank you, doctor.

COMMISSIONER: Mr Chowdhury?

CROSS-EXAMINATION:

MR CHOWDHURY: Dr Strahan, my name's Craig Chowdhury, I act for Mr Leck. Could I take you to paragraph 6 of your statement about the vacancy of the hospital manager or District Manager? Do you have a copy of your statement there?-- Yes, I do.

All right. You make it quite clear in your statement that when Mr Marshall left, there was an expectation amongst the staff at the hospital that someone from within the hospital would take up the new position, either Dr Thiele or Kim Whitmell; that's what you say in your statement?-- I wouldn't say it was an expectation, I would say it was speculation, we realised that anybody could have been appointed district manager, but you speculate about the people you know.

Well, I used the word "expectation" because that's the word that you use in the first sentence at paragraph 6?-- Well, if I have the choice, I'd like to change it to "anticipation" or-----

COMMISSIONER: Yes, certainly?-- -----"speculation".

MR CHOWDHURY: Sorry, which is it?-- "Speculation".

COMMISSIONER: Or "supposition" or "anticipation" but something less than expectation?-- Yes.

MR CHOWDHURY: You say that there was not, as far as you were aware, any interview process or other selection process?-- That's correct.

I take it then you weren't aware of the fact that Mr Leck was in fact interviewed by the general manager of Health Services, Dr Youngman and some members of the District Health Council; that's news to you?-- Yes, it is.

Thank you. You know who I mean by Dr Youngman?-- Yes, I do.

And you make it quite clear that once it was announced that Mr Leck was coming from Mount Isa to be your new manager, that created considerable resentment, in fact, they were the words you used?-- That's correct.

And the feeling was in the hospital that head office was forcing someone on the Bundaberg Hospital?-- Yes.

So the point that the Commissioner made this morning is a fair one, even before Mr Leck started, he was well and truly behind the eight ball-----

COMMISSIONER: I'm not sure that I said precisely that, Mr Chowdhury.

MR CHOWDHURY: I'm paraphrasing, he had a hard act to follow was the point that the Commissioner was making, I'm putting it even more strongly, that he was really behind the eight ball before he really started; do you accept that proposition?-- I think there was a feeling that it wasn't a transparent process, nobody understood, you know, the process that had been involved, it looked like it was an imposition on us.

Yes. But as you've acknowledged now, you weren't aware of what the process was and so it makes those comments-----?-- Well, from what you tell me, it doesn't really sound like it was a selection process, it sounds like it was an interview process.

Yes?-- You haven't told me that there were other candidates that were considered or that they interviewed multiple candidates or that the position was advertised.

Yes. But all of this, these concerns led to the resentment that you mentioned; is that so? Is that putting it fairly?-- I didn't hear that, I'm sorry?

The concerns that you've just raised?-- Yes.

All contributed to this feeling of resentment about Mr Leck's appointment; is that a fair statement?-- Yes, that's correct.

Thank you?-- I don't think that resentment was shared by everybody in the hospital, but there certainly would have been some people would have felt that.

Well, did you feel it? Did you feel resentment?-- No, I - I'm more often amused by what Queensland Health do than resentful of it.

The last sentence of paragraph 6, at that time - that is, I take it, the time that the appointment was announced, you believe that Peter Leck was only in his early 30s-----

COMMISSIONER: It just says his 30s.

MR CHOWDHURY: On my statement - I'm sorry, I didn't realise there'd been a change. All right. You believed that Mr Leck was only in his 30s; was that from rumour or was that from meeting him for the first time or was that from some other source?-- I was advised of that and I felt that that was probably correct at the time.

Someone advised you that Peter Leck was in his 30s; is that so?-- That's correct.

And as a result of that, because he was in his 30s, was there then this concern he was too young and inexperienced for the job?-- I think that was one aspect among many.

I take it in a workplace like a hospital, there's all sort of rumour and talk going on, who's going to get the next appointment-----?-- Of course.

-----that sort of thing, and as you'd appreciate, a lot of misinformation gets spread around as well; that's so?-- That's often the case.

So at the time of Mr Leck's appointment was announced, you yourself did not know what actual experience he had; would you accept that?-- Yes, I guess we had some idea of it because Queensland Health was always quick to tell us the background of new appointees, but I wouldn't have known all of his experience, no.

Okay. I'm just trying to understand your statement there in the last paragraph - last sentence, I should say, of paragraph 6, "There was a concern that he was too young and inexperienced for the job."; does that simply come from his age because he was in his 30s?

COMMISSIONER: No, I think the doctor's already told you that that was just one factor amongst many.

MR CHOWDHURY: Well, what were the other factors, doctor, because you don't specify them?-- We understood that he'd been district manager in Mount Isa Hospital before he came to Bundaberg.

When you're talking about "we understood" who are you talking about? Are you talking about yourself?-- My colleagues.

When you're talking about your colleagues, are you talking about the other medical doctors?-- Medical colleagues.

Medical colleagues. Yes?-- And our understanding is that Mount Isa Hospital would not be - would not - would differ in a number of respects to Bundaberg Hospital.

It would be smaller?-- Very much smaller, and would have very different level of medical staffing.

Any other factors?-- No, that's all.

Those two, the fact that he was in his 30s and that he was coming from Mount Isa which was a very different hospital from Bundaberg; is that right?-- That's correct.

Thank you?-- But we - later on we acquired other concerns.

All right. Well, we'll deal with it step by step, doctor. You're obviously a very good friend as well as a professional colleague of Dr Thiele?-- That's correct.

What about Mr Whitmell; were you a good friend of his?-- I'd never met Mr Whitmell before he came to Bundaberg and I encountered him on a few occasions, so I wouldn't regard myself as a friend of Mr Whitmell's. I had great respect for the work that he did there and for the approach he had to his work, he was a very popular administrator in the hospital.

What about Mr Marshall? As well as being a professional colleague who worked in the hospital, were you also a friend of his?-- I can't remember ever having social contact with Mr Marshall outside of the hospital, but I would regard myself as a friend of his and the fact is that we had a lot of encounters in the course of our work.

Were you aware that when Mr Marshall left, the hospital's accounts were in a state that there was some 400 to $500,000 outstanding in unpaid accounts?-- I think that was a common circumstance amongst many hospitals in Queensland at that time.

And, indeed, was over budget to that amount?-- And I think that that was a common experience amongst many hospitals in Queensland at that time.

I take it from that, your answer, you were aware of that fact?-- Yes, we were.

Thank you. It became quite obvious that after Mr Leck became Hospital Manager, that there was this concern of Queensland Health to ensure that the hospital - all hospitals ran on budget. No question of that?-- That's correct.

That was a clear policy directive coming down from Head Office, wasn't it?-- A sensible one.

Yes. And were you aware that there was pressure on district managers to keep to budget?-- Yes, we all knew that. We were told repeatedly.

And-----

COMMISSIONER: Mr Chowdhury, I see it is 1 o'clock. Will you be much longer?

MR CHOWDHURY: I will be about 15 minutes.

COMMISSIONER: Mr Farr, do you have many questions?

MR FARR: I would have thought 10 minutes. Most of what I wanted to ask has been asked.

COMMISSIONER: Dr Schulz, you had questions?

DR SCHWARTZ: I would only be about five minutes.

COMMISSIONER: Mr Morzone, we have another witness planned for today, don't we?

MR MORZONE: We do. Mr Tait, I think. He will probably be relatively short, I think, on the whole, although there's obviously commitments to travel to Townsville today by a number of persons here.

COMMISSIONER: That's my concern. Look, I'm going to say this

and risk the enmity of people at the Bar table: would everyone be agreeable to having a very abbreviated lunch - say, half an hour - and coming back at 1.30?

MR FARR: Yes.

COMMISSIONER: Is that acceptable? Okay. I got away with that. We will have a break now and resume at 1.30.

THE COMMISSION ADJOURNED AT 1.02 P.M. TILL 1.30 P.M.

THE COMMISSION RESUMED AT 1.36 P.M.

DR A SCHWARTZ, President of the Australian Doctors Trained Overseas Association, appeared for the aforementioned Association

THOMAS MARTIN STRAHAN, CONTINUING:

COMMISSIONER: Whilst we are waiting for Mr Chowdhury, perhaps, Mr Schulz, you would like to take the floor?

DR SCHWARTZ: Thank you.

COMMISSIONER: Come through to the microphone so everyone can hear you. Mr Schulz represents the organisation called the Australian Doctors Trained Overseas.

DR SCHWARTZ: My name is Andrew Schwartz, S-C-H-W-A-R-T-Z. I'm the President of the Australian Doctors Trained Overseas Association. I have a couple of very quick questions, if I may ask of you, doctor?

CROSS-EXAMINATION:

DR SCHWARTZ: Number 1, your story sounds remarkably alike to what happened at Campbelltown and Camden Hospitals in New South Wales - of patients dying, of patients not being treated properly - and there was some fairly lengthy inquiries held in New South Wales prior to the Dr Patel case. To your knowledge, did Queensland Health - Bundaberg Hospital - make any attempt to learn lessons from what happened there?-- Well, I'm sure we will.

But it didn't happen yet?-- Well, I think it is happening as we speak.

No, but in the meantime, as it was happening in New South Wales, and the reports were released, no attempt was made within the New South Wales - within the Queensland Health system to learn lessons from what happened in New South Wales; would that be correct?-----

COMMISSIONER: I think, Mr Schwartz, in fairness, this isn't the right person to be asking the question. I realise you haven't been here, but, for example, last week Dr Fitzgerald from the Department was here, and it would be fairer to ask someone who was involved in administration, rather than someone on the outside.

DR SCHWARTZ: My apologies, Commissioner. I will leave that point.

COMMISSIONER: Yes.

DR SCHWARTZ: Were you aware of Dr Patel personally - were you aware of any of the circumstances leading to his appointment?-- No, I don't know of any of those circumstances, other than perhaps I could comment that the hospital was desperately short of surgical staff at the time he was appointed.

Because I - our organisation, we deal a great deal with the recruitment of doctors - overseas trained doctors into Australia, so I have come to know a fair bit of knowledge about it. If a doctor from the United States, a surgeon, is willing to come to Bundaberg Hospital for $90,000 a year, to me the alarm bells would start ringing. Why? Do you have any knowledge of that?-- At the time Dr Patel came, another American surgeon also came to the hospital who has proven to be a very successful surgeon, and - so, I don't think that alone is an indicator of concern, necessarily.

One final question: I have a letter from the Queensland - well, Mr Nuttall's office, the former Queensland Minister For Health, stating that Dr Patel was never registered as a specialist in Queensland. Again, you may not be the right person to ask this question, but just how, to your knowledge - how could a person not registered as a specialist be allowed to undertake these highly complicated procedures?-----

COMMISSIONER: That has been thoroughly canvassed already.

DR SCHWARTZ: My apologies.

COMMISSIONER: Thank you for your questions. Mr Chowdhury?

MR CHOWDHURY: I apologise.

COMMISSIONER: Not at all. We put the time to good use, as you can see.

CROSS-EXAMINATION:

MR CHOWDHURY: I want to take you to paragraph 7 of your statement, doctor, where you say in the first sentence you observed Mr Leck had difficult relationships with several of the various executives. Who, in particular, are you referring to amongst the various executives?-- I was referring to the Director of Medical Services at the time, the Director of Corporate Services and the Director of Nursing Services.

Director of Medical Services at the time. You mean at the

time when Mr Leck first started?-- That's right.

Was that Dr Thiele?-- That's correct.

That was simply something that you observed. One would have to speak to Dr Thiele himself about how his dealings went with Mr Leck; do you accept that? You would accept that? You have to speak your answers, I'm sorry?-- I think there was considerable evidence to suggest that, in terms of things that Dr Thiele would say and what other staff would say.

But as to Dr Thiele's personal dealings with Mr Leck, one would have to talk to Dr Thiele about that; do you accept that as a proposition?-----

COMMISSIONER: Well, we have had evidence already from Dr Thiele. It is obvious that Dr Strahan can only give evidence based on what he saw and observed.

MR CHOWDHURY: Thank you. You mentioned the Director of Corporate Services. Was that Mr Whitmell?-- He was acting in that capacity initially.

The Director of Nursing services, was that Ms Glennis Goodman?-- That's correct.

You conclude that paragraph by saying that in the first couple of years after Peter Leck's appointment, several senior executives departed and the place became unsettled. You are aware, aren't you, that Glennis Goodman retired?-- You know, Queensland Health have sort of told us those stories before. I had the opportunity to talk to Glennis Goodman and I had a better understanding of the reasons she gave. Are you aware that she's still working as a nurse at the Gin Gin Hospital, for example?

I should just explain something to you, that you really can't ask questions of me. I'm asking questions of you. What I was asking was was your understanding that she had retired?-----

COMMISSIONER: I think the answer is entirely responsive. The witness has made it clear that he doesn't accept it was a voluntary retirement, given the fact that Ms Goodman is now still working as a nurse at a different hospital.

MR CHOWDHURY: Who else do you refer to in respect of that last sentence? You say several senior executives departed-----

COMMISSIONER: It is covered in the preceding sentences. Dr Thiele, who was Director of Medical Services, and the Director of Corporate Services, ^ Ken Whitmell. Is that who you are referring to?-- Yes.

MR CHOWDHURY: So, these three - Dr Thiele, Whitmell and Goodman; is that correct?-- That's correct.

I just wanted to clarify who precisely you were referring to.

Can I take you to paragraph 12? I'm sorry, it is paragraph 11 of your statement. This is about the meeting that occurs when the Health Minister visits town and Dan Bergin and the Director-General were present. You say, "I understood that Peter Leck endorsed those views because he was visibly angry during the meeting." Are you meaning to say that because he appeared angry, he was endorsing what the Minister was saying? Is that what you are conveying there?-- I formed the view that he was angry with me and that he agreed with the Minister that I shouldn't have spoken to the newspaper or I shouldn't have expressed the views that I did and I think that was probably a turning point in my relationship with Peter Leck and he was visibly annoyed that I had made complaint about his hospital.

Well, let's take it one step at a time. You say you formed this view. I take it you formed that view from nothing that was said by Mr Leck or nothing that was put in writing for Mr Leck; simply that he appeared angry during the course of this public meeting; is that right?-- I had reason to think that the view was reinforced by later conversations and behaviour.

Well, I can only go from what you say in your statement, of course?-----

COMMISSIONER: Mr Chowdhury, you have challenged that and the witness has said it is not only what took place at that meeting, it was later conversations and behaviour as well, so he can go from that also.

MR CHOWDHURY: I accept that, but I'm taking it step-by-step, Commissioner.

COMMISSIONER: Yes.

MR CHOWDHURY: What you are referring to in paragraph 11 of your statement is, in particular, the views expressed by the Minister, and you understood that Peter Leck endorsed those views because he was visibly angry during the meeting. That's what you say in your statement; do you accept that?-- Mr Chowdhury, when this statement was put together, it was drafted by one of the Counsel Assisting and sometimes the language isn't language I might have used myself, but I agree with everything in the statement and what I'm saying now is that I formed that view about - on the basis of Peter Leck's demeanour during the meeting and in terms of subsequent behaviour and conversations.

When you talk about "subsequent conversations", are you able to be specific, because there's no reference to any subsequent conversations in your statement?-- Are you suggesting I didn't have that view?

No, no, I'm asking you, can you be specific about these subsequent conversations because there's no reference to any subsequent conversations?-- No, I have a hazy memory going back that far and I can't remember any other specific events

that supported that view.

Thank you. Look-----

COMMISSIONER: Did Mr Leck ever distance himself from what had been said by the Minister? As I understand from your statement, the Minister was specifically critical of you for having spoken to the press. Did Mr Leck ever distance himself from that? I'm not saying he should have or he needed to, but was there ever a comment from him that he didn't agree with what had been said?-- No, not at all.

MR CHOWDHURY: Can I just raise this issue of a waiting list - and correct me if I've misunderstood your evidence given earlier today - but you made the comment that you thought that there was too much focus being put on waiting lists?-- Well, perhaps not too much, but I felt it was disproportionate to the concern that Queensland Health and the local hospital had on a whole range of important medical issues, and it seemed that we were always focusing on waiting lists to the detriment of other issues.

The issue of waiting lists had a problem at least as far back as 1997 before Mr Leck arrived when Dr Thiele was Medical Superintendent; is that so?-- Waiting lists have always been a problem, certainly in the last 10 years.

In particular, back in 1997, were you aware that both Dr Nankivell and Dr Anderson have expressed considerable concern about the waiting lists for diagnostic procedures such as endoscopies and colonoscopies?-- Yes, just a comment on that. Endoscopies were excluded from the waiting lists. They weren't considered in the same category, but we felt that was an artifice because we felt they were equally important, if not more important than a lot of other surgery that did attract waiting list status, and we could never understand why the endoscopies were relegated to a different category when they weren't taken into account in the reported waiting lists.

COMMISSIONER: Indeed, doctor, it has been suggested to us by Dr Molloy from the AMA that it's a system of manipulating the figures so that if a patient is referred by a GP for a procedure, most people would think that you go on the waiting list the moment you are referred by a GP, but, in fact, the waiting list doesn't begin until you have seen a specialist, and if you are going to have a diagnostic procedure such as an endoscopy or a colonoscopy, the waiting list doesn't begin until you have had the diagnostic procedure, got the results back and seen the specialist a second time. So, the suggestion is this is an artificial way of making waiting lists shorter than they are?-- I agree 100 per cent with what you say but there's another issue as well and the additional issue is that whereas orthopaedic joint replacements, hernia repair, various surgical procedures were taken into account in surgical waiting lists, endoscopies were excluded from that list, so when we report waiting lists, we are not talking about endoscopies. They didn't even rate a mention. When the hospital was given additional funds for lowering the waiting

list, endoscopies weren't regarded as part of that effort to reduce waiting lists. They were considered as a sort of non-surgical event, or they weren't taken into account, and to give you an example of that, we put a proposal to hospital administration in about 1999 or thereabouts that we would have an "endoscopyathon", and we would set aside a Saturday, we would do 50 gastroscopies on that day. I think the waiting list was probably 150 or thereabouts, and we could do 50 in a day. We would have a roster of three surgeons. We talked to the nursing staff. They would come in. We talked to junior medical staff. We would do it at no cost. You know, we were concerned about the waiting list and we offered our services free of charge. We thought it would attract some media exposure and perhaps create some goodwill in the hospital. We felt it could be done without compromise to patients' welfare or the quality of the procedures that would be offered, and we would wipe out half the list for endoscopies that were there, and the hospital administration declined to accept that offer, and I don't understand the reasons they had, but it just reiterates the point that endoscopies didn't rate.

I have asked other witnesses this, but I would like to have your input as well; my impression, as someone outside the medical world, is that endoscopies and colonoscopies are probably the two most important procedures, with the possible exception of mammograms, for the early detection of potentially fatal cancers?-- That's true.

And it is a recipe for disaster to have people waiting literally years to have those diagnostic procedures?-- That's absolutely correct, and the waiting list at that time in Bundaberg Base Hospital for these procedures exceeded 12 months - the routine procedures.

D COMMISSIONER EDWARDS: Did they give you any reason why any such a program shouldn't be-----?-- I wasn't given a reason. It was just regarded as-----

Too hard?-- It wouldn't have made any contribution - it would have incurred costs, but no income benefit. It would have incurred some cost to the hospital because they would have had the pathology to interpret - the biopsies that we would have taken - there would have been some consumables that would have been used, and, no, it was never said, but I assume the concern was that it would generate cost without any monetary benefit because it - it wasn't considered as the elective surgery for which bonuses were paid.

COMMISSIONER: Whereas if you had been doing a "Whipple's-athon", that would have reduced the waiting lists and brought more money into the hospital and that would have had support?-- It would have had benefit in their elective surgery targets.

Yes, Mr Chowdhury.

MR CHOWDHURY: You made it quite clear in your evidence earlier this morning that during the time that my client was

at the hospital, and when Dr Wakefield came on Board as Medical Superintendent, and then Dr Keating, that there was this clear pressure from Head Office for the administrators to follow what you call the "letter of the law"?-- Mmm.

And it was quite obvious to you that those administering the hospital were anxious to be compliant with policy and procedures?-- They certainly gave us all that impression.

Look, I do have to raise this with you, and this is your suggestion - sorry, your statement - that five out of the eight medical directors were forced out. This is in paragraph 10 of your statement. Five out of the eight clinical directors at the hospital were forced out of their positions and this was soon after Dr Wakefield was appointed. Who are the five?-- Pitre Anderson, the Director of Surgery.

Yes?-- Dr Malcolm Stumer, the Director of Obstetrics and Gynaecology.

He is still at Bundaberg?-- He was forced out for two years.

He was suspended on pay for two years?-- He was told not to step foot inside the hospital.

Who is the third?-- Dr Marsh May, Director of Psychiatry.

Yes?-- And Dr Gavin Cooper, the Director of Pathology.

Right?-- And myself as the Director of Medicine at that time.

Now, in respect of Dr May, were you aware of a review being conducted by the Director of Mental Health, Dr Peggy Brown, into psychiatric services at Bundaberg Hospital when Dr May was director of that unit?-- I'm aware that Queensland Health has a view about the circumstances relating to Dr May's leaving the hospital.

Sorry, my question was were you aware of the review done by Dr Peggy Brown?-- I don't specifically recognise the name, but I was aware that reviews were in progress at that time.

I take it you were friends with all of those five - four people you mentioned?-- Of course, yes.

As well as being a professional colleague?-- Yes.

Look, can I just make this clear: with respect to patient 220, which you first raise at paragraph 16 of your statement, do I understand that you did not raise your concerns about patient 220 with anyone in management until the meeting of 2 November 2004? When I talk about "management", I talk about my client, Mr Leck, and/or the Medical Superintendent, Dr Keating?-- No, I didn't have any communication with them about that.

It is quite clear, as one reads your statement, that at the very time - that is, June 2004 - you obviously had genuine

concerns about this patient and the way Dr Patel was proceeding with her; is that correct?-- Yes, I did.

The first initial concern was looking at the CAT-scan where obviously he had misread the CAT-scan; is that so?-- That's correct.

And the other concern was even though, as it turns out, the Whipple's procedure may not have been performed or wasn't performed, the fact that he was suggesting performing such a procedure raised concerns with you because you didn't believe that that should be performed at Bundaberg?-- That's correct.

COMMISSIONER: But I think between those two, you had another concern, and as you told us you were concerned that he wanted to go ahead with the operation on the assumption that there was a - the CAT-scan showed a problem that didn't exist. So, he wasn't prepared to change his proposed procedure, despite having had his error pointed out to him?-- That's an interpretation of mine of his behaviour at the time.

Yes.

MR CHOWDHURY: I believe your evidence earlier was that you wouldn't have thought that any surgeon would have operated to do that exploratory -----?-- No, that's correct, I don't think another surgeon would have.

You didn't raise any of those three issues with anyone in management at that time in June 2004?-- No, I didn't. My experience has been that other specialists often interpret clinical circumstances differently to myself and over the years people have done things that surprise me and my approach has been to accept one or two of these circumstances in the course of things, but, you know, when it becomes a repeated or - you know, you don't give people a second chance. So, I would have been more concerned by repeated episodes of that.

Thank you. I just want to check my notes, doctor. You have worked in the medical profession now for many years and I haven't thoroughly gone through you CV but you have worked at hospitals other than Bundaberg?-- Yes, I have.

And a hospital is a busy place with lots of people working there, doctors, nurses, support staff, that sort of thing?-- Yes.

And from time to time conflict can arise in the workplace?-- Of course.

And it's a simple fact of human nature that not everyone gets on with everybody else from time to time. That's so?-- Of course.

That doesn't reflect on anyone's individual competence or ability, it just indicates a very basic fact of human nature. Do you accept that?-- I'd accept that.

I have nothing further, thank you.

COMMISSIONER: Thank you, Mr Chowdhury?-- Can I just - before we leave, Mr Chowdhury, can I make a comment about your client, that I would like to say that my view of Mr Leck is that he's no longer young. He's not as young as when he came to Bundaberg and he's no longer inexperienced. He's been in Bundaberg for seven years now and you might take the view that I have been highly critical of Peter Leck but, in fact, I'm not and I have considerable respect for his role as a District Manager and, you know, I think that this circumstances of his appointment and some of the early decisions he made early in his tenure were unfortunate, but I think in recent years I have developed a respect for his role in the hospital.

MR CHOWDHURY: Thank you.

COMMISSIONER: Thank you for that, doctor. Can I ask you about two other things arising from Mr Chowdhury's questions, and it may be that Mr Chowdhury wants to follow this up. A lot of his questions asked you whether you were friends with particular people. Has your evidence in any way been influenced by your either your friendship or enmity towards individuals?-- As far as I can understand one's own motivations, I'd say no.

Thank you. You were also volunteering some comments about Dr Marsh May and that doctor's departure from psychiatry. Can you very concisely tell us what it was you wanted to say about that?-- Just - I missed that last-----

Very concisely, can you tell us what your understanding is regarding that doctor's departure from psychiatry?-- I had a conversation with Marsh May soon after the time that he left the hospital and I attended his going away party that was widely attended. My understanding is that he had conflict with the hospital regard - in relation to the management of the psychiatry unit. I think at the time of the review

changes were made to administration of the psychiatric unit. For many years, I think for 20 years, Marsh had been the head of that department and I think administrative changes were brought in where he was no longer the head of the department and an administrator was put into the psychiatric unit and Marsh became subject or answerable to this administrator, and my understanding is that that's where tensions arose and developed because of that change of management structure, and that he had frustrations with that and felt that his clinical capacity was compromised as a result of those administrative changes.

Well, whether or not that's true, that's the source of your understanding, that that was one of the five clinical department chiefs-----?-- Yes.

-----who left following Mr Leck's appointment?-- Yes.

MR CHOWDHURY: I'm sorry, I should make it clear, it says following Dr Wakefield's appointment.

COMMISSIONER: Yes, indeed, following Dr Wakefield's appointment. Mr Chowdhury, do you have any questions arising out of those two matters?

MR CHOWDHURY: No, I don't.

COMMISSIONER: Mr Farr?

CROSS-EXAMINATION:

MR FARR: Thank you, Commissioner. Doctor, my name is Brad Farr. I'm appearing on behalf of Queensland Health and I have just a few questions, you will no doubt be pleased to know, to ask you. You spoke earlier in your evidence of Mr Leck having some big shoes to fill when he replaced Bruce Marshall. Could I suggest that upon everything that we know it would seem that Dr Wakefield perhaps had even bigger shoes to fill in trying to replace Dr Thiele?-- That's true.

Dr Thiele would seem to have been someone that was very well regarded, a local boy, was held in the highest of esteem?-- Dr Thiele is the godfather of medicine in Bundaberg.

Fair enough. I daresay it would be very difficult to follow the godfather of medicine in Bundaberg?-- That's correct.

All right. So, he had his work cut out for him, I suppose, to start off with?-- He did.

Just taking up on a point that was just made a moment ago, after his appointment and within a period of some months - that's Dr Wakefield - there were the departures of the five clinical directors that you have just been speaking of. You

wrote to the paper, as you have indicated in your statement, and we have seen the attachment that you refer to, and it was, I take it, after that newspaper article that Dr Wakefield spoke to you and expressed his disappointment in some of the things that you wrote at least?-- I think he probably did.

All right. Can I just try and perhaps clarify one of the issues at least that Dr Wakefield was concerned about. Would it be true to say that one of his concerns was that the way the article appeared would or might tend to indicate that or allow the inference to be drawn that the resignations were in some way due to his administrative abilities? That was a concern he had? I'm not asking that was the intention, but that that was a concern?-- It was intended to draw attention to-----

COMMISSIONER: Sorry, Dr Strahan, Mr Farr isn't really asking you about what you intended in your own mind. He's asking you what Wakefield's complaint was. Did Wakefield complain to you that he felt the article conveyed that impression?-- Yes, I am sure that was his concern at the time.

MR FARR: All right. And just dealing very briefly with those five directors, Dr Anderson we have heard from, so I won't trouble you with him. Dr May you have just spoken of and I won't trouble you with those particulars, with the exception of this: do you agree that the management of the mental health service doctors was not the responsibility of the Director of Medical Services?

COMMISSIONER: Or don't you know.

MR FARR: If you don't know, please just say so?-- Yeah. I think it was an opportunity for the Director of Medical Services to be involved in every doctor in the hospital, and I would have thought that any doctor if he had a concern in his working environment would have had access to the Director of Medical Services or would have hoped that the Director of Medical Services would have acted on his behalf.

COMMISSIONER: Do I take it from your question, Mr Farr - sorry to take over your cross-examination - but is it the implication that Dr May's line manager wasn't the Director of Medical Services?

MR FARR: Yes, that's right. That's my next question. That might assist Dr Strahan. Can I suggest to you, Dr Strahan, that there was - and I can't give you the person's name - but there was a manager of Mental Health that reported directly to the district manager?-- That's possible.

Okay?-- I don't know whether that was always the case, though-----

All right?-- -----and whether that was a new innovation.

If I suggested to you that that was the position at the time of Dr May's resignation-----?-- And it may have been

contributory to his resignation.

I see.

COMMISSIONER: Is that the administrator you were talking about earlier-----?-- Yes.

-----that may have led to Dr May's resignation?-- Well, my understanding of events was that Dr May was in charge of the Mental Health Unit for many years and then an administrative change was brought about where a nonmedical person was placed in as the administrator of the medical - Mental Health Unit above Dr May, and so Dr May's role - his role changed significantly.

MR FARR: Look, I think you have answered the question perhaps as far as you are able to take it so we can move on. The Director of Obstetrics - and I won't refer to these people by name - and once again I'm not asking for details, but there were allegations in relation to competence which were subsequently investigated; that's correct?-- That's correct.

COMMISSIONER: That doctor was subsequently cleared?-- Yes. The director was suspended for two years and the circumstances of that suspension were that at the time Queensland Health was able to refer a doctor to the Medical Board if there was concern about his clinical competence. The Medical Board would suspend the doctor's registration and then Queensland Health then had grounds to terminate that doctor's employment. It could all happen very quickly. My understanding is that the AMA learnt that this was a pathway that Queensland Health was taking to easily dispatch of doctors that were a problem and the AMA intervened and pointed out to the Medical Board that Queensland Health was asking the Medical Board to do its dirty work for it, if you like, and so the Medical Board refused to suspend his registration and that then created a dilemma for Queensland Health in that they then had a greater responsibility to resolve the issues, and the investigation took a period - took over a two year period before it was finally - the director was reinstated in his position. I don't know if that's the correct explanation. That's the explanation we understood at the time.

MR FARR: Did you also understand that the investigation was conducted by these - I suppose it was the CJC in those days?

COMMISSIONER: The Criminal Justice Commission?-- No, I didn't have any knowledge of their involvement at the time.

MR FARR: I see. All right. And did you understand that there were a number of complaints?-- My understanding was that there were three-----

Just before you answer that question, can I just again make it clear I'm not for a moment attempting to determine the correctness of the complaints or otherwise. There's been an investigation. I'm just asking about the chronology, you see. That's all?-- I understood that there were three letters

written of complaint and that many of the staff in the hospital were familiar with the circumstances concerning those - that correspondence, and some of us had the view that there weren't strong grounds of - for complaint, and as I was president of the local medical association at that time I wrote to the Medical Board and inquired what opportunity there would be for medical doctors to make representation to the Board on the director's behalf. I received a reply from the Medical Board and I shared that reply with several senior doctors in Bundaberg at that time and I understand that seven senior doctors wrote to the Medical Board in support of the director.

Did you understand as well that litigation arose - may even be still pending, I am not sure - but it arose out of some of these matters?-- I think obstetrics is a prolific area of legal activity.

Certainly?-- I think over the years that there have been dozens of litigation events surrounding obstetrics at that hospital, as with many others.

Certainly. I take it, though, you would agree that a Director of Medical Services has an obligation to ensure that allegations of confidence or incompetence are properly investigated?-- It just seems a curious thing that - you know, there were four or five of these events that all coincided within a very short timeframe.

Yes, but in response to my question, I take it you would agree?-- I do agree.

All right. Thank you. The Director of Pathology, I think, was another director that you spoke of. Can I just suggest to you that there is a body known as the Queensland Health Pathology Service, which is a completely separate business unit within Queensland Health?-- Yes.

And that service is the organisation responsible for appointments, resignations, that type of thing, in that area?-- That's correct.

And that this Director of Medical Services has no role to play in that regard?-- Well, the Director of Medical Services was responsible for recruiting the pathologist concerned and it required a great deal of effort and there was some debate and differences of opinion regarding the appointment of a pathologist, and it seemed that Dr Thiele at the time was strongly pushing for that appointment and in support of that or a better appointment. The pathology service were dragging their feet on it. They weren't - didn't fit with the mood of how they wanted it to go, and as soon as Dr Thiele left it was expedient to - within a short time to terminate that appointment.

All right. Well, can I suggest this to you, that the resignation of that person had nothing to do with Dr Wakefield in his position at that time?-- Well, he didn't support the

idea to the extent that the previous Director of Medical Services did.

All right. All right. I take it that you don't know - well, can I ask it this way. You accept that the Queensland Health Pathologist Service might well have been the body responsible for whether that doctor stayed, left, resigned, didn't resign, whatever it might have been?-- They always were of the view that the appointment didn't fit with their model and - you know, the Director of Medical Service had some discretion to what extent they made a judgment about what was in the interests of the local hospital as compared with complying with Queensland Health policy.

Certainly. Finally, there was yourself, and just please correct me if I have dates wrong here, but you indicated your resignation. You sent a letter in July of 1999-----?-- July, yes.

-----resigning from the position of Director of Medicine?-- Was it July '99 or 2000?

Well, can I suggest-----?-- Because I think that we were recruiting Peter Miach to the position.

Well, that might just be the next point that I will make with you?-- And I was asked to submit a letter of resignation in my role as director to allow his appointment.

Right?-- But the reason that we recruited him, one of the reasons was that I felt that I couldn't continue in the role as Director of Medicine because I didn't have the support of the Director of Medical Services.

All right. I have given you the wrong date but still the right year. Can I suggest that your letter of resignation was dated the 14th of October 1999 but that you continued on as the Director of Medicine until Dr Miach was appointed in October 2000?-- That's possible.

All right. You resigned your position in October '99 stating that you were resigning in response to the hospital's failure to provide annual increment in your contract rate?-- I can't remember that.

I might ask you to have a look at this. It's a photocopy. It's got handwriting all over it, but you may recognise it. Does that refresh your memory?-- That's obviously my letter

and I can't remember the details but I presume there was some resolution of that issue because I did continue.

Yes. In fact, I was going to suggest to you that you were consequently paid at the increased rate and it was backdated?-- Yes.

Is that consistent with what you were - can recall?-- Yes, it kept me there for an opportunity to resign another day.

Well, in fact, you have stayed on as a VMO from then until the present time, as I understand it?-- I did have a gap of about nine months.

Yes, with a short period of time where you were absent. When Dr Miach was appointed, he was, of course, a renal specialist and I take it that the vacancy of the director's position enabled him to come into that hospital and take up that position?-- My recollection of early in the year 2000 was that I was working as the Director of Medicine, that we'd sorted out that issue.

Yes?-- And that I felt that I didn't have a close or trusting relationship with the Director of Medical Services at that time and that and as a result of that, you know, I was contemplating when I might leave. We had heard that Dr Miach might be interested in coming to Bundaberg and I had - I rang him up and talked to him and I participated in the process of recruiting him to Bundaberg and he subsequently flew up to Bundaberg and spent a weekend visiting and I drove him around and showed him the sites, we had a meal with Brian Thiele and Peter Miach and myself and we - and part of the bait that we used to recruit him was that we would offer him the position of Director of Medicine and I would step down from that position and it was our view that - it was my view that he probably wouldn't have accepted the position of nephrologist without offering him that additional position.

All right, and as I understand it, you volunteered to do that?-- I did.

As you say, as a bait to try and entice Dr Miach to come to Bundaberg?-- It was also in the context that I was unhappy continuing in my role of Director of Medicine given the present administrative structure at that time.

Certainly?-- And I felt that I couldn't act with enthusiasm in that role and I felt that it was happening at a time when all of these other directors were leaving and, you know, I felt a degree of discomfort with the medical administration at that time.

Right. The effect of it, though, was that Dr Miach did come to Bundaberg?-- Yes.

He took up that position?-- Yes.

You remained practising in Bundaberg?-- Yes.

And Bundaberg benefitted consequently?-- Exactly.

All right. Commissioner, I won't tender that document, unless you particularly need to see it?

COMMISSIONER: No.

MR FARR: Taking things back then to Dr Wakefield again and that newspaper article, he expressed to you, did he

not-----?-- The newspaper article or the AMAQ article?

Well, whichever was the article that concerned - that caused him to have concern?-- The AMAQ article, newsletter.

Thank you. He was concerned that the statement - planned statement that five of eight would allow an adverse inference to be drawn against him; I think you've agreed with that, because there were some stories - there are some reasons, there are some background that of course would be impossible to put into such a note; you'd agree with that?-- Yes.

Rather-----

COMMISSIONER: You agree that that was Dr Wakefield's viewpoint?-- Yes.

You're not agreeing that he's right?-- No.

MR FARR: And could it have been the case that he said to you - and I'm not sure if this was in writing or verbally and you can explain - clarify that for me, but could he have said to you when discussing this issue that he might need to take legal action or that he would take - sorry, take legal advice?-- His threat to take legal action was not something that he ever said to me directly that I can recall.

Right?-- There was something that was reported to me by other doctors in the hospital.

All right, so I take it therefore that it wasn't something in writing to you?-- No, of course not.

Okay. All right. Thank you. Can I ask you on a related but slightly different topic, it would seem that the hospital back in the perhaps the late 1990s had, in your view, a very experienced and senior team of clinicians and or administrators?-- Yes, it did.

There seemed to have been over a relatively short period of time, a changing of the guard, if you like?-- That's correct.

Involving a number of different positions?-- That's correct.

And my understanding of your evidence is that you're not intending to be particularly critical of the newcomers, but they did not possess the experience or the seniority of the previous title holders?-- Yes, that's - there's some merit to that-----

All right. And as a consequence-----

COMMISSIONER: Sorry doctor, did you want to add something to that?-- I just make the comment that in January 1999, Mr Leck awarded me an Australia Medal on behalf of Queensland Health for performance in the hospital, so you know, it wasn't as though there was, you know, in the first year or two that he came that there was, you know, antagonism or difficulty, so my

good run extended through to later in 1999.

Yes.

MR FARR: And do I understand correctly that your evidence is that administrative difficulties or problems arose at the time of the changing of the guard with the less experienced people; do I also understand your evidence to be that you're of the view that some of these problems might not have arisen had you had the original people still in place, for instance?-- I do have that view, but you're making it sound like, you know, it's on the strength of personal relationships or you know that-----

I appreciate that you have spoken of other matters?-- Yeah.

I'm just focussing on this because it's just something you raised earlier in your evidence, that's all?-- Yeah. My view is that we had very experienced people, and in a short period of time we had an influx of inexperienced people in administration.

All right?-- And I think that, you know, that created a lot of difficulties.

Can I ask you this also: you have spoken of just after lunch, in fact, of endoscopy and the elective surgery lists and waiting lists; do you have knowledge of the definition of "elective surgery" and what is incorporated within that term being a Commonwealth government definition? If you don't have such knowledge, then please say so?-- I think I know what elective surgery is but I'm not aware of the inter-relationship between State and Commonwealth funding.

COMMISSIONER: What is your understanding of elective surgery?-- Is surgery that somebody would choose to have done at their leisure or within a reasonable timeframe but not emergency surgery, so it's a time dependent indication.

We've heard one version that suggests if you can survive for 24 hours without the operation, it's deemed to be elective?-- Yeah. I don't know the specific definition of "elective surgery", my understanding is elective surgery is when you are booked into hospital to have it, you don't go into hospital through the emergency department to have elective surgery.

See, doctor, I have the impression there's a lot of confusion out in the community when people read about elective surgery, they think it's facelifts and tummy tucks and so on, but we've been hearing a lot of elective surgery which no-one would choose to have if they had an alternative?-- Yes.

Bowel resections and oesophagectomies?-- Yes, a Caesarian section is elective surgery, maybe.

So on any view, the community idea that elective surgery means something entirely voluntary and cosmetic or unnecessary is wrong?-- Certainly.

It's in most cases surgery that the patient needs to have but doesn't need to have with the utmost urgency?-- Yes, that's right.

D COMMISSIONER EDWARDS: And goes on a waiting list until the appropriate time is allocated?

COMMISSIONER: Or the inappropriate time?-- If it's a Caesarean section, there's no waiting list.

Yes.

D COMMISSIONER EDWARDS: Other than a Caesarean section?-- Yes.

Yes.

MR FARR: Dr Strahan, you may not know the answer to this question and please say so, but do you know if all of the States of Australia, for instance, use the same definition?-- I'm not aware of that.

All right. Just one final matter that I wanted to ask you about, and that was again in relation to Dr Wakefield. Do you recall that he commenced as the Acting Director of Medical Services firstly before being appointed to that position?-- Yes, I believe that's true.

Can I suggest that he took up that position upon Dr Thiele's resignation which was in April of 1999; does that sound about right to you?-- I can't recall the time period, the gap between when he took up the position and Dr Thiele left. I would have thought there may have been a longer period of gap there, but I'm not certain.

All right. In any event, he followed Dr Thiele?-- Yes.

And do you recall in fact that he was suggested to take over that position by Dr Thiele?-- I missed that, I'm sorry?

Do you recall that Dr Thiele in fact was suggesting that Dr Wakefield should be the person to step into his shoes?-- I don't, I don't have a recollection of that.

All right. Can I suggest that Dr Wakefield then acted as the Director of Medical Services for about a year until his permanent appointment to that position in April of 2000?-- That might be correct.

So there was about a 12 month period of time when he was acting in the position to show his wears, as it were?-- Yes.

Okay. That's all I have, thank you.

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

MS GALLAGHER: Nothing, thank you.

COMMISSIONER: Mr Morzone?

MR MORZONE: Nothing, thank you.

COMMISSIONER: Thank you. Doctor, I can say quite sincerely I'd like to keep you here all afternoon and get your views on a number of other issues that are relevant to us, but unfortunately we have a plane to catch. We are very grateful for your time coming down from Bundaberg to give evidence and the frank and candid way in which you've given us the benefit of your views. Thank you very much and you're excused from further attendance-----

MR DIEHM: Commissioner, before the doctor leaves the witness box, can I just inform the Commission in the doctor's presence that passage that he raised this morning concerning my cross-examination of Miss Hoffman where I suggested to Miss Hoffman that Dr Strahan had approached Dr Patel and spoken about this patient: I've checked the transcript and accept readily the quote given back by Dr Strahan and I can say with apologies to Dr Strahan that that appears to have been an error on my part, hence why I did not put any suggestion to Dr Strahan today-----

COMMISSIONER: Yes.

MR DIEHM: -----that he had done such a thing. It was not my intention. I'm not now certain as to whether my error was a slip of the tongue or a misunderstanding on my part at that moment in time, but whichever it was, it was not intended to be conveyed in that way.

COMMISSIONER: I appreciate that very much.

DIEHM: Thank you.

COMMISSIONER: Thank you, doctor, you're excused.

WITNESS EXCUSED

COMMISSIONER: Ladies and gentlemen, we'll adjourn now because we do have planes to catch and we'll resume tomorrow morning in Townsville at 9.30 a.m.

Just before everyone goes, can I mention - perhaps Ms Murphy will take a look at this - but I'm inclined to think that patient P20 has been mentioned in Mr Strahan's evidence should be released from the suppression order, but I won't do anything about that until there's been an opportunity to contact that patient's family. Yes, Ms McMillan?

MS McMILLAN: Mr Commissioner, can I just raise one matter? I believe that on Friday Dr De Lacey is giving evidence here?

COMMISSIONER: Yes, that's right.

MS McMILLAN: I've heard it mentioned that he'd prepared quite a few medicolegal reports.

COMMISSIONER: That's what I understand too.

MS McMILLAN: I just wonder whether we could obtain those reports before Friday?

COMMISSIONER: I think Commission staff who are remaining in Brisbane will be dealing with that, it might be Mr Atkinson, I'm not sure, but if you can liaise with - Mr Morzone?

MR MORZONE: I'm instructed they're not available at the moment but as they become available they will be made available to parties on the same basis that patient records were previously made available to those parties.

MS McMILLAN: I take it my learned friend means the undertaking?

MR MORZONE: Exactly.

MS McMILLAN: So some of us are staying in Brisbane.

COMMISSIONER: I'll look forward to seeing most of you in Townsville tomorrow.

MR CHOWDHURY: Can I just raise a matter?

COMMISSIONER: Yes, Mr Chowdhury?

MR CHOWDHURY: It was a matter raised last Monday. I haven't seen the witness list, but whether Dr Sam Baker will be giving evidence in Townsville?

COMMISSIONER: No, Dr Baker, because his evidence may be relevant to Mr Leck and possibly Dr Keating, we're keeping him out of the Townsville sittings, as it were.

MR CHOWDHURY: Thank you, that's all I needed to know.

COMMISSIONER: I hope to see you here next week, gentlemen.

THE COMMISSION ADJOURNED AT 2.33 P.M. TILL 9.30 A.M. THE FOLLOWING DAY IN TOWNSVILLE