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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

TOWNSVILLE

..DATE 02/08/2005

..DAY 32

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THE COMMISSION RESUMED AT 9.30 A.M.

COMMISSIONER: Good morning, ladies and gentlemen. There are a couple of matters that I should canvas before the evidence begins. The first relates to the issue of Medicare fraud.

The Commission of Inquiry has received a substantial amount of material from people concerned about allegations that within some public hospitals, including the Townsville hospital, charging systems either are being used, or were used at times in the past which were inconsistent with Medicare agreement and arrangements between the state and federal authorities.

I would like to make it clear that those allegations have been very thoroughly reviewed and investigated by Commission staff. That investigation has been unable to achieve any concluded view as to whether or not there is substance in the allegations. There is certainly evidence going both ways. What it has, however, clearly established is that any problems that do exist are isolated cases rather than a system-wide problem. We come here, of course, under very limited Terms of Reference. Our primary areas of interest are issues relating, firstly, to Bundaberg Hospital, and secondly relating to the overseas trained doctor situation, and so far as the Inquiry staff have been able to establish, there is no connection with any allegations of Medicare fraud or Medicare abuse and any of the issues raised in our Terms of Reference.

It also has to be kept in mind that we are operating under a very tight timeframe, and my advice from Inquiry staff is that if those issues were to be thoroughly canvassed in evidence, it would take a minimum of five days to hear all of the relevant evidence relating to Townsville, and at least as long again relating to places outside Townsville.

I am therefore of at least the preliminary view that those matters do fall outside our Terms of Reference and therefore shouldn't be canvassed in these proceedings. I will, of course, hear submissions from anyone who wishes to contend to the contrary and who seeks to urge that we should deal with those matters, but for the time being let me say that I have brought that evidence to the attention of both the Premier's Department and the new Director General of Queensland Health Ushi Shrieber. The evidence that has been gathered, including submissions from the public and members of the medical fraternity are available, and will be made available to the appropriate authorities to ensure that that work isn't wasted and that proper use will be made of any outcomes which are available.

I would now invite anyone who wishes to contend that those matters do fall within our Terms of Reference and ought to be considered to say so now.

In the absence of any such submission, what I expressed to be my tentative ruling will be the ruling, and we will not embark

on any evidence in relation to those matters.

The second thing I wanted to raise is this: Mr Boddice, are you still representing Dr Buckland?

MR BODDICE: I've asked for inquiries to be made in relation to that-----

COMMISSIONER: Just stop for a moment. Is there a problem with the PA? It's important that everyone in the room be able to hear things. Could you try again?

MR BODDICE: I have asked for inquiries to be made. I don't understand my position to have changed, but because of changing circumstances, I'm obviously seeking to have it confirmed. So at the moment I can't positively say, but I've asked for inquiries to be made in that respect.

COMMISSIONER: Mr Boddice, I would ask you - and consistently with the extremely co-operative attitude which you and the legal team instructing you have provided to date - to expedite those inquiries, because some of the matters we'll be hearing over the next three days are at least capable of giving rise to adverse inferences concerning Dr Buckland, and it's therefore important that he be properly represented at these proceedings.

MR BODDICE: I understand the matters you're referring to, Commissioner.

COMMISSIONER: That also brings me to another matter, Mr Boddice. You might recall that when we were in Bundaberg about four weeks ago, I raised with you the issue of what I referred to, perhaps emotively, as secret reports or hidden reports. That issue really has come to the forefront with the bundle of evidence that we're going to be looking at here in Townsville. The material includes the documentation relating to Dr Victor Berg. Amongst the material that's been provided to me is a very detailed audit report prepared at Townsville Hospital, which I understand was only obtained by Inquiry staff as a result of coming to Townsville and, in effect, conducting something of a raid at the Executive Offices at Townsville Hospital.

It is unsatisfactory that we're left in the situation that a report like that was only uncovered as a result of our investigative efforts, and it really leaves in the back of the mind a question of how many other similar reports there are throughout the state that haven't been brought to our attention. I realise that there have been administrative changes at Queensland Health recently, and I understand it may make your position a little bit difficult, but can you convey to those concerned our serious concern that we have not been provided with that sort of material, and indeed the material relating to Dr Berg is a particularly acute example of that because the material I've seen includes e-mails from Dr Buckland personally directing staff to conceal that information not only from the public, but also from the Crime

and Misconduct Commission and from the Queensland Police Service.

There can be, on that material, little doubt that Dr Buckland, who until a week ago was Director General, knew of the existence of that material, knew that it had been kept from public scrutiny and has chosen, one would think deliberately, to withhold it from this Inquiry. Can I ask you, please, to follow up those matters and see what else there might be lurking in cupboards in Charlotte Street.

MR BODDICE: I will convey that. I do understand there have been communications with Commission staff providing a whole change of reports since the matter was raised in Bundaberg, and that there are ongoing searches being conducted. Some of the difficulties associated with those searches are set out in our correspondence in the sense that reports are not kept under the heading of "overseas trained doctor", for example. A report might refer to an overseas trained doctor, but that's not how Queensland Health, of course, refer to their staff. But I understand, and I will have that conveyed and ensure that the searches continue in respect of those matters.

COMMISSIONER: Thank you, Mr Boddice. Mr Andrews?

MR ANDREWS: Commissioner, it is proposed today to call three witnesses, a Dr Andrews James Johnson, Dr Donald Louis Myers and Jon Gallagher.

With respect to Dr Myers, there will be today, and during the course of this week's sitting, considerable evidence which relates to the propriety of the processes by which Dr Myers was engaged. I should point out that tomorrow you will hear from perhaps the major critic of the processes, Dr Eric Peter Guazzo, that notwithstanding his criticism of the processes by which Dr Myers has been engaged by the Townsville hospital, Dr Guazzo sincerely - so his statement when tendered tomorrow will read - sincerely hopes that after proper accreditation by the Royal - RCAS in fact is what appears in the statement - that the person appointed as a locum will "decide to stay and join us in neurosurgical practice in North Queensland".

The evidence which you will hear which analyses Dr Myers' experience is all with a view to illustrating the process of his engagement, and not with a view to criticising his capacity.

COMMISSIONER: Mr Andrews, I'm sorry to interrupt you. I suspect that whoever set up this room read a comment of mine that proceedings of this nature should take place in the full blaze of public spotlight and has taken that a bit too literally. I, frankly, find it a bit uncomfortable to have these spotlights shining in our eyes. I wonder whether there's someone here from the support staff who can rearrange the lighting so that we can see.

I should explain, by the way, that the Commission of Inquiry staff have pulled this together very quickly and at fairly

minimal cost, so there will be these teething problems. I apologise for any inconvenience that caused.

Can I inquire whether people at the back of the room can hear us all right - can hear me and Mr Andrews? Thank you. Please proceed, Mr Andrews.

MR ANDREWS: Commissioner, I am instructed that patient 220 may now be identified.

COMMISSIONER: All right. Yesterday in Brisbane we heard some evidence from Dr Strahan in relation to a patient referred to by the number 220 who was a patient of Dr Strahan's who then underwent a surgical procedure by Dr Patel and subsequently died. That name is released from the suppression order. The name is Janice Grambower. Thank you, Mr Andrews.

MR ANDREWS: I call Andrew James Johnson.

ANDREWS JAMES JOHNSON, SWORN AND EXAMINED:

MR ANDREWS: Please make yourself as comfortable as possible. Do you have any objection to your evidence being video recorded or photographed?-- None whatsoever, Commissioner.

COMMISSIONER: Thank you.

MR ANDREWS: Dr Johnson, would you tell the Inquiry your full name?-- Andrew James Johnson.

And you have, with the assistance of Inquiry staff, sworn to an affidavit on 13 July 2005?-- That's correct.

Do you have a copy of it before you?-- I do.

Are the facts contained within it and the opinions in it true and honestly held by you?-- That's correct.

COMMISSIONER: The statement of Dr Johnson will be Exhibit 233.

ADMITTED AND MARKED "EXHIBIT 233"

MR BODDICE: Could I just interrupt and indicate that we seek leave to appear on behalf of Dr Johnson.

COMMISSIONER: Such leave is granted.

MR ANDREWS: Have you also provided to Inquiry staff, doctor, a statement of 91 paragraphs which will have been signed, I

understand, today?-- Signed yesterday.

Thank you. Are the facts contained within it true to the best of your knowledge?-- They are.

Are the opinions you express in it your honest opinions?-- They are.

I tender that statement, Commissioner.

COMMISSIONER: The second statement of Dr Johnson, which we will distinguish by referring to as the 91 paragraph statement, will be Exhibit 234.

ADMITTED AND MARKED "EXHIBIT 234"

MR DEVLIN: I don't have a copy of that statement, Commissioner.

COMMISSIONER: I'll make sure that is made available to you, Mr Devlin.

MR DEVLIN: That's the second statement. I think Ms Gallagher is in the same situation.

MS GALLAGHER: Indeed, Commissioner. Mr Devlin is not on his own.

COMMISSIONER: Yes.

MR ANDREWS: Doctor, I'll take you through your first statement.

COMMISSIONER: Mr Devlin and Ms Gallagher, during the morning tea break - I understand Mr Andrews is going to focus on the other statement first. During the morning tea break, please let me know if you feel disadvantaged or inconvenienced and I'll do what I can to rectify that situation.

MS GALLAGHER: Thank you, Commissioner.

MR ANDREWS: You are a Fellow of the Royal Australasian College of Medical Administrators and you have both general and specialist registration from that College?-- My registration is with the Medical Board of Queensland. I hold a Fellowship of the Royal Australasian College of Medical Administrators.

I see. You have been a medical practitioner, you were the Deputy Director of Medical Services at Hornsby Hospital in Sydney in full-time clinical management duties, you were then Director of Medical Services of Manly and Mona Vale Hospitals in a full-time clinical management role. I assume the clinical management means in non-clinical duties?-- It's a

distinction that is being made quite often at this Commission. Many in my role see their duties as being clinical management rather than non-clinical. I think it's a subtle distinction, but an important one. My role is effectively about managing the clinical conduct of care within a hospital that does require a clinical background and an application of clinical knowledge. So I do not directly look after my own patients, however I am responsible for the standards of clinical care which I regard as a clinical role.

COMMISSIONER: Doctor, that is a very important distinction and I thank you for making it. Do you have any knowledge or views as to whether your opposite numbers in other hospitals throughout Queensland have a similar view, that they are managers of clinical services rather than managers?-- To use the Prime Minister's words, we are a broad church, Commissioner. I would suggest that some see their role as more management and others as more clinical management. I can speak for myself and for - I believe for my college, that we regard that - the clinical component to be extremely important. In fact to attain your fellowship of the College of Medical Administrators there is a prerequisite of a number of years in clinical practice. We see the contribution that we can make being significantly in the management of clinical services, using that clinical background to best effect.

Doctor, I'm probably anticipating things we're going to come to, but certainly viewing the situation in other hospitals, the concern has arisen that those in a similar position to yours conduct their roles more as bureaucrats than as doctors, if I can put it that way, and the suggestion, I guess, arises that people who have no day-to-day hands-on clinical involvement are not as well placed to administer clinical services than those who have that sort of day-to-day ongoing involvement. Do you have a view about that?-- I certainly do, Commissioner. I have seen that criticism and that suggestion that one needs to be an active clinician to be effective in a clinical management role. I simply don't agree with that. My rationale is this: the spread of clinical knowledge that's required to discharge my duties is in fact greater than the spread of clinical knowledge I require as an active clinician treating my own patients. I now know more about breadth of medical fields to do my current job than I did when I was in clinical practice. Now I don't have a vested interest in any one area of clinical practice. My training includes the skills of management and leadership, it includes an understanding of finances and how the health system is run. The training for other clinical disciplines is specific to those clinical disciplines. A surgeon is trained to be a surgeon, a physician is trained to be a physician. They may have an interest in management and can make an extremely valuable contribution. In fact many do make extremely valuable contributions to the management of our clinical services. Indeed in our hospital we have very significant involvement by active clinicians in the management of services. However, in my role it really is rather more of a balancing act which requires specific knowledge of management, specific knowledge of how health systems operate

and how finances operate. So I think the reality is if you were to have a medical superintendent, if you like, as an active clinician, they wouldn't be very active clinically for very long. In fact where we do have medical superintendents with hands-on clinical duties, many report that they are not able to attend effectively to either their administrative or their clinical duties. So there is, I believe, a very significant role for a full-time medical administrator, one who does regard themselves as a doctor, who draws on their clinical training to effectively administer services.

Doctor, I hope you will forgive me for playing the devil's advocate for a moment, but one of the difficulties we face is that any sort of system of management has to be designed for a worst case scenario rather than a best case scenario. As you yourself have said, there is a broad church of views as to what the role of the Director of Medical Services should be, and when we are making recommendations regarding system reform, I don't think it is realistic to proceed on the assumption that everyone who holds a position like that in any hospital in Queensland has either your commitment to clinical issues or, frankly, your ability to deal with clinical issues, and that's what leads me to the view that, whilst accepting without hesitation that our medical system needs people with managerial and administrative skills, they shouldn't necessarily be at the apex of the decision making in relation to clinical issues, that maybe some sort of compromise structure is appropriate where you do have a Director of Medical Services who is primarily a manager, but also a person - and various names have been suggested, a chief of staff or a chairman, some other title - who is the chief clinician at the hospital and who is a full-time clinician, but is there as a mentor, a source of guidance, a final court of appeal, if you like, for clinicians in relation to clinical issues. How do you feel about that sort of approach?-- With respect, Commissioner, I disagree.

Yes?-- I believe that there is a very effective way to engage the senior clinicians to have those sorts of roles, and in fact that's what we have done. We have a number of very senior clinicians who effectively form the chief of staff of their clinical institutes. Now, we run an involved management structure, which means that the head of medicine is - the head doctor of medicine is the head of that institute. They work in partnership with an operations director, but they are the final point of call, if you like, with myself as the point of appeal. I would suggest to you, Commissioner, that it's not that uncommon for complaints in fact to be made about the chief clinician.

Yes. The system you've just described is, I understand, unique to Townsville?-- On the contrary, Commissioner. It may be unique to Townsville in Queensland.

Yes, I meant - that's what I meant, I'm sorry?-- It's actually a very common management structure across the country, and in fact internationally. We run an involved structure. It's a world-recognised concept, and that is where

budgets, responsibilities and authority are negotiated with the team at the top of each clinical institute, and that's an ongoing negotiation. Budgets are devolved on an annual basis, and we provide, from the executive management team, a level of support, guidance, mentorship et cetera in how they run their institutes. But the capacity to move resources around, clinical decision-making, is done from within each of those clinical institutes. I have to say that the role of the clinical director of those institutes is a very difficult one, because again it comes down to balancing competing demands from colleagues across the organisation. I think the reality is some of these roles are particularly difficult in times of resource constraint, which is somewhat of an endemic condition of our health care system in Australia.

With the system of devolution of authority that you've described, can I ask first whether that has received the support of Queensland Health Corporate Office?-- I don't actually recall asking for permission.

Can I also ask whether that is, in your view, feasible in a smaller hospital such as Bundaberg where there is simply fewer clinicians and therefore, I suspect, even more pressure on their time?-- It is more difficult in smaller places. I mean, in truth it's not that easy to find clinicians who want to give up their time to be the boss, if you like. It's an onerous task. It takes an awful lot of time. Dealing with doctors can at times be rather challenging. We're talking about a highly intelligent, highly driven group who have a range of opinions. Being able to work through that to achieve consensus and direction is a challenge. Many we find in clinical leadership positions find that challenge too onerous, and filling clinical directors' roles is one of the hardest things for us to do. So to suggest that someone may want to take on that role across an entire hospital, I would suggest, would be very difficult.

And we have also been a little bit pragmatic. We all know there's a shortage of doctors and we all know there's a shortage of funds. We have a competent clinical specialist who has spent maybe, eight, 10, 12, 15 years of his or her life achieving qualifications in a specialist area. It does seem to be a waste of resources to have that person doing something that they're not trained to do which is to be an administrator rather than doing what they're good at?-- Especially, Commissioner, when you have specialists who are trained to be close clinical managers, clinical leaders and it is a specialty unto itself. I suggest to you having a medical administrator trying to do surgery would be very inappropriate. I would suggest that having a physician trying to do surgery would be very inappropriate. Having those specialists attempt medical administration, I would suggest, would be equally inappropriate.

Let's draw the line for the moment between different categories of hospital. Obviously Townsville is one of the state's matron hospitals?-- The jewel in the crown, Commissioner.

The jewel in the crown, yes. At the other extreme you have the very small country hospitals where there is one GP medical superintendent and there's really no scope to debate what structure you should have there because there is only one possibility. Obviously, a lot of the evidence we have heard has been focused on a hospital at an intermediate level, of which Bundaberg is an example, but there would be probably a dozen others throughout the state and, laying my cards on the table, one of the things that has concerned me greatly with the evidence we have heard in relation to Dr Patel is that he was at the top of the tree in terms of clinical decision-making in surgical issues within that hospital. Once you got above him there was fresh air. There were people, many in clinic, director of medical services, who seems to have focused mainly on the administrative rather than the clinical aspects of his job, above him a district manager who's got no medical qualifications at all and so on and so forth above the chain of demand. That is the sort of situation with reference to that sort of regional hospital that it seems to me that there could be merit in saying, well, we have got a very senior VMO here in town, maybe even a retired specialist, and we're going to give him the titular position of chairman or chief of staff or head of clinical services, or however you describe it, so that young clinicians, nurses and doctors have someone as a mentor or someone they can go to with their problems and, similarly, the Director of Medical Services and the District Manager have someone from whom they can take advice and receive assistance when issues like the Patel issue surface in the locality?-- Commissioner, I think the concept of mentor, of recognition, of the value of senior clinicians is exceedingly important. In fact, it is something we adopt as a routine practice. I myself use mentors in the retired medical community in Townsville. I know that that's a common practice with specialists from many fields. From my position to be able to carry out my role I rely very heavily on a network of senior

clinicians. When an issue gets raised with me I don't rely on my own clinical knowledge. I draw on the network of clinicians who have expertise in those areas to provide me with advice. Many times it's a balancing act. Many times there are multiple valid opinions and it's essential to try and work through the potential issue, establish whether or not you have got a major clinical problem or whether you, in fact, have an interpersonal dispute or whether, in fact, you just have two different, but valid views across the clinical spectrum. These things are quite difficult to work out and I personally rely very heavily on the availability of senior clinicians in our medical community to get their opinion, establish the facts and try and form a view. To vest that in one person, I would suggest, is somewhat challenging. It's impossible to be all things to all people and to have all knowledge of all areas. Being able to draw from a range of people and not only within Townsville, but also across the broader medical community is extremely important. So I hear what you're saying. I've read much of what's been put up. I would suggest, however, that where we have perhaps a variation in how medical superintendents apply their role that can in some respects be due to the different expectations that are placed on medical superintendents. If, for instance, the medical superintendent is being held accountable for the conduct of elective surgery, how many operations get done within a time frame, then that may well focus their mind on that particular part of the hospital's activity. If they are being held accountable for financial outcomes then that might well be the area that they focus on. If, however, they are being held accountable for the quality of service provision and the safe and ethical conduct of that practice then that may well be where they focus. I'm in the fortunate position in my role that financial accountability is not one of the central themes in my position description. Safety and quality of services is. I am held accountant for that. That is particularly challenging, but an area that I relish.

I suppose, doctor, ultimately there are three options: one is to change the position; one is to change the position description; and one is to change the individuals who occupy the position?-- Or a combination of the three.

Or a combination of the three. My difficulty at the moment is that if we had a cloning machine and could put a Dr Andrew Johnson in each of the hospitals in Queensland we probably wouldn't have a problem, but-----?-- How nice of you to say so, Commissioner. I'm not sure that everybody would agree with you.

But, as you say, there is a broad church and there is inevitably a spectrum in experience, ability, qualifications, application, all sorts of factors. That's what makes me think that we need a fail safe. We can't simply rely on having one person in each regional hospital who is capable of discharging the role the way you do here in Townsville and that's why obviously we have spent a lot of time thinking about these things and my feeling for the moment is that we have these district health councillors that in some parts of the states

seem to be almost nothing at all. Wouldn't it be a good thing if the sort of mentorship you're talking about was institutionalised so that a senior clinician, whether that person is a doctor or a nurse or maybe even from an allied health profession, might be a dentist or a pharmacist, but someone who's primary focus is on patient care, is the figure here, the spokesperson and the chief mentor within the hospital structure?-- Now you're talking, Commissioner. The - I think the suggestion of a local board is an extremely good suggestion. We must be careful not to throw the baby out with the bath water. There has been much that has been gained in Queensland Health through having a level of centralised administration. Now, I can talk much about the bad things, but there are also some very good things that have come out of that, but the local board concept I think is one that really should be explored. Now, the senior clinicians, I think, could really make a significant contribution in a Government's role, that is, establishing that level of mentorship, et cetera, and one potential model that I think would work very well is to have a local board with senior people from the community, but also perhaps some subcommittees looking at issues such as clinical practice standards, credentialing, et cetera, and the administration, if you like, the hospital executive, could be held accountable to the local board. Now, I do believe that that has worked very, very well in some jurisdictions and I'm aware that it works very well, for instance, in New Zealand where they do have very empowered local boards and they do have active buy-in by senior commissions and key roles within that board structure so there is that opportunity to have engagement at the Government's level.

The difficulty then becomes one of allocating an appropriate range of powers and authorities to that board. My perception - and I'm probably being more candid than an inquiry commissioner should be. My perception, as matters stand, is that we went too far one way in the old days when we had local hospital boards who really ruled the roost and each hospital board was their own governing authority. It may be that we have now gone too far the other way and there is too much centralised control, but there's no point having a local board unless there is a clear list of authorities and powers conferred on that board, and I suspect one of the problems with the current district council is that whilst the Act has about 30 sections saying who they are and how they're appointed and how often they'll meet and so on there's actually nothing that gives them any power to do anything. They're just there as nominal representatives of the community. I know in some parts of the state, and Townsville may be one of them, those people are embraced by the hospital management and the hospital management makes use of their contributions, but, nonetheless, they have no real authority?-- We certainly do try to make use of their contributions, Commissioner, but I would agree with you that there is no significant authority vested in those district health councillors, and there really should be, but I would - council - if I may say, Commissioner, that there is a difference between central control and central coordination.

Yes?-- And essentially the gains that have been made in Queensland Health through centralisation could have been achieved with much more central coordination rather than control. For instance, each month my counterparts from across the state and I meet in Brisbane to work through issues of significant concern. If we have a clinical problem in Townsville maintaining services it's an expectation that my counterparts in Brisbane will assist us with that in taking, for instance, patients that may need to fly if we can't provide an on-call service in a particular district. That can be lost when we have individual areas that end up competing for resource, influence and control. Now, I've worked previously in New South Wales Health, Commissioner, where we had area health services that had totally different computer systems that didn't talk to one another. A patient could not go from one area health service to another and expect that their information would flow effectively. In Queensland we don't have that problem. We have systems that can talk to one another. When we're looking to establish benchmarks, if you like, for how services may be provided we're, in fact, measuring the same things. There is much to be gained from this, however, there has been on many occasions obstacles put in the way of progress through central control.

Well, I'd like to follow that up. I'm very sorry, Mr Andrews, to take you out of your course, but I think that this is tremendously useful, but, please, take a seat if you prefer. Doctor, obviously one of the primary issues that this Commission of Inquiry is looking at relates to the recruitment of overseas trained doctors. We heard evidence in Brisbane last week from Dr - I can't think of the name?-- Dr Jeannette Young.

Dr Jeannette Young?-- Yes.

And she was telling us with justifiable pride at how good PA is at recruiting staff because it has the reputation of being a major hospital, of already having world ranking specialists on the team and so on. The tragedy of that is that the hospitals in Queensland that have the most desperate need to get good doctors don't have that sort of opportunity resource and that struck me, for example, as one thing where cooperation - not necessarily control, but cooperation state wide could be tremendously important. It strikes me as really very strange that hospitals like Bundaberg are paying consultancy firms interstate to recruit doctors for them rather than Queensland Health having a recruitment organisation in-house and being able thereby to coordinate it so that if there's an overseas trained doctor who comes to Queensland, there are perhaps uncertainties about his or her clinical skills, that person can spend three months at the PA or Royal Brisbane Hospital under supervision and once they've proved their qualities then have the opportunity to move somewhere else. I don't say that that would work in every case, but it does seem to me that that is one area where centralisation of, you know, coordination seems to be probably useful?-- Commissioner, I think you raise a really good

point, but perhaps if I can just remind the Commission that Brisbane is closer to Canberra than it is to Townsville. It is closer to Melbourne than it is to Cairns. It is probably closer to Antarctica as it is to the Torres. The difference between recruiting to Brisbane and recruiting to other areas of the state is really quite significant. There is a very significant value in seeing some centralised coordination and some establishment of, at the most, sufficient process. I think we need to recognise that we, in fact, are competing in a global market for practitioners and when people see that they are coming into a system where our registration processes take anything up to nine months to complete, where we are questioning or perceived as questioning their standards of clinical practice, often people coming from very highly regarded facilities - throughout the first and, indeed, through to the third world there's some very highly regarded facilities - when they are faced with the process that may take them nine months, 12 months from the point of application to actually being able to do the job they've been employed to do many will question whether that's the organisation they wish to work for. If I may illustrate, Commissioner-----

Yes?-- -----that the process for getting a practitioner from the point of application to a - from the point of advertising to appointment is very simple.

Yes?-- When you see a spaghetti diagram like that it's not hard to imagine how things can go awry, how we can end up with a situation where a step may be missed or a situation where people look at that process and think, my goodness, is there not a way that I can get somebody in to fill the job that I have that needs to be done today. When we talk about supervising people in practice in Brisbane for three months prior to letting them loose I think we perhaps overlook the fact that we have very real and pressing needs in the hospitals that are trying to recruit these practitioners.

And, doctor, I guess in a sense I'm putting some of these questions to the wrong person because I imagine that Townsville has resources which perhaps may not be quite the equal of the PA, but are of a very high level?-- The PA would wish to have some of our resources, Commissioner.

Yes, but when one talks about recruiting, say, for - I don't even know if there is a hospital at Hughenden, but if there were one that's the sort of situation where a probationary period at Townsville, or perhaps even at Charters Towers, or at Cairns would, in my view, avoid the risk of sending someone to a remote location who's just not going to be right for that job?-- You are absolutely right, Commissioner, and that's the experience that we have. That's exactly what we do in the northern zone. In fact, when we recruit someone to work in Hughenden, for instance, the expectation would be that they would come through Townsville and would spend some time working with our practitioners. Now, we look at what clinical privileges are expected to be exercised in the town that they're going to and on that basis will look at a period of supervised practice to establish whether or not they appear to

have the skills in sufficient measure to deliver that service. I can give you a number of examples where we, in fact, brought practitioners through the Townsville Hospital for an assessment, for instance, in anaesthetics or obstetrics and we, on that assessment, established that they do not appear to have the skills as advertised, so we either worked on a remediation program or changed the appointments so they don't exercise those privileges. So it's exactly what we do, Commissioner.

Seeing I interrupted Mr Andrews, there is one other area I thought you would touch on because it doesn't seem to be in your statement. We heard about at a very early stage of your evidence a gentleman involved in recruiting medical practitioners and he made the point that there is a pool of or a resource of practitioners, particularly in the United Kingdom, but also in some European and North American jurisdictions, of medical graduates who treat it very much as a gap year or learning experience, or something like that. It seems to me far North Queensland and North Queensland are all really high on the international list of backpackers and young tourists. Is that a resource that you've been able to tap into?-- Commissioner, that is a group that we do try and tap into. We have, perhaps, though, tried to lift our recruitment push. Rather than saying come to North Queensland, it's a great place to have a holiday and, by the way, you can do some work here, what we are trying to do and are quite successful in doing, the number of areas are saying come to North Queensland. It's a fantastic place to train. You have outstanding work opportunities and, by the way, there's lots of things to do on the weekends or on your days off. Now, that approach I wish I could say to you is universally successful. The reality is we would love to have more junior doctors able to come to us from particularly UK and Ireland. Some of that goes to the global shortage of doctors. Where we have been successful, and particularly have seen much easier recruitment, is in areas where we have been able to establish a good critical mass of practitioners and a strong collegiate relationship between those practitioners. I give you the examples of emergency medicine and anaesthetics in Townsville to name two. We have a very strong core in those disciplines where we are now starting to train our own and being recognised as being training centres. In fact, we're now recruiting the people that we once trained as fully fledged specialists. Now they're coming to us for choice because the work is excellent. We need to create an environment where people will expect to have a good work life balance and where they can expect to get first rate training in a first rate facility and try to bring them in on the basis of the work that they can do rather than the holidays that they may not get because we're working them too hard.

Is the James Cook University Medical School up and running now?-- Indeed it is, Commissioner. We have the first drop of 60 graduates coming out next year which is extremely exciting for us.

Yes?-- That has been a wonderful thing to watch evolve but

now presents us with both a challenge and an opportunity. It is only very recently that we were able to get a commitment to employing the additional medical graduates out of the first 60 additional medical graduates coming out. Over the next five years we expect the number of medical graduates in Queensland to double from its 230 baseline up to approximately 500. Now, I think it would be an absolute travesty - we should be strung out and whipped - if we allow any of those doctors to leave Queensland without a jolly good fight. The reality is that at the moment we have not got the structures and plans to be able to engage those practitioners and offer them the training positions and places that they need to see their future in Queensland and I think that is something that needs to be addressed urgently.

D COMMISSIONER EDWARDS: Sir, thank you very much for those comments. I think that the Commissioner's suggestions and questions have answered a lot of the matters that I was concerned about, but I do have one or two matters, if I could. You referred to central control indirectly or directly by the Health Department. How do you think that could be devolved so that budgets are still maintained, standards of public health care in hospitals within public policy are maintained rather than the very involved way of bureaucracy so that even if you were to get a pair of scissors, I am told, almost an extra pair of scissors, the time spent over that minor issue, whilst exaggerating some of the comments we had, but is the principle by way people have referred. Could I ask you, therefore, would you like to make some comments about the devolution of so-called control, but still maintaining similar standard through the state the size of Queensland?-- Deputy Commissioner, thank you for that. I think there are models that we can look at internationally for how that could work better. It's my personal view that the - that health is overly politicised in Queensland and that there is insufficient division between the political arm, if you like, and the bureaucracy. If one was to look at a near neighbour, and in New Zealand - I hesitate to say anything positive about New Zealand, but I think there are aspects of their health system that we could learn from, particularly with regard to the separation of politics from health care delivery, and what has been evolved there is a system, as I understand it, with a Health Commission which is at arms length to the political process and then the Health Commission is responsible for developing a policy and the framework under which health care is to be provided establishing the standards and the processes, then the actual service delivery is devolved to boards that are run in local areas. Now, those boards may have a significant budget to control and, in fact, one of the things that New Zealand has that I'd dearly love to have is to not have this stupid federal state split that causes us such untold grief here in Australia and the health boards actually have control over full budget for health for their region including the community health, general practitioners, et cetera, so they are able to invest rather than just in acute hospital services. They are able to look at the planning for future health care needs and establishing mechanisms to look after people more effectively in the community. We do that in

Queensland or throughout Australia by a dint of cooperation rather than being structured to be able to do that. People see that it's sensible to work closely together rather than on separate sides, but I doubt that whilst this Commission has many powers we are not going to be able to overcome the federal state split, but certainly looking at how we could perhaps trim down the central control aspect to one where the Health Commission, for instance, might sit at arms length to political process and have a remit to establish a framework, policies and direction, but leave it to the boards to actually administer and manage.

Could I also ask you would you like to expand a little on the evolution of budgets and their associated control of when it is necessary and when they are devolved to locality groups and local hospitals? We get the impression that budgets are very rigidly controlled down to the most minute detail from central office and the flexibility at a local level is much less and I referred to that in my previous question to you. I just wonder whether you would like to make a comment from an operator at this regional level on this central controller budgets and flexibility and so forth on that issue?

COMMISSIONER: If I can just add for a moment to Sir Llew's question. We have also heard the criticism from a number of people from a number of hospitals about this historical budget structure which in the extreme circumstance has the problem that come April, May you're running out of everything because you've only got so many dollars to keep you through to the 30th of June and then suddenly from the 15th of June there is this spending spree because if you don't spend the budget you not only lose it, but you don't get it the following year as well. That may be an exaggeration but I think it illustrates the concern that Sir Llew was raising?-- The spending starts a little earlier, Commissioner. We have to make sure the expenditure was - actually hit the books right through to June. We do have an interesting system with - to talk in financial terms. We are expected to run on accrual accounting systems which mean that their costs are entered into the books, the time the costs are incurred rather than pay the bill, however, each year we are held to account on a cash basis which means that on the 30th of June - if you haven't spent your allocation by the 30th of June, which would be unusual, then you certainly don't get to carry forward a surplus, but you do get to carry forward a deficit, so it's a - it is an odd situation where the political accountability and accounting principle perhaps don't align.

Does that mean you have to keep two sets of books - I mean, I know these days they are not physically in written journals, but, in effect, on cash system and on an accrual system?-- Fortunately, Commissioner, that's not part of my job description, but there is a need to report at the end of year - certainly on what your cash outcome is at the end of the year. Yes, I suppose that would be a logical outcome.

Or the illogical outcome?-- Yes. You asked the question about devolution of budgets and the flexibility. I would argue that from across service executive perspective, the maximum amount of flexibility is certainly desirable because it gives you the opportunity to look at where you have specific needs developing in your community and address those needs perhaps in creative ways. We perhaps are rather fortunate in some respects. I suspect that health services that are closer to Brisbane may be subject to more scrutiny than those that are further away and we do exercise quite a significant degree of flexibility within financial allocations within our health service. There are some things, of course, that are tied. There are some Commonwealth moneys that are tied, there are some new moneys that are offered up based on inputs rather than outputs and I would suggest that's a particularly outdated concept. We should be looking much more at funding health outcomes; that is improving the health of our community in specific ways rather than saying, "I will fund you full-time equivalent staff specialists in emergency medicine or full-time staff specialists in renal medicine", whatever it may be. We tend to get our funding coming in in terms of, "You'll get one more appointment out of this", and in the case you want a doctor or nurse, "we will do that but we won't do the allied health professional that needs to support it." We would prefer to be getting funded particularly with the new initiatives on the basis of agreed outcomes that could be expected for that investment.

D COMMISSIONER EDWARDS: One more question, if I could. No doubt, as you know, the basis of our being established was the events that occurred at Bundaberg and relative to Dr Patel's outcomes of operative procedures. There is not the slightest doubt that there were concerns expressed by a lot of people, and that evidence has been given to us. Can you give us a view as how we could be assured from the Townsville Hospital system that such an existence of a Dr Patel would not go as long unnoticed and what audits do you have in place in your hospital that we could hear about that would prevent the reappearance of Patels in our system?-- I can't comment on the specifics of the Patel case. I simply don't know enough about the systems that were in place in Bundaberg. To describe, however, how we operate in Townsville, we have established over the last several years a patient safety framework. It started off with political jargon, clinical governments framework, the concept being to try and bring together the threads of information that might help a district manager or somebody in my position be able to offer the community an assurance that the right things are happening. We do that through a number of mechanisms. Firstly, we try to make sure that we have the best available staff coming to work

with us, so our credentialing processes are - we spent a lot of time on making those robust so we can establish what people should be doing when they come to work with us. We try to make available the effective training and support required for people to be able to do their jobs and we have invested very heavily in that area in Townsville. We have a large number of training rooms which have been very comprehensively fitted out with audio/visual equipment, et cetera, so people can access training programs, not only locally but also dialling into training that may be provided in Brisbane or, indeed, around the country. I myself dial in regularly to video conference training through my college, which is provided nationally and run through Queensland. So we have facilities available for that. We also make available through the award structures, particularly for senior medical staff - and I suspect it would be useful to have it available for other staff - facility for conference leave and study leave for people to maintain their currency in their particular discipline. We obviously have challenges from time to time where we have staffing shortages for people to avail themselves of that but in the main that's fairly well accessed. We support that with funding through the Private Practice Trust Fund, which is a fund established using some of the Medicare funds that come into the hospital to reinvest in training, research and education facilities, and each year we spend - well, this year I think our budget is approaching $800,000 for facilities and support for training. So that's an extremely important part. We tend to focus on the downstream end where problems are identified, but I think it is very important to push it upstream, if you like, and invest in getting the right people and training them appropriately. If we look on the negative side, if you like, where things have gone wrong or where things might go wrong, we have gone to some lengths to look around the world for the best practice systems and we have tried to bring together all the threads of information that may be available, through things such as infection control committees, drug therapeutics committees, ethics committees, clinical privileges, et cetera. All of those areas now report into our patient safety committee. Now, we will often find issues through those. We may find issues through our regular morbidity and mortality meetings where we review all deaths that occur of a significant nature - and I am not suggesting at all any death is not significant, but where there is an unexpected death or where there is perhaps an issue of concern - and those are debated between peers and we try to establish whether there is any learnings from that. We have also a number of mechanisms we can learn about potential concerns. Clearly we have complaints that come to the hospital. That can come from anybody in the community. Our complaints officer, called client liaison officer, actually sits on a Patient Safety Committee and reports to the Patient Safety Committee any significant issues that are raised. We have capacity to generate from computers around the hospital. People can log in and enter a clinical incident through what we call PRIME. It is the Proactive Risk Identification Management Environment. We don't really care how we hear about an issue, so long as we hear about it. We welcome reports, we seek reports. We have a patient safety officer who has their nose

to the ground, if you like, and tries to look for issues. I have an open-door policy and I very regularly will get an issue raised to me, perhaps as a tip-off from a staff member if they have a concern. We'll then have a look at a particular concern and try and establish whether in fact we are dealing with a significant issue or not. Now, oftentimes what we find is that - well, in the vast majority of circumstances individuals are not to blame for adverse events. Approximately 80 per cent of deaths, the problems we identify are in fact system problems where what happens is that we find a very well trained individual who has turned up to do a good day's work, who finds himself at the scene of a problem not of their making, but rather of the system's creation. So we try and understand that. We try and establish what's happened, why it has happened, how we can prevent it from happening again. To assist us with this we looked around the world to establish what was best practice. The concept of root cause analysis was being tossed around three or four years ago and we were one of the first hospitals in the country to send a team away to learn about the process of root cause analysis, and this is specifically an investigation technique that's aimed at looking at either a near miss or an actual event to establish what we can learn from it and how we can modify our system to prevent it from happening again. So we did some initiative training, found that particularly useful, and then learnt about a new process that was being used in the Veterans Health Authority in the United States. I went with one other Queensland Health member to a training session in the States and learnt about their system, brought back the tools and started to implement them in Townsville. They were implemented the same time in the PA in Brisbane. We've based our system around the PA model and that's now been picked up statewide, and with the Patient Safety Centre has been rolled out statewide. So how can I be confident that an issue would be identified early in Townsville? I believe that we have a spider's web of ways to find out about issues. We take issues very seriously when they are raised to us. Sometimes, you know, we find it is simply a difference of opinions, sometimes we find it is just a variation in clinical practice. But we certainly work through issues when they are identified to us and try and establish into which category they fit.

Doctor, going back to the dichotomy you drew between central coordination and central control, I guess, as someone outside the medical system, it has surprised me to what extent there is sort of a reinvention of the wheel at every hospital throughout the State on these issues. We have had debate, for example, about what sort of clinical audit system should be used in Bundaberg, even down to the level of what sort of software. I would have thought that, as a matter of coordination, Queensland Health could do the tests and investigate the various systems and say, "This is the best software and everyone should use it." But particularly with what you have been saying about the root cause analysis and the system from the American Veterans Hospital, if it is good for Townsville, presumably it is good for Cairns, Rockhampton, and Toowoomba as well. Surely where there is scope for statewide coordination is establishing a template system that

is going to be best for everyone?-- That's - I think a very valid view, Commissioner. I think what we need to understand is that clinical cultures have evolved throughout Queensland and, indeed, throughout the country and around the world, and individual hospitals and individual organisations will often feel the need for sovereignty over decision making taken in their area. There are many, many, many ways to skin this cat and the reality is, to some extent, it doesn't matter what you are doing, so long as you are doing something and not getting bound up waiting for a decision to be taken. Now, the reality is many of these different audit systems and different approaches will yield the same outcome, and that is a greater level - a greater but not a complete level of assuredness that the right things are happening. We live in a risky environment. Health care is a risky business. We know from international literature that somewhere between 10 and 15 per cent of patients coming into a hospital will have an adverse event as a result of their hospital care. We know that's there in the background. Fiddling around trying to establish what's the best system or, you know, what's the agreed position, I think in some respects is just putting your head in the sand and ignoring the reality that's out there. You know, in many ways it just doesn't matter which system you employ, so long as you are doing something systematic and resourced then you have a very much greater chance of success. The resourcing is a critical issue here. We have very busy clinicians, and to have these systems work requires the buy-in from clinicians and that's time. That's - time is perhaps the most precious commodity and we need to be able to recognise that clinicians need support to be able to do that. Now, that support may come in the form of extra administrative staff who can take on part of their non-clinical duties, it might mean they need a research assistant to perhaps be able to go through some of the data. It may mean they need a data entry clerk or a data manager, and this level of support is something that's often denied to clinicians because it is not seen as being directly related to patient care, and we're not funded to be able to do that.

What alarms me, though, doctor - and we've seen a number of instances of this - that a hospital has a system which may not be the world's best practice but is good and effective and everyone understands and it has worked well in the past. And then Queensland Health says, "Now you will use this system", and "now you will use this system." Usually, once the oracle has spoken, the oracle then doesn't provide any funds to implement the new system. People have to be retrained, new paperwork, new software, new protocols and systems are put in place, and then 12 months later they change their mind and there is another system again. Add to that the fact that if you have an experienced nurse at Bundaberg who then moves to Mackay, they are going to have to learn a new system all over again because they are moving from one to the other. It seems to me these are the sort of things where, going back to your point about divorcing the politics from the administration of health care, there should be something like the system that Dr Nankivell was telling us about last week, of a sort of inspectorate rapid response team that says, you know,

"Politicians can have their fun with waiting lists and arguing about who gets what money and so on, but when it comes to patient care, there has to be something above politics and it has to be coordinated statewide."?-- Absolutely agree, Commissioner, and I think the reality is we have a vehicle for doing that now. My good friend and colleague, Dr John Wakefield, heads the Patient Safety Centre in Brisbane. John trained with me in the States in the Veterans Affairs model and we will in fact be seeing that roll out across the State. Again, I say it comes back to an issue of resourcing and, you know, we keep getting asked in the districts to do more and more things without - with the same people in place. We simply have to recognise that there is only so far we can stretch them. At some point we need to provide them with more support to be able to do this very important work.

Just going back to the point you made - and it is a very valid point about taking the politics out of health administration, I have the impression, if you will forgive me for saying so, that you and I have been wrestling with the same problem and come up with different answers. It struck me that there is a monumental conflict of interest in having the major health service provider in Queensland also being, for all intents and purposes, the major health service regulator and that we should have, for example, an officer like the Chief Health Officer outside the body that is actually providing the health services so that there is both the reality and the perception of genuine independence, and you don't have those political and budgetary and other factors influencing the provision of regulatory functions and the implementation of scrutiny and inspection and safety control?-- I think that has some significant merit. The ability to raise issues outside - or to have, I guess, an avenue to raise the issues of clinical quality and safety is essential. To have that outside the stream of financial accountability is probably sensible and, you are right, it needs to be above politics. I could see a role for the Chief Health Officer taking on that sort of function. The Chief Health Officer, of course, has many other functions that are integral to the functioning of Queensland Health.

Yes?-- Particularly in respect to disaster management, et cetera.

So it would be necessary to draw a fairly arbitrary line in the sand and say these are operative or operational roles which belong to the service provider and these are regulatory roles that belong to the regulator?-- In my previous role with the private health system - I was working as Director of Medical Services in a private hospital in Cairns prior to taking up my appointment here - I had quite a lot of dealings with the Chief Health Officer's office in their regulatory capacity overseeing the conduct of private hospitals, and I think that role is well developed in the Chief Health Officer's office and they take that role very seriously in private hospitals.

That's actually one of the things - because we heard evidence

from Dr Fitzgerald at the end of last week - that's one of the things that highlighted my concern that his office is extremely robust in imposing safety and clinical standards in the private sector, and, yet, as part of Queensland Health, they really don't have the scope to exercise that independent scrutiny over hospitals in the public sector?-- I think one of the criticisms that used to be made when I was in the private sector - I sat on the Private Hospitals Association for Queensland on the management committee. One of the things we consistently raised was there appeared to be a double standard, in that our facilities in the private sector were very tightly regulated, whereas those same standards weren't being applied in the public system. So I think there is a valid concern there. The requirements, however, have been, to some extent, developed now to encompass public and private and that comes in the form of a service capability framework which-----

Indeed, Dr Fitzgerald told us about that last Friday?-- I think it is a very welcomed development but it does in fact raise a number of questions. It raises questions about resourcing, what you can provide safely and what goes together to create a safe environment for practice in patient care. I think some of those challenges presented by the service capability framework - which really does come out of the private sector regulatory component of the Chief Health Officer's office, I think that really does present us with an opportunity to scrutinise our facilities, our services, what we provide, where and what we need to be able to provide services safely. It demarcates, for instance, what matrix of things you need to have come together to be able to deliver a service at the various levels. Townsville, of course, doesn't need to send many patients south at all. We have a very comprehensive service branch here which, when you look at the service capability framework, actually gives us some questions about what additional resources we perhaps should be having to deliver those services safely.

D COMMISSIONER VIDER: Just a quick question. It is back to where we started. It is to do with your position description. Is the position description you work from the generic position description of Queensland Health and you've particularised that to your own interpretation of it, or has your position description been developed to best assist the implementation of the institute management of it?-- Deputy Commissioner, thank you for that. The reality is our position descriptions are developed on a facility-by-facility basis.

Right?-- We occasionally do look at what has been developed in another area, so that we don't reinvent the wheel. The position description that I was employed against was modified slightly when we adopted the institute management structure and we review it on an ongoing basis. I sat down for a performance appraisal with my district manager only a few months ago and we established that in fact the position description is still valid. In truth, it has become more valid as the emphasis has shifted more on to clinical standards, ethical professional practice standards than on

financial management.

So you have put a lot of effort into achieving the status you prepare as being the jewel in the crown?-- Well, I was being a little tongue in cheek, of course, but we are very proud of the services we have built up in Townsville. There is a lot of areas for improvement and a lot of areas that require investment. We are significantly challenged in very many ways but I think we have first rate staff that do a first rate job, and much of the things that hit the media, unfortunately, of course, don't reflect the groundswell view that I get when I walk down the street and people take me aside and say, "Look, I just want to let you know your hospital does a wonderful job. Auntie Mary was in there and your staff really looked after her well." That level of community ownership of her in the hospital often gets missed. We only hear about the negatives. Townsville Hospital needs another 40 beds immediately. We need to be planning for growth and development into the future. We are challenged in very many ways but I think the jewel in the crown, if you like, is our staff, is the real commitment of some extraordinary professionals. I have to say that many of the clinical areas in our hospital, I have been struggling to find a better department anywhere in the country.

The clinical services capability framework in this zone, for example, does that require now to have a lot more mapping at zonal level so that you could pull out and define that? I have just looked at the document and I have wondered - I think the document provides a broad framework but I think for it to be workable so that everybody has a common interpretation of it and so that you can identify the resources needed to support it, you would need to be able to almost sit down collectively and define so that the smaller places know what their capability is and what it is not?-- We have had a go at that in the northern zone. We have had a couple of sessions where we've tried to work through some of those issues and understand the implications and ramifications. That's an evolvement process. We use the service capability framework now to look at services where they are challenged. You know, we - perhaps when an issue arises, we look at should we be delivering that service in that environment with the resources that are available to us. That's a process in evolution. Service capability framework hasn't been around for that long. To understand it, to implement it, to use it as a planning tool requires time, effort and understanding. It also requires engagement with the clinicians and it comes back again to that issue of dividing a clinician in so many ways, to understand truly what the impact of implementing the service capability framework is, does require a lot of concentration with our clinicians.

I think there is community benefit in 2005 by being able to define service capability in particular areas and publish it so that that community at large would know what services can be provided in their local area and which services they will have to go elsewhere to receive should they ever require them?-- Certainly our view in Townsville has been we need to

engage with the community and keep them informed about what we can safely deliver in the area that's under our control.

Yes?-- We have taken a very active approach to communicating with the community through the media. That can be somewhat tricky in a bureaucracy and we're not always rewarded for such openness, but we believe very strongly that, you know, if the community knows what we're capable of and when we are challenged, then the community can understand better why things are happening the way they are. For instance, recently we had a huge problem with just a major surge of patients coming into the hospital and we had to cancel some elective surgery. Nobody likes to cancel elective surgery. It is a tragedy. If people are sick, they need to have care. We use the term elective surgery rather loosely-----

Yeah?-- -----as something that can be postponed or can be cancelled. In truth, people who have, you know, operations scheduled, that's the most important thing to them in their life; you know, that we have to phone them up and front them when they arrive and say, "We're terribly sorry, we can't do your operation today."

COMMISSIONER: Particularly if they've taken time off work or made family arrangements, put in place arrangements to look after the kids and so on and so forth?-- We do everything in our power to avoid that but it gets to a point where you have got 20 patients in a bed waiting in the emergency department, it is simply not safe to proceed to do things that can be put off before the care of patients that can't be put off. It comes down to a decision we prefer not to have to take and it simply is a matter of resources. Sorry, not simply a matter of resources but substantially a matter of resources.

Mr Andrews, would that be a convenient time for the morning break?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: Before we rise I would like to welcome and acknowledge the presence of the Member for Burdekin. Given that these are public proceedings I feel it is particularly gratifying that the elected members of the community take the opportunity to come to the coalface and see what's actually going on here and we welcome and support not only the Member for Burdekin but other members of parliament who participate by their presence in proceedings both here and in Bundaberg. We will now adjourn for 15 minutes.

THE COMMISSION ADJOURNED AT 11.01 A.M.

THE COMMISSION RESUMED AT 11.20 A.M.

ANDREW JAMES JOHNSON, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: I think in a room like this we needn't bother standing. It seems a bit inappropriate. Can I just mention before the evidence resumes, Dr Johnson during the break very properly brought to my attention the inappropriateness of my use of the word "raid" this morning. The point I was seeking to make is that we obtained from Townsville Hospital documents which had not been made available to us from Queensland Health Corporate Office in Charlotte Street. If my use of the word implied any lack of cooperation on the part of Townsville Hospital, I withdraw that unreservedly. Indeed, the level of cooperation the Commission staff have received from the hospital has been quite outstanding and I thank Dr Johnson for that?-- Thank you, Commissioner.

MR ANDREWS: Commissioner, it is in fact easier for me to access the paper and the microphone if I stand.

COMMISSIONER: Thank you.

MR ANDREWS: Doctor, part of your duties involves the recruitment of senior medical staff and the oversight of the junior medical staff recruitment process. You say that you delegate that task to the Deputy Director of Medical Services. I see that at paragraph 3 of your brief statement. Do you retain responsibility in a practical as well as in a technical sense for the recruitment of senior medical staff?-- The process has changed somewhat this year. It would be fair to say and it's currently under review again. Earlier this year we sought to take the next step, if you like, in the devolution of authority to our clinical institutes. Up until that time I had run the recruitment process for senior medical staff and then the credentialing process that followed. At the beginning of this year we changed that to my involvement coming in at the point of credentialing and allowing the clinical institutes to run the recruitment process themselves with my involvement being limited to appointments for directors or more senior positions, or when the institute required specific support and sought my involvement. So, we are reviewing that again. I think the recruitment of senior medical staff is a complex issue which has become more complex in recent months.

Let me take you then to a couple of particular examples?-- Certainly.

So that you can explain what the system has been and what review you're considering. It seems, for example, that some time within recent months two overseas trained doctors have been appointed in circumstances which have generated some controversy. One was the appointment of Dr Myers, a person who is a neurosurgeon qualified in the United States of America?-- That's correct.

Now, for instance, with respect to Dr Myers' appointment, was his appointment the responsibility of a clinical director or was it your responsibility?-- As I recall, Dr Myers' appointment was the first that we were looking at managing under the new framework so it was under the control of the clinical institute and clinical directors.

And when you say it was under the control, do you mean the ultimate selection of the neurosurgeon to fill the need was made by the institute?-- Yes, that's correct. I recall they had a panel advising the Clinical Director of the Institute of Surgery, the Operations Director of the Institute of Surgery and one other surgeon.

And there was also the appointment of someone with ear, nose and throat qualifications which caused concern to one of your VMOs, a Dr Lindsay Allen?-- That's correct. That was the appointment of - I hope I get the name correct - Dr Sudakhiran Kalavagunta.

Is that K-A-L-A-V-A-G-U-N-T-A?-- That's correct.

And whose responsibility was the selection of that

candidate?-- I was actually involved in that process. There was - I can't recall whether the Clinical Director of Surgery was away at the time or whether in fact that predated - I think that may in fact have predated the change in the recruitment process to the institute taking control of appointments. I certainly sat on the panel for that appointment with the Operations Director of Surgery and the exiting Director of Ear, Nose and Throat Surgery, Dr Andrew Swanston.

With respect to the appointment of Dr Kalavagunta, is he currently employed at your hospital?-- No, he is not. Dr Kalavagunta was assessed by the appointment panel. There was a couple of applicants for positions. We had, as I recall, two positions on offer. Dr Kalavagunta did not have the full range of expertise that we would particularly like in that he did not have expertise in head and neck surgery, but there was another candidate who certainly did appear to have that expertise, so we were seeking to explore both options. The reference checking for Dr Kalavagunta was delegated to the previous Director of Ear, Nose and Throat Surgery. On reflection, it's possible that there was a miscommunication between that director and myself. My recollection is that he advised me that Dr Kalavagunta's referees checked out well. His recollection is different to that. An offer of appointment was made conditional upon being able to satisfy the requirements of a specialists registration in Queensland. Subsequent to that, his credentials were submitted to the College of Surgeons through the Australian Medical Council for assessment, as is our normal process for permanent appointments. Only two days ago I received the outcome of that assessment. I might add that this has been in train for some several months. It must have been commenced, I think, late last year. We finally received the outcome of that two days ago which advised that there would be a need to work in a supervised - in supervised practice to be able to obtain specialists registration and, as such, the appointment has been withdrawn. He has never left his home country. He has never commenced duties. The checking process was in train through the College of Surgeons and it's regrettable that there appears to be confusion about this matter but I am absolutely clear that he would not have commenced duties here without having been appropriately scrutinised by the college. There was never any intention to do so.

And the concern expressed, allegedly by Dr Allen, was that he, as a VMO ENT specialist at your hospital, was not consulted by whoever it was who selected Dr Kalavagunta as the appropriate candidate?-- As I recall there had been some attempt to engage with the leading ear, nose and throat surgeons in the town. I don't recall the specifics of that. However, I recall being advised that they had - that at least the Operations Director of Surgery had attempted to engage with them to provide an assessment of the applicants. It appears that that didn't happen for whatever reason. It would be a reasonable expectation that colleagues should be consulted wherever possible in these sorts of appointments. I think what we're seeing here is a level of unfortunate

miscommunication but certainly no issue of an attempt to recruit an under qualified practitioner. Indeed, we were in the process of going through the college check. So, unfortunately miscommunication would be my description of this.

The need for an ear, nose and throat specialist arose because of the resignation of Dr Andrew Swanston?-- That's correct.

Which then, as I understand it, placed significant stress on the VMO Dr Allen, who-----?-- Two remaining VMOs, Dr Allen and Dr Altman. They were then under significant stress and we certainly did want to recruit to fill that vacancy as expeditiously as possible.

As I understand it, to recruit to fill that vacancy you were obliged, following Queensland Health protocols, to first advertise locally for a period?-- We aren't obliged to advertise locally as in in Townsville. We are - there are somewhat archaic rules that we are required to observe in advertising and I would have to say that we do not perhaps market ourselves as well as we might because of the Queensland government policy towards advertising. For instance, advertising in national newspapers for positions such as a staff specialist in ear, nose and throat surgery may be limited to 150 characters, it appearing once in a national journal, national publication. Now, when you compare that to the banner advertisements for positions in difficult to recruit areas in other states, it's not hard to understand how our positions may not be able to attract the eye of potential applicants. So the advertising processes that we need to go through are somewhat protracted, it can take a long time to get advertisements listed and it has to go through a centralised agency to achieve that. But that is certainly a significant challenge to us.

Doctor, I'm going to put on to a monitor at the moment an e-mail or a series of e-mails which seem to have been exchanged between you and Dr Allen with respect to the engagement of Dr Kalavagunta. As I read the document, Doctor, once it appears, the first of the e-mails is probably at the bottom of the page and I wonder if the document can be adjusted upon the monitor so that the bottom of the page is visible on the screen. That's very difficult for the operator, who can't see the monitors at the moment. It's improving. The first e-mail seems to be that at the bottom of the page and it seems to begin, in the correspondence, in about February of this year, the 11th of February I imagine. It speaks of the resignation of Dr Swanston. When did Dr Swanston resign?-- I don't recall the exact time of that resignation. It was late 2004.

And it's-----?-- He would have given, I believe, at least three months' notice. So it was - if I recall correctly, he left at the ends of 2004, so it must have been around August or September.

Now, the writer seems to be criticising a Queensland Health

approach to advertising in the local media. I gather you share some of the writer's criticisms?-- As I indicated before, the process for recruitment of senior staff is somewhat archaic. We have tried to get a very good handle on the various steps that need to be taken. Unfortunately, at around this time, we had some gaps in our personnel management areas. This is - the advertising of positions is not a task that I undertake directly myself. It is one that I oversee and I look for a regular report back from my personnel officer. However, I recall that around this time and we're still having challenges in settling in a permanent appointment to our personal position. So some of the mechanics of getting advertising going have been frustrated not only by the processes that we're required to observe but also available staffing to make those processes happen in a timely and efficient fashion.

Doctor, as I read the e-mail, it suggests that after the resignation of Dr Swanston, it took about four months for advertisements to be placed in appropriate journals. I assume that means after advertising inadequately in newspapers?-- The decision of where to advertise is one that's taken - has been taken for some time and-----

Would it be correct that it took four months for-----?-- Quite possibly, yes.

And-----?-- And can often take - even if we were to try and advertise directly today, it may - and develop - the process goes firstly to develop a position description which needs to be in a required format. That format has recently changed so all position descriptions then need to be revised, appropriate people consulted in the development of the position description, position description then needs - sorry, I'm-----

Thank you, Doctor. Dr Allen then opined in February that there might be a replacement ENT specialist within four to six months' time and I gather that process of looking for the replacement continues today?-- It does. From the point at which we identify now an appropriate applicant for a position, it may take up to nine months to get them into place, particularly if they're an Area of Need applicant.

And has it meant an inappropriate level of workload left for the remaining ENT specialists?-- To the extent that both have resigned. We have no ENT services at the Townsville Hospital which is an absolute travesty. We're a tertiary hospital and can't provide one of the basics. Part of that is an issue of the recruitment processes, part of it's an issue of local shortage of specialists ENT practitioners, and certainly the new requirements for supervision and support through the Area of Need process complicate the issue even further.

D COMMISSIONER EDWARDS: How many sessions were they doing between them?-- They were doing on call, and I believe it was one session between them per week. It was not a significant amount of time. I think it was one operating list per week. I'd have to go back through the records to be certain about that, Sir Llew, but I recall they alternated who did the operating session each week, and I imagine there was an outpatients with that.

MR ANDREWS: Doctor, let me see if I understand as a summary what the problem was with Dr Kalavagunta. As I understand it the references which were supplied relating to Dr Kalavagunta revealed that the doctor's experience was limited, and that the doctor needed significant time under supervision, and that that hadn't been appreciated at the time that he was conditionally approved. Am I correct?-- Well, you're providing one part of the recollection. I'll offer the other part. Dr Swanston was to do the reference checking. He contacted me at home late one evening, having completed the reference checking. My recollection of that conversation is different to his recollection of that conversation, and the fact is I would never appoint somebody to a position or allow an appointment to go through if I thought that the reference checking had revealed that they required substantial assistance. So I'm very confident with my recollection. However, Dr Swanston's equally confident that he advised me that the reference checking did show him to be requiring significant supervision. My recollection is that Dr Swanston told me that Dr Kalavagunta had a range of practice where he could be confidently assumed to be able to practise independently in the majority of ear, nose and throat surgery, but he would require assistance and development in head and neck surgery. Given that head and neck surgery is only one part of the gamut of ear, nose and throat surgery, I was satisfied that we could have him operating independently on that basis in the majority of ear, nose and throat surgery, and perhaps look at a development plan to support him in gaining skills in head and neck surgery. Now, there is a level of disagreement about that advice, and I acknowledge that. However, I can assure you that I am not in the practice of proceeding with an appointment where there are significant concerns raised to me.

Yes. Doctor, would you have a look, please, at the e-mails that are about to be handed to you? Do you recognise them to be the correspondence between Dr Allen and yourself relating to this issue?-- Yes.

I tender it, Commissioner.

COMMISSIONER: Exhibit 235 will consist of the e-mail correspondence between Dr Johnson and Dr Allen.

ADMITTED AND MARKED "EXHIBIT 235"

MR ANDREWS: I see from paragraph 5 of your statement, doctor, that when hoping to attract suitably qualified practitioners, you identify an appropriate selection panel incorporating department representatives, college representation, where appropriate university representation and any other representative considered appropriate?-- That's correct.

What happened in the case of the appointment of Dr Myers?-- As I indicated previously, this was the first of the appointment processes that I was not in direct control of.

Do you know whether the institute initiated a similar comprehensive process prior to appointment?-- The panel for that appointment, as I recall from looking at the appointment correspondence, was Mr Reno Rosatto, the Director of Neurosurgery, Professor John Golledge was - I'm not sure whether he was specifically in place as a representative of the college or of the surgical community, and the operations director, Mr Jackie Hanson. Now, out of that group certainly the neurosurgical expertise would be expected to be provided by Mr Rosatto and the balance provided by other members. Would I consider that to be an appropriate panel? Where there is an opportunity to get a specific representative of a community, or where you have a group of practitioners who may be expected to work with - work together, I may well seek to get them on the panel. At the time of Dr Myers' appointment, I can't recall whether or not Dr Guazzo had in fact tendered his resignation or withdrawn his resignation or was in a position of limbo, but it was certainly over a period when he was - when his status with the hospital was uncertain. So would he normally have been engaged in the appointment process? I would suggest that if you had two neurosurgeons who had an unambiguous relationship with the hospital, that you would engage both of those in the appointment of a third neurosurgeon.

Doctor, as I understand it the selection panel for the selection of an overseas trained doctor to fill a significant position is one that you used compile relying on persons who were not engaged by the hospital, as well as those who were engaged by the hospital. Am I correct?-- There is some variation in that regard.

But on occasions you would conscript to the panel persons who were not on the payroll of the hospital?-- Certainly. We have done that in the past.

Why would you have not conscripted Dr Guazzo to assist Dr Rosatto in the selection of the third neurosurgeon for North Queensland?-- As I said, I was not involved in that appointment process and I didn't meet the candidate. I had no involvement in that appointment process until some time subsequently to that.

You've mentioned that you - 20 minutes or so ago you mentioned that you were considering some improvements to the process by which candidates were selected. Can you tell us what

improvements you have in mind?-- Well, I will be re-engaging in the appointment of all senior medical staff and reverting to a system where I do take a more direct role in recruitment of all senior medical staff. Now, that's, I guess, going back to what we did previously. I think also some of the approaches that were considered appropriate before in the light of current circumstance we have reviewed, whereas previously practitioners coming through for a locum period may have been appointed as a senior medical officer in order to streamline the process and avoid the need for lengthy college assessment. Now, I'd like to go into that a little if I may, but we will, wherever possible now, have practitioners that we recruit for local positions come in as a deemed specialist. Now, the issue of college assessment, I think, is a very important one. The reason that we had previously brought people in as senior medical officers is by no means an attempt to bypass the system or to end up with a loophole, if you like. Our rationale is simply this: when you have an emergent need for a locum practitioner and the process of college assessment takes a minimum of three to six to nine months to complete, you may well have an assessment process that takes two to three times the length of the locum. It's clearly just an impracticality. Now, the assessment process is a paper-based approach, and I believe that it's done by members of the learned colleges on a pro bono basis. That is, we have paperwork submitted to the college through the Australian Medical Council, and senior fellows of the college will have a look at the curriculum vitae, look at the experience of the practitioner and make a recommendation based on that. Now-----

I'm right in thinking that takes such a long time that you can't really, if you have a short-term need, wait for-----?-- It's a total impracticality in that situation.

It's for that reason that you engage people as SMOs who might have qualifications sufficient to allow them otherwise, if they had the time-----?-- Absolutely.

-----to obtain specialist qualifications from the college?-- I would say the vast majority would be recognised as deemed specialists by the college should we have the time to put them through that process.

Now-----?-- And if there was to be something that could be done to expedite the college review process, I think that would be an enormous achievement, and something that would be a very good recommendation from this Commission, to see that the colleges are perhaps given licence to charge for services. We would not be averse at all to paying for an assessment if it expedited that assessment, but waiting for a minimum of eight to 12 weeks for an assessment - and that, I would stress, is the bare minimum - is just one more delay that seals our fate.

When senior medical staff are engaged by your hospital - and they're an unknown quantity because they come from overseas - you confer interim clinical privileges upon them pending the

assessment of their skills?-- Not quite. All practitioners, whether they're Australian trained or overseas trained, will be considered for interim privileges. Now, I rely on the expertise of the senior clinicians in that area to provide me with advice about what interim privileges should be awarded.

You don't allow any new doctors to practise unsupervised, do you? Unless, of course, they are specialists?-- Well, indeed. I mean, we will often recruit specialist staff to come and work unsupervised. It would be exceedingly difficult to do otherwise.

If their qualifications are not yet recognised by an Australian college, do you allow them to practice unsupervised?-- If their specialist qualifications are not recognised and they're coming to a clinical appointment, then - well, for a start we don't bring people into a permanent specialist appointment if their qualifications are not recognised by the college. We certainly - that standard for us is quite clear. We seek to have people brought in as a deemed specialist, and that would normally have been done before they commence their duties with us. There will be occasions where we have practitioners come through for a locum that we have not been able to put them through the specialist college. They may be registered on the general register, however on an assessment of their curriculum vitae, their qualifications and experience, we may establish that after a brief period of oversight they can practise independently.

Doctor, paragraph 8 of your statement. Please look at it. You say that senior medical staff are normally granted interim clinical privileges. How long does it take before the interim privileging takes place?-- The interim privileging is done as part of the recruitment process. So the panel will make a recommendation-----

Before their arrival?-- Oh, yes.

Thank you?-- At the time of the interview and the - and in the appointment letter we actually refer to the interim privileges.

At paragraph 13 you observe it's normal for you to carry out an orientation of medical staff tailored to meet their needs and the role they will perform?-- Yes, that's correct.

So if you have, for instance, an overseas trained doctor, you would, I suppose, have a longer and more detailed orientation?-- It's not a one-size-fits-all proposition. If I have someone coming to us from the Guy's Hospital in London to practise as Professor of Surgery with expertise in colorectal surgery, frankly I'm going to accept that person's credentials. We will certainly submit them to scrutiny during the process of their interview, and certainly do a thorough reference check. However, the orientation will be tailored more to an orientation to our environment, to our clinical culture, to ensure that they know their way around rather than checking out their clinical practice. If, however, we have

somebody coming from an environment we are less certain about their clinical skills and attributes, then we will provide them with a much greater level of support and scrutiny, particularly over the initial period of their appointment. It's horses for courses.

Doctor, you have on occasions identified overseas trained doctors whose qualifications and experience have been questioned, and through subsequent investigations you've confirmed that they've misrepresented their qualifications. You tell us that at paragraph 23 of your statement. One of them, I understand, was - is allegedly a Dr Berg, Dr Vincent Berg, a psychiatrist - or alleged-----

COMMISSIONER: Mr Andrews, I'm sorry, if you're moving on to the evidence about Dr Berg, from my reading of the material last night, the story really doesn't make sense unless Mr Whelan's statement is also in evidence, because it has many of the exhibits that are relevant to filling in parts of the picture. So unless anyone feels otherwise, I'm inclined at this stage to mark Mr Whelan's second statement as an exhibit so that the entire documentary story is there together.

MR DEVLIN: In the same vein, Commissioner, does the Commission have the Medical Board's file on Dr Berg?

COMMISSIONER: I don't know the answer to that.

MR DEVLIN: Again it fills in other parts of the picture.

COMMISSIONER: All right.

MR ANDREWS: No, the Commission does not have the Medical Board's file on Dr Berg.

MR DEVLIN: I will check. I think it was delivered-----

COMMISSIONER: In any event, for the moment Exhibit 236 will be the 75 paragraph statement of Mr Whelan which has a number of exhibits through to KDW11. Is that satisfactory, Mr Andrews?

MR ANDREWS: Yes, thank you, Commissioner.

ADMITTED AND MARKED "EXHIBIT 236"

MR DEVLIN: Commissioner, would you be prepared to reserve 237 as the Board's file?

COMMISSIONER: In fact I was going to give 237 to Mr Whelan's other statement which is shorter - it's 26 paragraphs - and then 238 will be reserved for Medical Board documents.

MR DEVLIN: Thank you.

ADMITTED AND MARKED "EXHIBIT 237"

MR ANDREWS: There was no publicity in respect of Dr Berg's interesting case. You were an advocate for the publication of the Dr Berg facts, weren't you?-- I was. This situation evolved over a few weeks at the end of 2002. At the time in November 2002 I became aware through a discussion with Dr John Allen, our Director of Mental Health, that he had been provided with advice through the College of Psychiatry about a non-doctor who was in practice in psychiatry in Townsville. I immediately followed that matter up with the College of Psychiatrists, and that correspondence trail is attached to my statement.

Let me interrupt, doctor. By the time Dr Allen came to you with the suggestion that Dr Vincent Berg may not have been a psychiatrist and may have misrepresented his qualifications, he had previously been employed at the Townsville Hospital but had left?-- Indeed. He was appointed at the end of 1999 as a psychiatry registrar. That is, a trainee in psychiatry. He claimed to have been a fully qualified psychiatrist trained in the Voronezh State University in the USSR. He had worked, by the time of my appointment, for a period of some six months in the Townsville Hospital Psychiatry Unit. That's my understanding from my discussions with Dr Allen, that there were concerns raised about the standards of his clinical practice at a very early stage. Dr Allen recalls that - and I recall him advising me at the time - this would have been July 2000 - that there had been some contact from my former deputy, Dr Barry Hodges, with the Medical Board of Queensland seeking to verify Vincent Berg's qualifications as he just didn't seem to add up. One of my earliest duties at the Townsville Hospital was to work with Dr Allen to develop a performance plan for a fellow we understood to be Dr Berg. We set about doing this. We established what gaps there were in performance. There were some very significant gaps. Those were addressed very specifically and our expectations were laid out. We managed this process very closely over a period of time and Dr Berg was required to answer to some fairly serious issues over the course of the ensuing couple of months.

COMMISSIONER: Doctor, can I interrupt you there? When you talk about there being gaps, reading through the material I see one category of problem where he changed medication for psychiatric illnesses without giving the first medication sufficient time to be effective. That was one type of problem. Another type of problem I noticed was simply inappropriate medication altogether. One instance mentioned in the material was prescribing testosterone for female patients, which would seem to be a bizarre-----?-- Quite.

-----practice. What other clinical flaws were identified in the doctor's practice - or the so-called doctor's practice?-- Gosh, Commissioner, you take me back a while, but he would change the treatment plans of the consultant psychiatrists

without discussing it with the consultants, clearly medication issues that you identified. He would not work well in a team environment. He told patients who had clear evidence of mental illness that they were not unwell. This was very serious - very serious matters. Unfortunately there were some psychiatrists within the service who actually felt that he was practising very sensibly. There is a variance of views about psychiatric practice and people will use different approaches to care. However, it seemed to me, from my discussions with Dr Allen, that this fellow was well outside the bounds of normal practice. So we addressed those specific concerns and outlined the behaviours that he was to observe.

Apart from clinical issues of the kind you've mentioned there are also, I have to confess, fairly vague references to his conduct generally. Nothing specific is mentioned. Do you have any recollection of the types of instances that that alludes to?-- I flicked through his file again yesterday. The sorts of things that came up - and this might be better addressed to Dr Allen when you meet with him, but he would work very poorly within a team environment, being very dismissive of other members' views. His attendance record was questionable. He failed to turn up for meetings. A very aggressive, intimidating form of communication, very gruff manner. Essentially there was an awful lot of areas where we had significant difficulties. So we sought to address that fairly comprehensively. We were conscious of the fact that he had claimed and had been awarded refugee status. We were conscious of the issues of reintegration into the workforce. We were conscious of the issues where sometimes interpersonal issues can arise and can cloud clinical performance, but we were able to establish, over the course of a relatively short timeframe, that his clinical performance issues were such that they really were unacceptable. As we increased the pressure on him to account for his performance he went for a period of stress leave, claiming depression. This continued right up to just prior to the end of his contract period with us. We made it clear to him that he would not be re-employed. He appealed right the way up to the Director General, engaging local members and anybody who he could to his cause. In fact a couple of psychiatrists wrote glowing references for him in support of his continued employment.

And this all occurred before it emerged that he had bogus qualifications?-- Indeed, Commissioner. This was - this process wound up essentially in January 2001 when Dr Berg was - his contract was not renewed. It would be my normal practice to contact the Medical Board and advise them of concerns verbally. I can't recall whether I did that in this circumstance. That would be my normal - my normal actions in - when we have a practitioner who we have effectively terminated. He then pretty much disappeared from view.

Going through the material that has been provided to us one has the impression that he was also a very colourful character. He talks, for example, in his CV about the fact - apart from his alleged medical qualifications he was also a deacon and then a priest and, finally, a Bishop in the Russian orthodox church; that he claims to have been arrested by the KGB and persecuted for his religious beliefs and ultimately came to Australia and sought refugee status. I assume you have never been able to verify any of those claims?-- I have not, Commissioner. I will confess the first time I saw those in July 2000 they struck me as extremely odd, however, it's not my place to question that sort of - in that sort of detail those activities outside of his claims of medical qualifications. I felt it certainly went to his application for refugee status and I accept that would have been checked out by the appropriate authorities. It certainty did seem to me to be odd to the point of being somewhat bizarre, however, the focus that I had was on managing his clinical competence issues which were quite significant.

And after those issues had been, in a sense, resolved by the fact that his contract wasn't renewed only then did the hospital find out quite fortuitously that there were also doubts, at least, as to the validity of his qualifications?-- Indeed, Commissioner. The process took an inordinate time. He left our employment in January 2001. He subsequently made application to the Australian Medical Council for recognition as a psychiatrist. He would claim all sorts of discrimination, that he was not being recognised, and his correspondence is rather forceful and colourful. The College of Psychiatrists did as they normally do and sought a verification of this through the Australian Medical Council and the application went to the College of Psychiatrists. The College of Psychiatrists did what they normally do. They sent correspondence to the Voronezh State University, the institution which sent - Berg claims to have gained his basic medical qualifications and his psychiatry qualifications. They received advice in January 2002, so one year subsequent to his leaving us, that his qualifications were bogus. In fact, were clearly fake documentation.

I saw somewhere the expression "crude forgery" being used?-- Yes. Yes, that's correct.

And I think it was even said that the course that he claimed to have taken at that university - for the reporters is spelt V-O-R-O-N-E-Z-H - that course wasn't even offered at the university at the time he claimed to have taken it?-- That's

correct, Commissioner, and the College of Psychiatrists wrote in the January of 2002 that - to the Medical Board of Queensland identifying to the Medical Board their concerns about this practitioner's qualifications. Unfortunately, the Medical Board did not contact us. We only learned surreptitiously in the November of 2002, some 11 months after the issue was first raised by the College of Psychiatrists-----

Just interrupting there, if I may, I guess it could fairly be said in defence of the Medical Board that by that time he had left employment with the Townsville Hospital and, therefore, you had no continuing right to know the situation?-- I would take a very different view to that, Commissioner. The reality is a practitioner at any level, but certainly as you move through the ranks to Registrar consultant levels, has a level of independent practice. Registrars do practice under supervision, but at times they will see patients on their own and report back their findings to consultant staff. Now, in this situation I believe that we had a clear need to know, not only a right to know, but that that was the situation as we had concerns about this fellow's clinical practice and - which cuts both ways. It meant that we had him more closely scrutinised, but I think clearly we had a need to follow up and establish whether, in fact, there had been any patients who required follow-up care. That's why we undertook an audit of charts and identified patients in a range of categories to establish what sort of issues we might have from having had this unqualified practitioner in our books. Now, that's the point at which we were - immediately we found out about this issue we briefed up the chain and I recalled having written an e-mail myself to the zonal manager and to the general manager Health Services, Dr Steve Buckland, identifying the issues as soon as we became aware of them. We subsequently followed that up with a briefing and a complete media plan together with-----

Just before you come to that follow up, there's one thing I'd like to have quite clear. I read the audit document and I think it's fair to say that it couldn't be concluded that any patient had suffered as a result of Berg's care, but there were at least some question marks. There was one patient who committed suicide and no-one knows whether that could have been contributed to by a lack of appropriate psychiatric management. Is that a fair comment?-- Yes, Commissioner. I think the issue is we didn't know what we didn't know. We were able to establish that there was a group of patients who really did need to be followed up and had potentially high risk-----

I think there was another example of a patient - it may have been at Charters Towers - where the patient died from a haematoma as a result of falling out of bed and there was a suggestion that Berg may have prescribed medication which caused dizziness and made that patient more susceptible to that fall?-- Potentially so, Commissioner, yes.

Yes. So those are perhaps extreme examples, but those are the

sorts of reasons why you felt a need to follow up with every one of the patients that could be identified?-- I think there's a couple of issues here. Whenever we identify something bad that's happened - and I would rank employment of an unqualified practitioner as a bad event - I think it's incumbent upon us to understand what's happened, why it's happened and how we might prevent that from happening again. Clearly, varying the issue does not help with that, but then there's the specific issue of follow-up of patients. Now, we were able to identify some, I think it was 250 plus, patients that we knew had been seen by Berg. We didn't know if there was others who he might have seen when he was on call and essentially we go back to that thing again, we didn't know what we didn't know. The reason for the media plan was to try and establish whether there might be some patients out in the community who had seen Berg and may require review. We wanted to be very clear in our communication with the community so that we could quite clearly identify that this was one practitioner and that they need only be concerned if they had ongoing issues and they had seen this one practitioner. We developed up scripts for a hotline phone line. We had intended to contact all of the patients and advise them of this circumstance. In the end what we did, as I recall, is actually arranged to review those patients that were considered to be at the greatest risk and establish whether or not they needed any changes to their treatment. I recall that the Director of Psychiatry, Dr John Allen, and myself were very concerned that we were blocked from doing the - the more open approach and that was a significant issue of concern for us.

Well, again, if I can interrupt, I guess there would be people that say that Patel in Bundaberg is a problem because he was performing surgery and people died from incompetent surgery, but equally in psychiatry, although the cause of death may be different incompetence, psychiatric treatment can contribute to things like suicide and other forms of very adverse outcomes to patients. Is that a fair comment?-- I think that's a very fair comment, Commissioner, particularly in the environment, whereas a Registrar in psychiatry the practitioner is required to come in and assess patients in the Emergency Department after hours and assess their mental state and whether they represented a danger to themselves or to others. If you have an untrained practitioner in that environment I think we have to acknowledge there is a significant degree of risk involved and potentially some fairly serious errors made.

Secondly, what I wanted to clarify is from reading the audit document it becomes clear to me that I think you mention the figure 259, I think it was, patients were identified, but you didn't know if there were more, and if there were more you didn't know how many more there might be?-- That's correct, Commissioner.

The third thing is that as part of the documentation for the proposed public disclosure of all of this someone - and I think it was Dr Allen - made the point that once the word gets

out into the community that there's a bogus psychiatrist that would bring all of the psychiatrists at the hospital under a cloud of doubt if the plan wasn't put out in the community and at least Dr Allen was very anxious that, not only for the sake of the other psychiatric staff, but for the sake of patients as well, that people could know that this problem was confined to Berg and didn't involve any of the other psychiatric staff. Did you see those as important issues?-- Most definitely, Commissioner. I think the reality for us is that public confidence is a very precious commodity and being open and up front with our community is essentially part of establishing and maintaining public confidence. Part of that is to have the guts and the commitment to being honest when things go wrong. People, I think, understand and respect that where that's done openly and honestly they have a far greater level of confidence in the services that are provided. Now, for us to allow this to evolve, have potential for major media exposure that may have grossly exaggerated the scale of the problem, people, I think, would have lost all confidence in our services. What we sought to do was to accurately communicate the issue, accurately communicate our plans and establish for the community that we had the issue identified and under control.

Mr Andrews, could you arrange to have put up on the screen an attachment to Mr Whelan's longer statement which is KDW8? It's the second page of KDW8.

MR ANDREWS: Certainly, Commissioner. Before that is put on the screen, Commissioner, I should tender a bundle of documents supplied by Queensland Health a couple of weeks ago which relate to concerns about Vincent Victor Berg and among them a correspondence from the CMC. It seems that the matter was drawn to the CMC's attention.

COMMISSIONER: Despite Dr Buckland's-----

MR ANDREWS: Despite that page of KDW8 that you are interested in.

COMMISSIONER: All right. Can you hand that up for the moment and we'll have KDW8 go up.

WITNESS: If I may, Commissioner, that matter was brought to my attention by Mr Andrews prior to the commencement of proceedings today and quite a revelation. We were unaware that the matter had at any stage been referred to the CMC.

COMMISSIONER: Yes. Yes, that e-mail is now on the screen. You mentioned that you were prevented from going public with this matter. Was that the source of that instruction?-- I believe it to be so, Commissioner. The communication about the - communication strategy I recall was most likely to have been a verbal direction because the communication strategy went up on the 13th of January and if I'm not mistaken is dated the 24th of January. We - well, I only became aware of this specific e-mail some few weeks ago. I recall having some fairly animated discussions with my district manager at the

time as I felt quite strongly that the matter needed to be reported to the Crimes and Misconduct Commission and the media strategy needed to go ahead. My district manager, Ken Whelan, made it very clear to me that he had received direction on this issue and that it had come from the general manager, health services area, but he did not show me this e-mail at the time. I suspect that was probably to protect me from seeing the fairly interrogatory comments made about me by the general manager, health services in that e-mail.

Well, I must say, no doubt, we'll hear from Dr Buckland in due course what he meant by it, but I've read the brief prepared by you and the people in your office and I simply cannot understand the source of that criticism, what is said to be wrong with your brief, but if we go on it says that, "QH does not register medical practitioners. We provide them. Dr Berg was registered by the board when we employed him. Our issue is about the quality of our performance. In discussions with the board they refused to acknowledge that he was not registrable. Game, set and match." Can I ask, would you have employed this man if you knew that his credentials - despite the fact that he was registered by the Medical Board - if you knew that his credentials were bogus?-- Absolutely not. I mean, the reality is we certainly do rely on the Medical Board's assessment for registration, but there is a directive employment contract between us and the practitioner. If they misrepresent themselves in applying for that contract I think there is a direct case to answer to us and, you know, I'm not a - I don't have a legal mind, but I'd suggest that that would clearly represent a fraud.

Well, from there we discover - and you tell us that you learned for the first time this morning - that the matter was referred to the Crime and Misconduct Commission and the Crime and Misconduct Commission in turn indicated that it should be referred to the Queensland Police. That's a fair summary, isn't it, Mr Andrews?

MR ANDREWS: It's a complicated document. It seems that the Crime and Misconduct Commission indicated that it should be referred to Queensland Health's audit and something branch?-- Operational Review Branch.

Audit and Operational Review. You will see, Commissioner, in the letter dated the 3rd of January 2003 towards the end of the bundle a Mr Walker from the CMC writes to Mr Michael Schaeffer, the Director of Audit and Operational Review, that section 44 of the Act provides that, "Upon referral by the CMC a public official must deal with a matter involving possible official misconduct in the way the public official considers most appropriate subject to the CMC's monitoring role. As you will note 'deal with' as defined in Schedule 2 of the Act includes investigate and take other action including managerial action to address the complaint in an appropriate way. Under section 44(3) a public official may decide to take no action in the prescribed circumstances.", and it seems that it was referred to Audit and Operational Review which ultimately decided to refer the matter to the Queensland

Police Service.

COMMISSIONER: What I find, amongst so many things, absolutely bizarre about this is how Audit and Operational Review or, for that matter, the Crime and Misconduct Commission, or anyone else, could properly investigate this matter without coming back to you who was the man who, in effect, had spoken for the employer about so called Dr Berg?-- It would seem a little odd, Commissioner. If I may, Commissioner, one of the reasons that we wanted to report the matter to the police, apart from the issue of suspected official misconduct, was the concerns, valid or not, about personal safety of members of our staff. When someone such as Berg's cover is blown, if you like, having lived a lie for such an extended period it may follow that they act irrationally. You will recall that it was around this time that Dr Margaret Tobin, the Director of Mental Health Services in South Australia was shot dead. We did have concerns about physical safety and we did want to know where Berg was to establish whether or not there was a need for perhaps some form of protection, if you like, for particularly - I know Dr Allen was concerned and I had concerns for my own safety. They weren't the primary motivators, but we were, in effect, ending somebody's lies that took on the basis for their life.

Doctor, is it the case that as a result of Dr Buckland's direction there was, in fact, no publicity of the incident at the time?-- Yes.

And this story didn't, as it were, leak out?-- That's correct.

Does it follow from that that even to this day Townsville Hospital doesn't know how many other patients may be out there in the community who were treated by Berg, prescribed medication by him and so on?-- That's correct, Commissioner, but I would hasten to add that the relevance of that lack of knowledge diminishes over time as the patients that are involved in our system will come back through the system for ongoing follow-up and support. So the issue of are there patients out there still who are still suffering, I would say to you the risk of that is extremely low.

Yes?-- But we don't know whether patients were harmed at the time.

And we don't know and now probably will never know whether there were patients who committed suicide or whose families broke up or who suffered all sorts of other stress, who lost their jobs or whatever as a result of receiving inappropriate psychiatric treatment from Berg?-- That's correct, Commissioner, yes.

Yes. Mr Andrews?

MR ANDREWS: Doctor, since that time when you were unable to pursue your own preferred course, which was to publish the events surrounding Dr Berg, can you tell us whether there has been from Queensland Health any other directions with respect to your ability to liaise with the media?-- Well, I think it would be fair to say that there is a reasonable degree of scrutiny over what we say to the media, which varies from time to time. As recently as yesterday we received a directive that all media contact is to go through corporate office including condition reports for patients who perhaps have been victims of car accidents. So there is an ongoing level of scrutiny of contact through corporate office.

D COMMISSIONER VIDER: To go through which office?-- Corporate office. I think it came through the - I can't recall exactly what the title is but Public Affairs Branch.

MR ANDREWS: And can you explain that last example for me, reports on patient-----?-- We might be reasonably contacted by the Townsville Bulletin to ask us about the condition of a patient who was brought into the hospital last night in a car accident.

I see?-- That's a very routine query that we would routinely respond to with a minimum of fuss. The current situation, as I understand it, is that we are expected to direct all media inquiries through the Public Affairs office in Brisbane.

COMMISSIONER: Doctor, I am quite interested in something you said earlier, that if you didn't go on the front foot and explain this story to the media properly, you perceived a risk that it would leak out and a distorted version would appear in the press, on television and so on. I have to say that based on my own life experience, that is certainly the case, that if something controversial has arisen, it is much better to be open and candid about it and that way not manage the media in a spin doctoring sense, but make sure the real facts are out there, rather than some distorted version of them. But have you found in your time at Bundaberg that you have been prevented from speaking to the media candidly about issues and that that's had adverse results for the hospital in terms of public perceptions?-- Commissioner, I have only ever briefly passed through Bundaberg.

Sorry, Townsville. I do mean Townsville?-- Yeah, I guess, you know, the approach that management team has adopted, and that survives through the last couple of iterations of our management team, is that openness and transparency is the most appropriate way forward and we do end up playing catch-up at times. The truth or versions of it will often appear when you least expect it. From our perspective, we're far better to be proactive and if there is a story to tell, positive or negative, we would rather tell that story rather than have it emerge and then have to deal with the fallout. I say a version for truth because I think the reality is many people can be telling the truth from a different perspective and provide a totally different picture and it is only through having the opportunity to put the range of views, that you can

establish a reasonable understanding of events.

Doctor, I ask these questions because I am genuinely interested to know. Over almost three months of evidence now, we see again and again cases of Queensland Health getting reports about problems here and problems there, that reports are covered up, and eventually Mr Thomas, or one of the other astute investigative journalists, gets hold of the facts and the story gets into the press in a way that probably produces the worst result for the hospital, for the hospital staff, and even for the patients because it comes across as this huge scandal that Queensland Health has tried to hush up, and I just wonder if you can see any logical justification for the culture, that seems to be pervasive at least to Charlotte Street, if it is bad news you hide it away in the basement and never tell anyone about it?-- Commissioner, I think there is a very simple answer and that's the fact that politics has really taken over the delivery of health care to an unreasonable extent. I mean, the fact is that the Minister's office is on the same floor of the same building as the Director-General's office. You know, separation there is really somewhat lacking, I would suggest. You know, the reason that we're being prevented from saying things is essentially, I would suggest, for political purposes. Now, I don't mean that in any party political way. No politician likes to have bad news on their watch. If they were provided with a mechanism to have an arm's length arrangement, perhaps through a Health Commission, we might actually be able to take some of the politics out of the discussion. But at the moment, you know, people have a very real and rational interest in health care. It makes news, it sells newspapers. You know, a negative story is always far more fun to run than a positive one. But the only reason that I can think of for suppressing information is for short term political advantage, and I don't aim that at anyone in particular, but I think the reality is that one of the roles of a Director-General is often seen to be to first protect your Minister. I think that's an unhealthy situation.

Mr Andrews? I am sorry, I will give exhibit number 239 to the Queensland Health Investigation File, Victor Berg.

ADMITTED AND MARKED "EXHIBIT 239"

MR ANDREWS: Thank you, Commissioner.

WITNESS: Commissioner, may I ask, that investigation file, when that was completed?

COMMISSIONER: I will have to get it back. It is a nice change to be asked questions rather than asking them?-- Oh, sorry, rather impertinent of me.

Not at all. It is in reverse chronological order, isn't it,

Mr Andrews, if I made sense of it? It is stamped as closed. We don't have a date on which it was closed. The last letter in it seems to be one dated 9 April 2003 from the Crime and Misconduct Commission which relevantly says, "Mr Berg is no longer employed by Queensland Health. Disciplinary action cannot be considered in relation to his behaviour. However, it is considered the concerns about Mr Berg's behaviour may involve possible criminal activity after considering the principles which must apply under the Act when performing its misconduct functions. The CMC has decided to refer the possible criminal activity to the Queensland Police Service to deal with. The CMC has no further requirements of Queensland Health." So that seems to be the end of it. In April it was referred to the Police Service and there is nothing else on the file?-- Thank you, Commissioner. The reason I ask is that we received further communication from police in - it would have been June 2003 seeking to close the file. They asked for advice as to whether we wished to press ahead with a formal complaint. At that stage the Queensland Health position remained unchanged, as I understood it, and I communicated back to - I believe it was the Acting Superintendent that we did not wish to pursue with a formal complaint at that stage based on the previous direction we had. So I just find that timing somewhat confusing.

Particularly in light of Dr Buckland's email saying, in effect, the QPS should be told that Queensland Health didn't have a problem?-- Mmm.

Yes.

MR ANDREWS: When-----

COMMISSIONER: Sorry.

D COMMISSIONER EDWARDS: I am still having some difficulty with Dr Berg, in that he could be around for so long and really very little was done until the last moment when his contract wasn't going to be renewed. It is all very well saying the Minister was next door to the Director. Every Minister has been next door to the Director for 30 years. I don't think those kind of comments really help the situation. What I am going to say to you is that I am finding it difficult to know where perhaps your responsibility and other senior people who were there when this man was allowed to practise for 12 months.

COMMISSIONER: I think, Sir Llew, it is important to bear in mind Dr Johnson wasn't himself there at the time.

D COMMISSIONER EDWARDS: I said, Commissioner, him and other people?-- Sir Llew, the reality is I arrived in July 2000.

I am not asking about you, the system?-- Please, the initial exploration of concerns have been, as I understand it, undertaken by the Director of Mental Health at the time. By the time I arrived, his concerns were so well developed that we needed to start an effective management plan for this

particular individual. Now, that took place over a matter of weeks, a couple of months at the outside. In terms of performance management, that's actually very, very quick. We did put him under much higher level of supervision and scrutiny, he was being held to account for issues - and there is a trail of correspondence that documents this performance management. So, with respect, in fact his performance was addressed rather aggressively to the point where he went off on stress leave after - I can't recall the exact time that that commenced but I believe it was in the August or September. I may have that - it is a long time ago now but we were - it is not a matter of doing nothing, we were aggressively managing the situation until he took stress leave, then that matter had to be investigated and resolved. Of course, finally, Dr Allen and myself were absolved of any wrongdoing in that stress claim. The allegation was that we had been bullying and harassing the practitioner. So certainly there was no sitting idle allowing this guy to go on. We did investigate at a local level, I would suggest fairly assertively, if not aggressively, and competently. He stopped practising with us after a matter of a couple of months after that process commenced.

MR ANDREWS: In fact, doctor, your statement at paragraph 9 informs us that in August 2000, a formal show cause notice was issued to Dr Berg, following which he went on extended sick leave and made a Workcover claim?-- Thank you, yes. So from the time that issues were raised to me, I could say - I can look myself in the mirror and say it was dealt with fairly promptly. I can't really comment on the time prior to my arrival but I can say that often it takes a while to actually establish what the concerns are and whether somebody is, in fact, aberrant in their practice. Now, we're not quite sure what qualifications or experience Berg has had, but clearly he knew something about the area. He wasn't content free. He was able to pass himself off. Now, a conman he may have been but he was able to pass himself off as a psychiatrist. Indeed, if you - if you look through the curriculum vitae, a couple of consultant psychiatrists recommended that he in fact be appointed at consultant level. So there was a variance of views but we - that is Dr Allen and myself felt that we were able to establish a very objective criteria that were not being met by Berg and we pursued those with some vigour.

COMMISSIONER: He was a plausible rogue?-- Yes. You know, basically a conman.

Yes. But I think the important thing for our purposes is that at Townsville Hospital you were able to - even before you knew about the problems with the Medical Board and the registration, and so on, you were able to identify him as a problem doctor within eight months, I think from January to August?-- Quite.

And put in train the processes to deal with that?-- That's right. It took eight months, I suppose, Commissioner, from the appointment through to the time that he effectively stopped work with us, but I would say it was substantially

shorter than that that concerns were developed, initially explored, as I understand it - and this is anecdotal - with the Medical Board to establish that he did in fact have reasonable qualifications.

And people will draw their own comparisons between that and, for example, the length of time it took for Dr Patel's situation to be dealt with in Bundaberg?-- Commissioner, we have a number of examples in the Townsville district where practitioners have been identified to us for performance issues and there has been a number of cases where we have in fact managed practitioners out of the organisation. It is a difficult thing to do but we have had to do it and they have been addressed in a professional but direct manner.

D COMMISSIONER VIDER: Does psychiatry use a case study process as a form of peer review? I am asking that question generally?-- Deputy Commissioner, I have to ask you to address that question to Dr Allen when he is on the stand. There are a number of mechanisms that they use for support, and I am aware that they have regular supervision and part of the issue with Dr Berg was his willingness to participate in the supervision, but the exact form of that takes with the registrars. I think Dr Allen would be able to address it.

Two further quick questions for clarification. When Berg left, he understood that his contract was not being renewed because you had concerns regarding his clinical competence?-- He was in no doubt about our concerns about his clinical competence.

And, secondly, did you say that you notified the Medical Board?-- I look back through the files to find a record of that. I was unable to find a record of it. I can't say with certainty that I did but it certainly is my normal practice to contact the Medical Board when there are issues of clinical concern.

Yes?-- Now, I do that for a couple of reasons: firstly to establish whether there is any record of issues and, secondly, I certainly don't want other places picking up a practitioner that we may have cut free.

Thank you.

COMMISSIONER: Mr Andrews, I was thinking of taking the lunch break now. Can I mention to everyone at the Bar table we do have a lot of evidence we're planning to get through in Townsville. Given that we have the benefit, if you can call it that, of being away from our offices and families and those sort of commitments, I was hoping that everyone would find it acceptable to sit some extended hours to try and get through this workload but I really would ask counsel amongst themselves and their instructing solicitors to discuss the best way to do that for your own convenience, whether you would prefer to start earlier, have shorter lunch breaks, perhaps break at 5 o'clock and for a dinner break and have an hour and a half, maybe two hours of evidence in the evening.

Just talk amongst yourselves and work out what would suit you best and I will try and make things as convenient for you as possible.

MR ANDREWS: Commissioner, I expect that if we reach and finish Mr Gallagher this afternoon, we're on schedule to complete the evidence on time on Thursday.

COMMISSIONER: Thank you, Mr Andrews. For the moment we'll adjourn till half past one. Does that suit everyone?

MR ANDREWS: Thank you, Commissioner.

THE COMMISSION ADJOURNED AT 12.49 P.M. TILL 1.30 P.M.

THE COMMISSION RESUMED AT 1.43 P.M.

ANDREW JAMES JOHNSON, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Yes, Mr Andrews.

MR ANDREWS:. Doctor, after you had discovered that months before Dr Berg, while in your employ, was likely to be unregistered, you were concerned that neither the Medical Board nor the Royal Australian and New Zealand College of Psychiatrists had informed your hospital of their awareness of the allegations?-- Just to clarify, there was no doubt about Dr Berg's registration. He was clearly registered. He was registered up to three days prior to his termination with us in Townsville. In fact, he was seeking to have us support the renewal of his registration. We refused to do that because we had no intention of re-employing him. So we agreed to him doing non-clinical duties for his last three days of employment.

COMMISSIONER: I think, Doctor, you're at cross-purposes. Mr Andrews only meant doubt about his registration in the sense of doubt about the way in which he got his registration?-- Thank you. I do apologise.

MR ANDREWS: Thank you?-- Yes, we had very significant concerns, not so much with the College of Psychiatrists. I would not regard them as being the authority to chase us down. In fact, they may not have known that Berg had been employed by us. It was then-----

But the District Manager Mr Whelan, he corresponded with the Medical Board of Queensland?-- Absolutely.

Informed the board of his disappointment and then the issue that arose because your patients needed to be followed up and the Medical Board responded in January 2003, advising that a process had been put in place to ensure that employing authorities are notified if it is subsequently found that a person who has been registered in fact did not hold registered qualifications?-- Yes, that's correct.

Now, do you understand the Medical Board to have ever made a determination that Dr Berg in fact did not hold recognised qualifications or were they simply aware of the allegations?-- I'm not aware of how that issue was concluded with the Medical Board. That's not been communicated directly to me by the Medical Board. I think in evidence that was previously presented, the e-mail from Dr Buckland suggested that the Medical Board continued to maintain that Dr Berg had registrable qualifications. So, I don't have any personal knowledge as to whether that was the result.

Thank you. In the circumstances, let me take to you to

Dr Myers?-- Yes.

Dr Myers is engaged by your hospital on rates I assume which are consistent with his being able to practise neurosurgery unsupervised; that is, his pay rates are at a level that you would have offered on the assumption that he would practise unsupervised?-- Not quite. Dr Myers is registered with general registration in an Area of Need through the Medical Board. He has not been offered a specialist appointment and has not been paid at specialists' rates. He is being paid at senior medical officers' rates. Now, the exact level of responsibility of a senior medical officer position and the level of supervision required will vary. It's not uncommon for instance - in fact, the most common form of appointment for us in a regional hospital would be at that senior medical officer level. So it's not that he's being paid as a neurosurgeon; he is being paid as a senior medical officer.

It's not the senior medical officer description nor the neurosurgeon description with which I'm concerned but the number of dollars per month or week that are offered to him?-- Yep.

My interest was in whether he was offered and paid a sum of money which was consistent with an employee who would practise unsupervised?-- The senior medical officer rate would normally practise unsupervised in non-specialty areas. They may practise in a supervised manner in a speciality area or, indeed, they may practise unsupervised in that area. It's not a clear-cut, black and white issue. For instance, we may have a senior medical officer in an emergency department who would be expected to function at the level of and on the roster for specialists staff. In other areas it's not that clear-cut. I think when we initially attempted to recruit Dr Myers, it was to a permanent vacancy and he was to come as a - his letter of offer was as a senior staff specialist. In that - on that pay rate, which is significantly greater than the pay rate he is on now, he would have had to have established his specialists qualifications and been registered as a specialist. On the senior medical officer level, there is no requirement to do that.

Has his pay grade been downgraded consistently with the fact that he must practise supervised while at your hospital?-- His pay grade is consistent with a practitioner of a senior level who may or may not require supervision.

Thank you. When he-----

COMMISSIONER: But it's less than a staff specialist would be paid?-- Correct, Commissioner.

Yes.

D COMMISSIONER VIDER: And is he registered as an SMO under the Area of Need specialist-----?-- Yes, that's correct.

Is he under the Special Purpose Registration?-- Yes, he is,

section 135 registration has a - to work in an Area of Need as a senior medical officer in neurosurgery. The level of supervision for Dr Myers - now, I think it is important to understand how this process evolved. The Medical Board requirements for supervision are as yet incomplete and have not yet been documented in a way that they can be followed clearly by practitioners such as myself trying to work through these issues. What is now mooted is a four-level supervision requirement where a practitioner may be at the lowest level of supervision, would require deemed specialist or formal specialist recognition by one of the colleges. At the next level down it's consistent with a registrar through to senior medical officer level where the level of supervision will vary depending upon the skills and attributes they are able to demonstrate to their nominated supervisor. Now, a registrar does a level of unsupervised practice as would a senior medical officer under that definition. Now, I - I'm at pains to say that this has not yet been provided in any form that we can rationally apply. When we are needing to submit paperwork for an Area of Need appointment, we now need to specify the level of supervision available and the board will consider whether that is appropriate or not. But at the moment we don't have the guidelines that would make that an easy process for us. When I say "us", I mean medical superintendents, people in my sort of role.

COMMISSIONER: And, Doctor, I want to be quite clear because anything that takes place in evidence here obviously has the capacity to affect people's reputation and, indeed, hospitals' reputations. I understand that there is no question whatsoever that Dr Myers is fully qualified and competent to do the job for which he is currently employed at the hospital and, indeed, quite possibly overqualified for the position that he currently occupies?-- That's correct, he has training in neurosurgery in a first world nation. For us to suggest that training in the United States is - is less than training in Australia I think would be, perhaps, a gutsy call. I don't know specifically. I think that's a matter for the college to resolve. We have put his paperwork to the college for assessment and that is currently in train. Again, when - when the appointment was made as a senior medical officer, as I indicated before I came to that process quite late and at the same time, Medical Board requirements for supervision were changing.

Yes?-- Now, in that environment, clearly we need to re-evaluate our approach to this. Now, Dr Myers, when you meet him, you will see you're meeting a very calm, very rational, very sensible fellow. When I met him for the first time I was deeply impressed by the fact that he acknowledged that there were some areas in his practice that he would need to brush up on. I think the mark of a good surgeon in many respects is that level of self-awareness. Dr Myers demonstrates that in abundance. There are some areas that he - that we would normally have established in any recruitment process that he required some support with because he'd been operating in an environment that he didn't have access to all technologies for perhaps the last five years,

but his basic training is - you know, I have no reason to doubt.

Can I ask, you have referred to the recent changes in administering the Area of Need provisions under the Medical Act and Medical Registration Act and so on. Had Dr Myers been appointed 12 months or two years ago, are there any significant differences in the way in which it would have been handled?-- He would - very likely, given it's a local appointment, he - he rejected the permanent appointment.

Yes?-- So as - as a way of trying to get him to sample the delights of working in Townsville, he would be encouraged to take up a locum position for a period of a few months. That gives him a chance to look at us and us a chance to look at him.

Yes?-- It would have been our practice in the past to accept that for a short-term locum period such as that, we would not put him through a college review that would be longer than the locum appointment.

Yes?-- And clearly, at the time that he was to come, we had some service deficits. We had one practitioner who was going away for an extended period of leave and another that also needed a period of leave, so there was an issue of service continuity to consider as well. Would we have handled this differently 12 months ago, quite possibly, yes, but times change, things move on and we learn about new and better ways of doing things. I think it will be fair to say that there is still a lot of room to consolidate the supervision requirements that are being put in place by the Medical Board because at the moment we simply don't know what mark we're aiming for.

I suppose, Doctor, you've anticipated what my question was going to be. Subject to clarifying the supervision requirements and making them more specific, is it your view that the current system as it's evolved over the last month or so is an improvement on the system that existed in the preceding years?-- Commissioner, I'll be honest, I was hoping you wouldn't ask me that question.

No, no, well, I-----?-- And the reason for that, frankly, I don't think the system has improved.

Yes?-- I think, in fact, changes that have been implemented have significant detrimental impact that needs to be understood.

D COMMISSIONER EDWARDS: In time or in process?-- Immediately and in the coming months.

COMMISSIONER: I think Sir Llew's question though is is it detrimental in the time at which things get done or is the process also flawed?-- I think both. Speed is certainly an issue but it's an issue from the perspective not only that it takes us longer to get the practitioner we want but many

practitioners are put off-----

Yes?-- -----by the length of the process. When you're competing for practitioners in a world market - and let's remember, the huge majority of the overseas trained practitioners that were brought into this country have been a superb addition to our system.

Yes?-- We have relied on them. I mean, through years and years of the failure to grow in the number of medical graduates, and how that was allowed to happen is just beyond me - you know, to have the same number of graduates coming out in Queensland for the last 30 years, it's absolutely no wonder that we have a dire doctor shortage in Queensland. We have 217 practitioners per 100,000 population. The rest of the country has 271 per 100,000 population and they're claiming that they have a shortage. My goodness, we are so short of doctors in Queensland it is just not important, and we'd be importing quality doctors and we have been in the main importing very high quality doctors. The risk is as we increase the length of time that doctors need to be assessed and increase the hurdles that they have to jump through, we simply are not getting the applications. The recruitment companies are saying to us, quite loudly, that they are considering going elsewhere for their business because Queensland is just too jolly hard. Now, I recognise the community's concern about need to make sure that we introduce doctors safely into our system but I think we've perhaps aimed at the wrong part of the solution. All of Queensland is an Area of Need. We have 217 doctors per 100,000 population. The rest of our dire shortage in Australia is 271 per 100,000 population. We are so far behind the eight ball. So the question of Area of Need to me is - I'm sorry, I'm thinking of an accurate expression - is quite obvious. What then do we do about it? Clearly there's a problem that there has been practitioners perhaps brought in without adequate supervision and support, perhaps without an adequate safety net. I'd suggest to you that they are vastly in the minority. I have around 400 doctors on the books in Townsville. 200 of those may have trained overseas. The number that I've had problems with I could count with the fingers in my hands. I don't need to take my shoes off to count them.

Yes?-- And that's in the space of five years where we've brought through hundreds and hundreds of these doctors. Now, the issues, I would suggest, aren't really - what these checks that have been introduced would do, would identify the one or two that perhaps have bogus qualifications or who don't have the good standing that they claim. I think in the vast majority of circumstances though we've had extremely competent people come in and all of this - all this is going to do is actually encourage them to leave, because there's going to be ongoing requirements for certificate of good standing every year from every jurisdiction in which they've worked. The hurdles to getting here are so enormous that my consultants and junior staff from overseas are saying that they won't recommend coming to Queensland to their colleagues back home.

Now, what that's going to leave us with is an absolute crisis in medical manpower worse than what we've had in the past.

Doctor, again playing the devil's advocate, I guess it has to be said that any system, any safety net has to be fine enough to catch the worst case. It's not good enough to say 98 per cent of foreign trained doctors that come to Queensland are not only competent but a valuable addition to our medical services. The whole idea is to catch the two per cent who aren't?-- Perhaps, Commissioner, if I may play the devil's advocate back to you, 50 per cent of medical graduates in Australia are below average performance.

Yes, I accept that?-- We have no monopoly on well trained practitioners here. The reality is we know that there are a number of jurisdictions where the training is at least as good as it is in Australia. Perhaps we're being a little bit politically correct in saying that we have to treat every overseas jurisdiction the same.

Well, I have to say that that was one of my concerns about the way in which some of our recommendations in our interim report were implemented. One of the views that I've canvassed is that, really, the Australian colleges should be looking at their counterparts overseas and considering whether a person who is, for example, a member of the Canadian College of Psychiatrists can't be automatically recognised as the equivalent as a member of the Australian college. Unfortunately, Doctor, what an inquiry like this tends to hear are the horror stories and not only the horror stories of what happens to particular patients but also the situation where we're told Queensland Health is recruiting doctors from Cuba and Albania and Uzbekistan and places like that where, undoubtedly, the national wealth and the national health care facilities are such that it would be an outstanding student who achieves average or above average standards to Australia. Now, we may be getting that average student and, if so, we'd be happy to have him or her but there is obviously a risk that has to be guarded against and I think my concern can be best articulated in saying that whilst we need to have that safety net in place to cover the worst case scenario, that has to be balanced against some recognition that people who come to us from the United States or from Canada or from South Africa or from Ireland or from the United Kingdom or from continental Europe probably need less scrutiny than those who come from Third World countries and that may be politically incorrect but it has to be recognised as a reality?-- I absolutely agree with you on that, Commissioner. I was a jurisdictional representative at a meeting in Sydney in I think it was April last year, or March last year, where the heads of all of the professional colleges came to together with the heads of all the Medical Boards to meet with the Federal Minister for Health and to try and nut through how we might go about streamlining the process for recognition for practitioners, particularly from those known quantity countries. Now, we're still grappling with this 18 months later. I do believe that some of the colleges actually have - have a little list.

Yes?-- And they do regard more fondly the qualifications from one country over another, but the reality is the changes that have been implemented now are a one size fits all which does enormously disadvantage, particularly in recruiting from the countries that we'd like to be able to target. Now, I personally believe that there's still a bunch of practitioners that we may well be able to attract from the UK and Ireland but we're simply at a marketing disadvantage when we have a process that's going to take them through perhaps seven or nine months of endless scrutiny before we can get them registered let alone on the job.

Doctor, since we've opened up this area, there are a couple of other things I would like to pass by you and I want you to understand clearly there is no implicit suggestion that the problems I'm referring to exist in Townsville. On the contrary, my suspicion from everything I've heard and read so far is that you don't have these problems in Townsville and I'd be interested in knowing how you've avoided problems that may exist elsewhere. Firstly, there's the repeated suggestion that Queensland Health is against VMOs because VMOs are difficult people, they want everything done according to what they think is the best possible standards, whereas if you get a foreign trained doctor, it's very much like having a bonded slave: they can't go and work for anyone else; they can't really make a fuss; they can't threaten to resign; they have to do what they're told. Do you have any views about that suggestion?-- I acknowledge that that is one of the suggestions that's been made through this Commission. I think the issue is rather complex. I've been fortunate to work across both public and private systems and I can talk with some personal experience about the difference in approach across the public and the private sector. When Dr Molloy gave evidence, I believe he referred to when he raises an issue with the Director of Nursing in a private hospital, that the matter is fixed.

Yes?-- In a public hospital, our considerations are somewhat different to those that exist in a private hospital. In a private hospital, to be frank with you, when a clinician would come to us with an issue such as that, one of the things that the clinician would often make you aware of is an implicit desire to move business elsewhere and a recognition of their own personal worth to you in your private hospital system. It was not uncommon for me to have people using veiled threats about what their business was worth to us when I was working in a private hospital. Now, in a public system, we work on quite different drivers. For my perspective, I think it is absolutely critical to keep a strong interlinkage between public and private systems. I believe the characterisations of private practitioners is, you know, money hungry, what have you, is really inappropriate. The reality is that we have a polarisation emerging in health care between the public and the private sectors. It's driven by a number of forces. Perhaps if you'll allow, I can run through some of those.

I think it would be very helpful actually?-- When you - I have prepared a statement which we can - I've provided this

morning. I developed it up some time back so there is some writing around this. But there are a number of things that I think conspire to drive VMOs away from public hospitals. If you look back historically, the vast majority of private practitioners had a commitment to public hospitals and they did so for a number of reasons not the least of which was the altruistic wish to put something back into the community that had educated them. I think also it's from desire to teach junior staff, a recognition that private hospitals were really not well geared to look after really sick patients and a recognition of the need to provide clinician support to maintain on-call rosters, et cetera. Over time, some of those things have actually been whittled away. For instance, private hospitals are now so technically advanced so that you can look after very sick patients in them. So strike one for the private hospitals. We no longer hold the advantage if you like. Private hospitals now offer resident medical officer support in many areas so private practitioners don't have to get up in the middle of the night to replace a drip as they used to. So, again, you can look after more sick patients in a private hospital. The on-call mode in public hospitals has become increasingly onerous and appears to be somewhat less so particularly in some areas of private practice, and I think the bureaucratisation helped and the over politicisation of health. I think they're probably technically neologisms.

If not tautologies?-- Indeed. They have certainly conspired against us. I think there is a view that's often expressed that VMOs feel valued in a private hospital and the reasons for that are quite obvious in a business sense in that they are the lifeblood of a private hospital. In many ways private hospitals regard the doctors as the primary client not the patient. They wouldn't mind me saying so but without the doctors, you won't get the patients.

Yes?-- In a public hospital, the VMO is in fact the highest paid member of staff. Now, what the rest of our staff don't necessarily perceive is the fact that they have ongoing background practice costs that don't go away when they come to work in the public hospital. So on the one hand you've got a hospital staff and culture that are leaning towards regarding a VMO as a highly paid dilettante. At the other end, from the VMOs perspective, this is their charity work because in many cases they are effectively and actually paying to come to work in the public hospital system.

Yes?-- And that's a reality. They may have practice costs that continue while they are not in the practice earning money in private sector that outweigh the hourly rates that we can pay them. So not only is there a differential in the remuneration between public work and private work but what we are able to pay them doesn't actually cover their background costs. So we wonder why in this system, where the advantages that a public hospital system has held over the private hospital are being whittled away and where there's such a marked disparity not only in the remuneration but the actual way in which it's constructed results in them having to pay to come to work for us in some circumstances, is it any wonder

that VMOs can get somewhat narky with the public hospital system.

Doctor, if - you've really spoken about the contrast between VMOs in the public and private system. I'd like to go back to the question of VMOs versus overseas trained doctors, because whilst it may not be the situation in Townsville, we've had evidence indicating that at places like Bundaberg there were Australian trained, fully qualified specialists prepared to help out at the hospital, and either actively discouraged or simply refused the opportunity to do that. Again the suggestion is this: that there is what's referred to as a shoot the messenger culture in Queensland Health and, quite frankly, we see an example of that with the e-mail from Dr Buckland relating to the Berg incident. I don't suppose you'd dispute that there is either a reality, or at the very least a perception amongst many Queensland Health employees that if you rock the boat you're going to be in trouble?-- I wouldn't dispute that.

That makes it particularly difficult in the case of foreign trained doctors, because an Australian doctor who rocks the boat at least has the opportunity of going down the road and working at the private hospital or working in private practice, whereas the foreign trained doctor simply has no alternative. He or she continues to work for Queensland Health or leaves the country. There is no other option?-- I can see where you're coming from, Commissioner, and I have to say I believe that that may occur on occasions, but on the converse, our approach in Townsville to overseas trained practitioners has been to support them to attain Australian registration, Australian recognition, to support them through college processes, to help them become one of the indebted members of our medical community. Now, we have a significant number who have come to us in an Area of Need position, have worked their way through college requirements, have gained fellowship of the relevant Australian or Australasian college and have either remained with us as valued members of our staff specialist ranks or have moved on to other VMO positions. I think to characterise all with that sort of problem is unfortunate. I would say that where that occurs it would be very much in the minority. I think we all would like to have staff who are nice and pliable and easy to work with. The reality is our staff, as well as the organisation, have competing interests to deal with. VMOs in the main have an interest outside of the public hospital, and it may well be, as I said before, that their primary interest lies outside the public hospital. So the work that they do with us is something that they need to fit in around their primary commitments. Now, that means that sometimes the flexibility that they would require of a private hospital, they would also expect of a public hospital. It's not uncommon in this town to have evening operating lists or weekend operating lists run in the private hospital, and where we have asked visiting medical staff to perhaps increase their commitment to the public hospital, they will occasionally say, "I'm happy to do it after hours." Now, that then becomes somewhat difficult to fit in in an industrial environment in a practical sense where we simply don't have the level of flexibility that there is in a private hospital system. Now, some of that goes to bureaucracy, but some of it also is about very practical

issues. For us, we operate at a bed occupancy that's closer to 100 per cent, not 75 or 80 per cent that a private hospital will often operate at. Our capacity to take additional lists and split them into a program where we simply may not have beds for the patients can be quite challenging.

Thank you, Mr Andrews.

MR ANDREWS: Doctor, you mentioned that the Medical Board's changed policy requirements for supervision of doctors have resulted in a new system whereby SMOs have a similar level of supervision now to a registrar. That is, the consultant must be satisfied that an SMO is competent to perform a particular procedure before the SMO is permitted to practise independently?-- That certainly is my understanding from what's been relayed verbally to us by the Chief Health Officer who sits on the Board, but I'm not aware of any correspondence from the Board that will provide a nice guideline around that.

Dr Myers would be a living example of that system. He, as I understand it from the evidence, is a person who is always supervised, either by Dr Guazzo or Dr Rosatto?-- At this point in time that's correct, yes.

Now, you say of that new policy that it may create recruitment difficulties in the future. Why would the need to treat an SMO as a registrar - that is, to have them supervised - create recruitment difficulties?-- The reason that we've brought people in as SMOs in the past, as I indicated earlier, is we may have a locum position to fill which requires somebody to function at a specialist level, but it's impractical for us to get the college to sign-off simply because of the timeframes of the processes involved. Now, in those situations we actually do require that the locum is able to operate fully and independently. Now, for us to try and recruit a locum and say, "We want to put you in our hospital. We value the fact that you've got a wonderful record. You've trained in a very well-regarded environment, you have excellent referees, but by the way, we're going to have you supervised while you're here" may, I would suggest, with respect, be somewhat difficult for them to swallow.

Doctor, I thought that there were four levels of supervision and one of those levels included remote supervision under which your SMO might perform surgery at your hospital but have a consultant even remote from the hospital - by which I mean elsewhere - available to be telephoned if assistance was required?-- I would have to say again we look forward to receiving documentation around this sort of thing.

Now, if that situation obtains-----?-- If-----

-----wouldn't that mean that there would be no insult to any SMO recruited for that kind of supervision?-- I think you've got to look at the practical aspects. My understanding is remote supervision is something that would be considered for a deemed specialist much more than for an SMO. As I say, we are looking forward to having guidelines that we can then discuss,

debate and look at the implications. At the moment we're debating vapourware. The reality is that remote supervision is a very difficult beast to be able to pull off. If you're asking for somebody to supervise, you're asking them to take responsibility, at least in some measure, for the conduct of a person they're supervising. Now, we're getting feedback from senior practitioners that they're very concerned about taking on the mantle of a supervisor when they don't have any clear guidance as to what that supervision might entail. Is this something where they should be doing a regular practice audit? Is there a requirement that they spend a certain amount of time in observed practice? What is it they're signing themselves up to and what level of responsibility are they undertaking when they do so? These are the questions that are being asked of us when we approach people to agree to being a supervisor. There is very real practical issues to work through, and there's very real resource implications for the people that are agreeing to be supervisor. Now, I would contend that if we're really talking about doing supervision, then we really need to do that seriously and have a well-constructed system that says minimum supervision for you to undertake when you're looking at a deemed specialist is a regular audit process, a period of direct contact, so that a super-----

Doctor, wouldn't it be better, instead of having a one-size-fits-all system, to look at the particular, either deemed specialist or SMO and have the person who is supposed to supervise design the level of supervision appropriate?-- That's what we've been doing at a local level, and doing it, I think, quite responsibly. Once-----

May I take you to another topic?-- If I may just finish?

Certainly?-- Once you require the Medical Board to actually consider that and make a determination on it, you're throwing in at least one meeting's worth of work for the Medical Board, perhaps two as they reconsider the draft that's been put. You are lengthening the process and making it more unwieldy. Sorry, you want to take me to another topic.

D COMMISSIONER VIDER: Mr Andrews, I've just got one quick question. In relation to what we're talking about, I think in the evidence that's come before us it's helped us form a view that of all of the things that are talked about in terms of being reviewer processes, new processes or whatever, I think there's been recognition by various parties that we have evidence before us that none of this can happen unless there is an adequate infusion of resources?-- Thank you.

MR ANDREWS: Would you put this up on the monitor, please? It's AJJ10.

COMMISSIONER: While that's happening, doctor, I also wondered - with the talk about remote supervision, I guess whatever epithet you put in front of the word "supervision", it's still equally offensive to a highly trained and qualified overseas practitioner to be told that he or she has to be supervised?--

Indeed, Commissioner. The person that you're recruiting may be someone who is considerably senior to the person who might be supervising them, or at the least may well be a colleague of similar standing. I mean, it does present a significant issue. Doctors are not known for their lack of ego, as indeed I understand barristers, similarly.

I'm not sure I can accept that. Again, though, we keep running into this problem, doctor, that the more you water down the concept of supervision - undoubtedly there are cases where supervision is necessary and appropriate, and the more you water it down, the less there is a point having any supervision at all?-- Undoubtedly there are circumstances where supervision is required. I do think there's ways in which supervision can be provided if adequately resourced that would be innovative, appropriate and could make a huge impact on the quality of service provision. If I could suggest, Commissioner, there's been a project conducted between Blue Mountains Hospital in Sydney and Nepean Hospital called Virtual Intensive Care Unit where, in effect, a staff specialist in emergency medicine or intensive care can be present at the foot of a bed 100 kilometres away, and I suggest to you that sort of technology could support us in Queensland very effectively across much greater distances where there is a very high definition, realtime linkage transferring data, multiple images and voice in both directions to enable the virtual presence of a specialist in a remote setting. That sort of thing, I think, is really where we should be targeting. It's much more about actually looking at the ongoing development and coaching and mentoring and supporting of practitioners coming into the system.

Doctor, can I ask you - perhaps you might even like to make a note of this. There are a couple of documents you've mentioned that would be, I think, quite useful to us, and you might make them available to counsel assisting at your convenience. One was - you referred earlier to your - I can't recall the official title - the terms of your employment.

D COMMISSIONER VIDER: Position description.

COMMISSIONER: The position description, and any others within your hospital - for example, for the directors of clinical institutes - that you think - that are significantly different from those existing elsewhere in Queensland that you think might be interesting to us?-- Certainly the clinical directors and operations directors of the institutes, I would suggest, is a highly innovative model. I certainly didn't design it. It was one that was brought in by managers we brought a couple of years ago from New Zealand. We have a partnership model for the heads of institutes between the operations directors and the clinical directors. I think it would be a very, very useful example for people to look at.

I'd like to see that. You mentioned earlier you had some notes about the private/public dichotomy, particularly relating to visiting medical officers and so on, so if we could have a copy of those comments that would be very useful.

Thirdly, you mentioned a study in the Blue Mountains, and if that's documented, I think it would be very interesting for us to see that as well?-- I have a video of that which I'd be happy to make available, if I can find the appropriate mechanism to do it. It would demonstrate that very effectively.

I had in mind you might make that available to counsel assisting and we can take it from there?-- Certainly.

The other thing I was going to say is that you remarked on ego issues, and it strikes me that so many of these ego issues are more a matter of wording than anything else. If you talk about someone being supervised, that's offensive, but if you talk about a co-consultancy position or something like that, it's something that most people can live with?-- Mentoring and peer support, perhaps.

Yes.

MR ANDREWS: Upon the screen is an exhibit from your statement. As I understand it you had some concerns about the recency and continuity of Dr Myers' practice when you reviewed his CV?-- The issues-----

That's correct, is it?-- Yes, that is correct.

And you discussed these matters with Dr Rosatto, who assured you that Dr Myers was current in general neurosurgery?-- That's correct.

Is it correct to say that there is a difference of opinion between Drs Rosatto and Guazzo about the currency of Dr Myers' qualifications?-- There's no issue of currency of qualifications. It's a matter of access to recent practice. Now, this letter was written shortly before I went away for a period of leave. It was at a time when Mr Rosatto was away on leave. I was somewhat miffed, and I think the tone of the letter shows that, and I think it needs to be understood in that context. This-----

Could the second page be put up, please? The issue here was that I had, I think, bumped into Dr Guazzo in the carpark and said to him that it was terrific we were having a locum coming on board. Dr Guazzo made some comment about, "I wonder whether he's up-to-date with everything." I asked him what he meant. He indicated that there had been a period where he'd been working in the Virgin Islands, and a period immediately prior to that where he had not been working in neurosurgical practice, and perhaps he may not be fully current with the breadth of practice. So I addressed that question to Dr Rosatto. He came back to me with the recommendation that clinical orders be awarded in the breadth of general adult neurosurgery - I think there was a couple of other terms in there, and I'd asked him specifically to consider a couple of issues. Now, I then - when Dr Myers arrived I interviewed Dr Myers. As I indicated earlier, he was an extremely pleasant man who was very open with identifying an area that

he thought he may need to brush up in, which was he hadn't seen a cerebral aneurysm clipped for a couple of years in the Virgin Islands. Now, I wasn't upset with Dr Myers over that. On the contrary, I thought that was extremely straightforward and honest of him to suggest that there was areas that he would want to avail himself of peer support and orientation. But I was somewhat cranky, because I had specifically asked that question of Mr Rosatto before the process had concluded. Now, this letter was written before I went away on leave. In fact when Commission staff arrived in Townsville a couple of weeks ago this issue was still being addressed, and it has not yet concluded, so I can't speak for what Mr Rosatto's process was in making that assessment. But I do understand that he did conduct reference checks and he did go to some lengths to establish the level of currency. So I think we may have a situation where there is certainly a variance of views, but I don't think anybody set out to do the wrong thing.

Doctor, so Dr Myers is a person whose qualifications are appealing, his specialty is in neurosurgery, and the need for a neurosurgeon is-----?-- Exquisite.

-----exquisite. If Dr Myers has a deficiency, it's more that he's rusty rather than that he has not had the competence before, and he can be brought up to speed with supervised practice?-- Look, I'd expect that it's the sort of thing that wouldn't take very long to bring up to speed at all.

And have you insisted that in the short term at least Dr Myers be supervised by either Dr Rosatto or Dr Guazzo?-- That's correct. We have initiated the process of assessment through the College of Surgeons. I have-----

When is that likely to be complete?-- Probably about the time that the locum is finished.

Do you hope then - assuming that Dr Myers continues to impress, do you hope to encourage him to remain?-- Absolutely, and I think "continues to impress" would be the appropriate way of positioning it. The feedback I have from hospital staff who have been involved with Dr Myers is that he is an extremely professional man who approaches the care of patients in a very diligent, effective manner. With that sort of feedback, provided the issues of rustiness, if you like, are overcome, I'd be absolutely supportive of having him on staff. I think to get an additional neurosurgeon is a critical issue for us at the moment.

I've no further questions, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. Ms Gallagher?

MS GALLAGHER: If I might, Commissioner.

MR BODDICE: Commissioner, there is some further evidence-in-chief, if I may.

COMMISSIONER: I beg your pardon. Yes. Please go ahead.

EXAMINATION-IN-CHIEF:

MR BODDICE: Could I have Exhibit 239, please?

COMMISSIONER: Yes.

MR BODDICE: Doctor, this is the audit file that you said you had not seen from Queensland Health. I'm just going to take you through a number of the documents, just to see whether you've ever seen those documents that may fall within the audit file. The first one that's on the screen now, you will see, is an e-mail from Mr Whelan to a Michael Schafer dated 9 December 2002?-- 9 December 2002?

It just needs to be brought down just a bit, if it could, so you can see the date. A bit further. You will see there the date, 9 December 2002. Now, do you know who Mr Schafer is?-- He's the director of the Operation Audit and Internal Review Branch.

All right. Have you seen that e-mail before?-- It's not one that I recognise. I mean, the content is stuff that Ken and I were discussing at the time this e-mail was written, so I'm not-----

Do you see that it starts off, "Afternoon, Michael. Steve Buckland suggested I contact you about the following"?-- I see that, yes.

Do you recall whether Mr Whelan told you that he had spoken to Dr Buckland in relation to referring it to Audit?-- I don't recall that.

Then if you go on two more pages, if we could, please - no, the other way, going backwards into the file. You see there's an e-mail from a Max Wise to a Ken Whelan - to Mr Whelan. Do you know who Max Wise is?-- I don't have any great knowledge of him, but I see here he's manager of investigations within Operational Review Branch.

You will see a reference there about suspected official misconduct. Have you seen that e-mail before?-- I don't believe I have.

And then if you go in another five pages, I think it is, Mr Bailiff, you will see there's a letter headed "Crime and Misconduct Commission", and you will see that's a letter dated 3 January 2003 back from the Crime and Misconduct Commission from Mr Schafer in which it's referred to the fact that Mr Berg's impersonation has been referred to the Crime and Misconduct Commission?-- I see that, yes.

Were you aware that it had been referred to the Crime and Misconduct Commission?-- No, I was not.

Because in your statement - at paragraph 28 of your second statement, if I can call it that, you speak of the fact of the direction not to refer the matter to the CMC?-- That's correct. My understanding of the events at the time was that the onus for reporting was to be put back through to the Medical Board.

So you weren't aware that in fact it had been referred to the CMC in early January of 2003?-- No. I'm just trying to think of those dates. January 2003 - no, I was not aware of that.

COMMISSIONER: Well, if it assists you to remember, the e-mail from Dr Buckland saying, "Therefore there is no official misconduct and no need to report" was on 24 January 2003. So that seems to be actually after the date on which it was in truth referred to the CMC?-- It doesn't make a lot of sense to me. I'm not sure-----

MR BODDICE: If you can continue on with the documents, if we can go in a further three more documents, if we could, you will see that is a document which is addressed to the Chief Officer and Deputy Director of the Complaints Section of the Crime and Misconduct Commission, and that's dated, on the second page, if you go to - if we show the second page you will see it's dated 17 December 2002, which seems to show that it was referred, and then there's that earlier e-mail I showed you of 3 January 2003 dealing with the letter back from the Crime and Misconduct Commission. So you weren't aware of the fact that that had been sent-----?-- I was not.

-----in December 2002. Then-----?-- Sorry, 17 December - that's right. We received notification - that would have been shortly after the initial brief.

And then if you could go, please, Mr Bailiff, to a document that's another six pages in, you will see it's an e-mail from Max Wise to Helen Little. I'll just put that up on the screen for you. You will see it's dated 11 December 2002. Do you know who Helen Little is?-- I think at the time she was either the General Manager Health Services assistant or the DG's assistant. I'm not - I can't recall what role Helen was in at the time.

And you will see that it is referring to the fact that Dr Buckland has requested Mr Whelan to refer the concerns to Audit. Were you aware of that e-mail?-- I don't recall having been made aware of that e-mail.

Had Mr Whelan discussed that with you in relation to referring the matter to Audit?-- I don't recall that discussion.

Because if you look at the document which is the page before that, you will see there's an e-mail there - it's from Mr Whelan to Mr Wise - dated 11 December in which Mr Whelan is speaking about referral of this matter and refers to yourself. You will see there, "I'm sure the person to contact in Townsville is Dr Andrew Johnson"-----?-- Yep.

-----"for further information." Were you contacted, as you recall?-- This is a few years ago. I don't recall that contact. I recall having been - I think it's important to reflect on the fact that this was a very difficult time, and my recollection of events has been renewed by my review of the files. My responses around that time were best recalled by my wife and family who recall that I was clearly very distressed around this issue and was - so I'm surprised by it.

All right then. And if we could then come another-----

COMMISSIONER: Sorry, Mr Boddice, but I imagine being contacted about this by, for example, the Crime and Misconduct Commission or the audit branch or even someone from Queensland Police isn't something that would slip your mind too readily?-- I would not expect so, Commissioner.

No.

MR BODDICE: Then if you could come about another five more documents in there's a - it's a memorandum, Mr Bailiff. Yes, that's the one. This is a memorandum to Mr Wise, it seems, from the audit division and on page 2 of that document - it should be the other way - there is a recommendation that it's not in the public interest to continue investigations into Mr Berg's actions. Do you see that? Have you ever seen that before?-- I don't believe so.

You'll see that's from a detective senior sergeant in the Audit and Operational Review section?-- Yes, that's so. My understanding is that police officers are seconded into Audit and Operational Review Branch.

And then if you can come on another five more pages you'll see that there's an e-mail, Mr Bailiff, that starts off at the top, "Max Wise, re 520". Do you see that?

BAILIFF: How many pages on was it?

MR BODDICE: Five pages. I think that's the one. Yes, that one is there. That's the one. This is an e-mail from Mr Wise to Mr Walker in which it indicates that the matter's been investigated and the department doesn't intend to take further action. Is that an e-mail that you've seen before?-- I haven't seen it.

In terms of the investigation of this matter was it more a matter of under Mr Whelan's control?-- Well, it wasn't so much a matter of investigation. I mean, we had clearly established that there was a bogus doctor from the information that had been provided to us by the College of Psychiatrists, so we weren't investigating per se. It was a matter of reporting. Now, clearly this has been addressed by the Crime and Misconduct Commission which certainly with that knowledge alleviates part of my concerns. My views on the matter might be at some variance to those that are recorded in this e-mail. I regard impersonating a doctor as an extremely serious matter, but I am not legally trained. Whilst it might excite my interest in attention I can't comment on the decision not to proceed.

Now, doctor, what I was interested to assist the Commission because, as you said, you weren't aware that it's been referred, was that more a matter that would have been under Mr Whelan's jurisdiction about referring it rather than yours in terms of your respective duties within the hospital?-- Yes, that's correct.

So it could be something that was done either without your knowledge or you have forgotten in relation that it was done?-- Well, over this period there was a substantial period there where Ken was, in fact, off on sick leave and I was Acting District Manager. That was in early January 2003. He returned to duties on a part-time basis for a period and that would cover some of the period of this correspondence, but certainly referrals to Audit and Operational Review Branch is something that goes through the District Manager.

COMMISSIONER: Mr Boddice, I wonder if you could help me. I just can't understand this correspondence and suggestion that there's no breach of the Criminal Code. I mean, you're someone to whom the criminal law is not unfamiliar. Why, for example, isn't it a fraud?

MR BODDICE: Commissioner, I must say, I can't answer that at the moment because I haven't really turned my mind to those things, but what I was more concerned about in representing Dr Johnson, because he said it hadn't been referred and this document said it had, in trying to elicit how it is that that may have occurred without his knowledge. In terms of the appropriateness or otherwise of that advice I really haven't turned my mind to it at all, Commissioner.

COMMISSIONER: I'm not sure how it helps us to know that someone came up with advice which strikes me as being plainly wrong in law without even bothering to speak to the person who could have provided the relevant evidence, but no doubt the significance of this will become clear as you go on.

MR BODDICE: Yes, and, no doubt, there will be further evidence, I suspect, Commissioner, called in respect of the matter.

COMMISSIONER: Yes.

MR BODDICE: And also a matter that, in fact, one of the Commissioners, I think, raised with you, Dr Johnson, which was that in Dr Buckland's e-mail, that e-mail to Mr Whelan, there was a reference to discussions with the Medical Board and the Medical Board not accepting that he was not registrable?-- There was reference in that e-mail, yes.

Are you aware of any discussions that had occurred with the Medical Board?-- I personally don't recall having been involved in any directly myself. There was contact. I - I have no significant recollection of any discussions.

And you had no discussion with Dr Buckland either in relation to the matter?-- In relation to that e-mail?

Yes?-- No. I did have, I think, initially a heads-up discussion and followed that up with an e-mail which is in my evidence.

Yes, but in terms of that e-mail I think your evidence is you

have only just seen it within the last few weeks?-- That particular one from Steve Buckland to Terry Meehan and Ken Whelan?

Yes?-- Yes, I only just saw it.

If that could be handed back, thanks. Now, some other areas. Dr Johnson, you were asked some questions by the Commissioners in relation to VMOs and the public and private system?-- Yes.

And you touched on the staff specialist. One of the issues that has been before the Commission is this question of whether VMOs are the answer or the staff specialists are the answer or a combination. Are you able to assist the Commission in terms of your experience of the benefits of which of those systems and what the benefits are of those systems?-- Absolutely. If I may, I think one of the discussion papers actually highlighted a view that VMOs might provide the majority of teaching and service provision in hospitals. I have to say that in a hospital such as the Townsville Hospital many of my colleagues took great umbrage to that reference. In fact-----

COMMISSIONER: Doctor, before you go any further there has been some clarification of that because one of the witnesses last week, Dr Nankivell, made precisely the same point. The context of the article is a comparison between VMOs and overseas trained specialists and I think that becomes clear at the end of the discussion paper that it's really only looking at that comparison. Nothing in it was intended to reflect on Australian trained specialists who are working full-time in hospitals as contrasted with VMOs and if it has been so construed I hope you pass on our apologies to any of your staff?-- Thank you, Commissioner. That's helped to an extent, but, with respect, I would suggest that many of our overseas trained specialists are now a staff specialist and VMOs.

Yes?-- And they are an extremely valued part of our medical community. Many of our overseas trained practitioners are holding very significant positions of authority and respect within our system and it would be a shame, indeed, if they were held up to comparison in the same way. I suspect what you're suggesting, with respect, is that VMOs may present a better option than an unknown quantity practitioner from - that's not yet been through a college process.

Essentially, better than an area of need appointee who may not be recognised in Australia as having specialist qualifications?-- Certainly.

And, therefore, may not be acceptable to the college as someone to train registrars and other trainees?-- Commissioner, there is an issue here about acceptability to the college as well and there is an argument that some colleges are, in fact, interested in protecting their patch.

Yes?-- Now, I think many colleges have, in fact, lifted their

game significantly in recent years and have moved on from that, but there is still some evidence of patch protection coming from colleges, so I think we have to be a little mindful of that when we are giving free range to the colleges to determine whether people meet the appropriate standards. I think they are the arbiters of standards in professional disciplines. I think we need to make sure that they base their assessments on objective criteria. It's been extremely difficult to get objective criteria out of colleges to help understand what it is that an overseas trained practitioner might have to do to attain equivalence. Some colleges have been more transparent in that regard than others so I think we do need to recognise that there is potential for at least some perception of market forces impacting on decision-making. I'm not suggesting that that does in normal circumstances, but colleges are very set up to train and support specialist staff, there is no doubt about that, and I regard their views very highly about the professional standards required, but the transparency process would need to be improved. To go to the question about staff specialists and VMOs, I think the reality is that in, particularly, the recent setting, it is absolutely imperative to have services provided in the most cohesive fashion across the public and private sector. If, for instance, we have practitioners that work solely in the private system they may be unavailable to provide their specific expertise to public patients and, indeed, it may not be available to support the on-call roster for public care. Now, this increases the burden on the public hospital doctors and if we end up in a situation where VMOs work in the private sector alone and only staff specialists worked in the public sector then we won't have enough critical mass. We will be missing out on opportunities to draw on specific expertise and, frankly, our system will be far poorer. Finding a way to integrate VMOs into our systems so they feel valued, supported and wanted and respected is particularly important to the extent that we have lost that at the moment. I think that is ground that we need to reclaim.

MR BODDICE: Is the better system both a combination of the staff specialist and the VMO?-- Without a doubt. I think the staff specialists provide to the hospitals a level of commitment and support which VMOs cannot do. The reality is VMOs have a split commitment to their private and their public lives. A staff specialist is a specialist of equal training to a VMO who has made a commitment to working, for whatever reason, full-time in the public system. That doesn't mean that they're work shy. That doesn't mean that they're incapable of performing at a level unacceptable to the private system. It simply means that they have made a choice to make a commitment to the public system. Now, that commitment is incredibly important, particularly for the training of junior doctors, the training of the next generation specialists for the supervision of care to a level that can only be provided when you are on site. Now, not everybody needs to be on site all the time. There are specific areas of skills and expertise that may be vested in only one or two people. To miss out on that because they won't work in the public system or because they won't work in the private system I think would

be to the detriment of everybody. Our community deserves the best possible mix of skills. It deserves a medical community that works well together in a collegiate framework to the extent that that's not happening at the moment. I think we really need to target that to ensure that there is a perception of equity across public and private sectors so that the VMOs and the staff specialists can work in an environment of equal support. It is incredibly important.

Now, another area that the Commissioners dealt with and you just touched on was the credentialing policy that you have put in place in the hospital as one of the safeguards. Could you just explain to the Commission what your credentialing policy is?-- Certainly. I have seen from previous evidence the Commission is well aware of the credentialing process and its concept. In Townsville we have a two-stage credentialing process whereby initially at the point of interview and appointment an assessment is made by interim clinical privileges. We always err on the safe side with award of interim privileges.

Just slow down, doctor?-- And I will take advice from the relevant clinical director and clinical experts to establish what those privileges should be. Now, where we have applicants for highly specialised roles such as, for instance, an interventional cardiologist then I will ensure that we have an expert in interventional cardiology perhaps from outside of Townsville to sit on the panel and advise us as to what that practitioner should be doing. So the interim privileges are awarded at the time of appointment. Subsequent to that and on a three yearly basis these privileges are renewed, but subsequent to that we have a formal process whereby certified copies of all original documentation, logbooks, statements of ongoing professional education and commitments to ongoing audit processes are submitted to our standing committee for prevention. On that committee I have a number of core members that we draw from each of the clinic institutes so we have, if you like, some level of oversight. I don't just use people from the one department. We bring in people from other departments as well to be able to provide that level of cross scrutiny. Now, we'll also bring on to the panel representatives from colleges where appropriate. Now, often people will be double hatted in this. If I have a department director that the college nominates as their representative then I consider that to be appropriate. I will also bring in an academic from James Cook University to look at their aspect. So we have college rep, we have a university rep, departmental rep and the core members and with that group we consider all of the senior medical staff privileges across the Townsville Hospital and, indeed, Mount Isa Hospital and those are renewable on a three year basis.

Now, in relation to the Berg matter you were asked some questions by the Commission in respect of how long the process took from the identification of a problem and you said that soon after you came on board there was this effective management plan set in place, but that also Dr Berg or Mr Berg had regard to his appeal processes that were put in place.

The appeals that you were referring to, did they also occur in this time period from the July 2000 to the beginning of 2001 when the contract was terminated?-- They did. They were largely during the period that he was off on stress leave.

You were also asked some questions in relation to advertising and you said there are constraints in respect of advertising?-- Yes.

Is that a Queensland Government across all departments constraint or a Queensland Health?-- Yes, it is. It's across the whole of Government and there's a document referred to by the human resources focus, the bible, which dictates how advertising is to be conducted. In my view it is somewhat restrictive. It limits not only the word count but where and how things can be advertised. There is processes imposed upon us to meet the contractual obligations that Queensland Health - sorry, that the Queensland Government, I believe, has with the advertising agency. Branding is considered very important so, for instance, if I can - if I can characterise it this way. Recently there was on the one weekend an advertisement for an intensive care physician or anaesthetist at the Prince Charles Hospital appearing in the Australian newspaper and it occupied approximately two or three lines in a boxed ad with all the other positions across Queensland Health. At the same time a doctor with the same qualifications could have applied for a position in, I think, it was Geelong at the time that had an eighth of a page ad running details of the sorts of clinical practice that could be entertained, the delights of the local area, much more attractive salary package and the perception that they really wanted somebody, not just a vacancy reference number, apply to the Human Resources Manager. It's a matter of how we pitch ourselves in a competitive marketplace. I think we often find ourselves at a significant disadvantage to our competitors interstate.

COMMISSIONER: If you don't mind, Mr Boddice, I'm interested in that aspect of your evidence. A couple of things come to mind. One is that we have heard about the use of recruitment agencies or headhunters for overseas trained doctors and we have actually heard evidence from a gentleman, Dr Bethell, on the same wavelength. Are you permitted to use headhunters to get doctors in Australia or is it only for overseas recruitment?-- Are we permitted to or do we do it on the sly? I'm not sure. We do it on occasions. To be honest with you there are so many rules around virtually every aspect of administrative practice in Queensland Health that I'm not quite sure which number rule I'm breaking each day I come to work. We do on occasions use headhunters. We are using one at the moment to recruit to a particularly important position in our organisation, you know, that - I'm not sure of the level of official sanction. We try not to ask questions like that. We might get an answer we don't like. In truth - in practice what we do is we do the right thing if we can get away with it. Occasionally we have to apologise.

Doctor, I was also going to ask - your comments, I know, were

mainly directed to the form of advertising rather than the actual package that you're able to offer, but we have heard suggestions that in other parts of Australia public health authorities are more flexible in what they offer to potential recruits. For instance, a hospital in Melbourne might offer a package which involves two or three days work a week plus the opportunity to participate in private work and it's presented to a potential applicant as such as a package, come to, let's say, Ballarat and you will have the opportunity of working here both as an ophthalmologist three days a week at the hospital and two days a week in private practice. Do you feel it would be advantageous if you had the facility to offer those sorts of packages?-- Look, I think that sort of thing is a very useful way forward and it does make positions significantly more attractive if they could be structured in that sort of way. The inflexibility is an interesting aspect. It comes down to some very minor irritations that, you know, I think are in terms of motivators and demotivators for people to want to work for Queensland Health and sometimes the demotivators are just - is little pinprick issues that each one on its own is so minor it's hardly worth mentioning, almost embarrassing to mention it, but when you put them altogether it's just annoyance factor that wreaks of bureaucracy and a system that just feeds on itself. I'll give you an example. Each senior medical staff member has a mobile phone. Rather than Queensland Health paying for the mobile phone bill and perhaps having a policy where, you know, any call over $5 might be subject to scrutiny or something like that we're actually required to pay the bill ourselves and then claim it back from Queensland Health making a signed statement that all of the numbers that are listed are, in fact, business calls. Now, frankly, for me I have an extensive phone bill because I spend long hours on the phone, contactable on weekends, et cetera, and for me to actually have to go through that bill and say that I am certain that something was a business call, I know I'm going to get it wrong and I know that I'm having to make a false declaration, but - so what I do is I simply take out known numbers, many of which are actually very valid for me to claim as work calls, but I take them out and work on a swings and roundabouts theory. Now, I shouldn't have to do that. That's nuts. It takes hours of my time to create a document that I know to be false to submit to get a reimbursements that takes a clerk's time to do the reimbursement. Then there's an audit trail around the whole thing. Now, a very simple approach would be Queensland Health pays the bill on the mobile and, you know, we audit the top couple each year to establish whether they're being overused, but we have generated this whole heap of bureaucracy behind a very simple thing that should be an incentive and becomes a disincentive.

Doctor, I have to say - and I've made no secrets of the fact that I believe in decentralisation rather than centralisation and control and it seems to me that those sort of pinpricking issues are the ones that get resolved in an efficient system at local level. You know, no-one is going to waste time sending a memo to the Director-General or someone in Charlotte Street saying we need to restructure the telephone system, but

if the local manager has authority to make that sort of decision it can be done in 10 seconds. You only need to explain the problem to get it solved as quickly as an intelligent person can turn his or her mind to it?-- I would completely agree with you, Commissioner.

D COMMISSIONER EDWARDS: Could it be though that that system - and I'm not defending it - is a whole of Government system?-- Sir Llew, I don't believe it is a whole of Government system.

I tell you it is in one of the statutory authorities-----?-- Sorry?

It is in one of the statutory authorities that I have chaired, the responsibilities?-- I think it varies.

I am asking does it, therefore, apply to the others?-- There is a couple of different approaches in health and-----

I'm not justifying it?-- -----I think the hard part of this is that some other staff members actually don't have to pay their own bills. They are paid by Health so, I mean, it - it's just the way that this particular part of the package was hooked up. I agree with you, Commissioner, that these sorts of things should be able to be dealt with effectively at a local level, but those decisions are taken at a very high level. Another stupid example is if a doctor wishes to put roof racks onto the company car it actually requires the Director-General to sign it. I mean, it's nuts.

COMMISSIONER: And I don't think there is one person in this room who would disagree with the sentiment that the ultimate object of all of this should be to spend a greater percentage of the health care dollars on providing health services rather than bureaucratic administrative services, and, as you say, it may be a matter of nitpicking items one by one, but if you strip all of them out of the system, you are saving significant amounts of money that can go back into clinical services; if you don't have clerks filing and dealing with claims over telephones or Director-Generals wasting their time dealing with roof racks?-- Absolutely. For example, there is study and conference leave provisions where, despite the fact that this is an award entitlement for senior medical staff, we'd have an inordinate amount of effort go into trying to maintain an audit trail for claims, et cetera. The simple approach would be to, instead of building a bureaucracy around this, simply say, "Here, doctor, here is your 7 or 10 or 12 or $20,000 a year. We expects you to maintain your currency across the area of your clinical privileges but here is the money to allow you to do the training and we will allow you this much time to do it." There is so many very straightforward and simple solutions. Indeed, that is one, I believe, which is being advanced under the current industrial negotiations. Many of these things have potential to be resolved in the current industrial negotiations. Hopefully that will occur.

Mr Boddice, do you have far to go with evidence-in-chief?

MR BODDICE: I don't. If you would like to have a break now?

COMMISSIONER: Whatever you prefer.

MR BODDICE: Happy to have a break now, Commissioner.

COMMISSIONER: Okay.

THE COMMISSION ADJOURNED AT 3.16 P.M.

THE COMMISSION RESUMED AT 3.42 P.M.

ANDREW JAMES JOHNSON, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Boddice?

MR BODDICE: Thank you, Commissioner. Dr Johnson, you also in your evidence raised about the patient safety program that you had put in place for Townsville and you spoke about the Patient Safety Centre now under the control of Dr Wakefield?-- That's correct.

Does that effectively put in place statewide this patient safety concept?-- Look, it is the first step. There has been a number of efforts in different jurisdictions across Queensland Health to address the patient safety issue and, as I said earlier, it doesn't matter, to an extent, what you do so long as you do something. That said, there is good evidence around the world about the sort of characteristics that make effective patient safety system and I think the approach that we're now taking through the patient safety centre, and it mirrors to a large extent what's been in place in Townsville and in Princess Alexandra Hospital, is a very effective step towards improving the safety of services in Queensland.

And that's a relatively new initiative, this Patient Safety Centre?-- It is. It came out of, I think, the restructure of Queensland Health last year and sits within - well, it sat within the innovation workforce reform doctorate. Now, the sort of characteristics I think are really important in the patient safety system are that people need to feel that there is a safe and effective means by which they can identify issues of concern, that they will be dealt with in a safe way. Now, the safe way, for my money, basically means that people won't be hung out to dry. Nobody is actually turning up to do a bad job at work, they are turning up each day trying to do the right thing by their patients. If we take that as a starting point for the huge majority of our practitioners, the huge majority of our administrative staff, I think it is a far more appropriate place for us to leap off from from where we have been previously, which is hang out the guilty sod. Now, the concept that - the Veterans Health Authority in the States really, I think, hit the nail on the head which was moving away from what had been described as a blame-free culture, which was where clinical governance was moving in the United Kingdom and in the United States in general, to a just system. That is where there is a clear understanding that some things are blameworthy whilst the rest are not. If an issue was identified as blameworthy, then it would not be dealt with through a safety system, and, indeed, in that environment there may be recourse to disciplinary action. However, where people were identified as having at least attempted to do the right thing, then the approach would be much more focussed on systems structures to support people to get the best outcomes. Now, blameworthy act is defined in the Veterans Health Authority, and quite effectively so, as an intentionally unsafe act, and an intentionally unsafe act might be turning up to work drunk, it might be being influenced by alcohol or - sorry, influenced by alcohol or other drugs. It might be seeking to deliberately harm or put in place a course of action that you know to be unsafe, in the context that you are not actually aiming to improve the care of the patient. Now, it is a little bit complex in this regard: we live in an inherently risky environment and practitioners are required on a daily basis to do risky things. So it is not saying you have to be risk free, but applying yourself to the care of the patient with appropriate professional standards and doing things which you consider to be in the best interests of

patients, you will not be subjected to disciplinary action.

And your understanding is that this Patient Safety Centre is working along that model on the basis to become a statewide concept?-- Yes, that's right. The training that is being developed at the moment is covering aspects such as root cause analysis techniques, other investigation techniques, as well as trying to focus on what sort of tools might be brought to bear in a health care environment to be perhaps loosely described as the grab bag of activities that might provide you with reasonable assurance that good outcomes will follow.

And you were also asked some questions by the Commissioners in relation to the concept of central recruitment with Queensland Health for Area of Need and one of the matters that you raised was a concern, in effect, that prevented an area from selling its attributes. Could you just expand on that?-- Certainly. I think that Brisbane-based hospitals would be extremely effective recruiting to Brisbane. If you are wanting to recruit people to work in rural, regional remote areas, then recruitment effort might focus on different selling points, if you like, given that we are competing in the market place for employees - and this is very much a seller's market, then we need to be able to differentiate our services in a completely open and honest way so that people know that if they apply to work in Hughenden, that they are not going to be finding themselves in a tertiary facility. But they will have access to aspects of life they may not be able to get anywhere else. They will be living in a community that values its practitioners, they will be well supported by a network of clinical coordinators, Royal Flying Doctor Service, et cetera. So the selling points are quite different and the knowledge of those selling points and the ability to construct a job that is suitable for the applicant I think is really important. That's not to say there couldn't be a role for a Queensland Health recruitment agency, if you like, and I would agree with the Commissioner's comments about paying inordinate amounts of money to recruitment agencies to provide staff for us. In many settings the recruitment agency does little more than act as an introduction agency, and if we're a little bit more inventive about the way we approach recruitment, I think we could perhaps do a far better job. But we can do that through a coordinator approach, by setting standards as to what's expected in the recruitment process and by streamlining the recruitment process effectively identifying our potential markets and exploiting those markets to best advantage. For instance, we have, in large part, written off the UK and Ireland as a recruitment market. It is my personal view that the reason we have difficulty in recruiting from that area is more about red tape in recruitment than it is about our under competitive conditions, or the state of the pound or any such other matters. I believe that if we effectively understood that market, perhaps did some market research, perhaps looked at more closely how we could tap into that market, perhaps look at mutual recognition of UK and Irish qualifications, then that may provide us with some mechanism.

COMMISSIONER: Or even unilateral recognition?-- Or even

unilateral recognition. One of the things that often gets touted as a potential solution to the workforce shortage - medical shortage is the use of nurse practitioners. I think it is really important for us to understand the very important role nurse practitioners can play, and this is a highly political issue, of course - and I am a strong supporter of the concept of nurse practitioners. I believe they are a very effective part of the mix. But they're not a doctor replacement. They can fulfil a very unique fulfilling and important role within the system, but they should be seen as additional to rather than replacement of medical staff. Our issue would still remain.

Now, you also were asked some questions about the concept of a local board and you spoke of some of the benefits, but you alluded to also some deficits in that autonomy. Would you just assist the Commission in what you see as the deficits? Have you worked in New South Wales under the board system?-- I have. I worked for three years in administrative capacity, clinical leadership capacity in New South Wales, and for a number of years in training in my internship and residency also in New South Wales. As a clinician I don't know that there was too much difference, but when it comes to looking at how the system actually works, I found a marked difference between the level of coordination and cooperation across Queensland compared to that which I found in New South Wales. For instance, I worked in the Northern Sydney Area Health Service, which is one of the perhaps better resourced regions of the country. We had a series of five acute hospitals. I worked over the space of three years in three of those. For a period there I was Director of Medical Services across two of them. The level of collegiate support in that environment was vastly different to that which I experienced in Queensland. As the most junior member of the Director of Medical Services group in that area health service, it was left to me to initiate, arrange, coordinate any form of formal meetings between Directors of Medical Services. There is no forum at which we could try and coordinate our approach even within the one area health service. There was significant competition between hospitals and a significant lack of trust. Here in Queensland, by marked contrast, very early in my tenure I went to my first Medical Superintendents Advisory Committee meeting in Brisbane and there were the - and the Directors of Medical Services or Medical Superintendents, I suppose, of about 15, 20 of the largest facilities in Queensland, and we had the opportunity to explore issues, discuss policy, look at how we could make the system work better, or at least cope with some of the policy decisions that were being made and come out with the best possible solutions. Now, that level of cooperation coordination, I think we have got to be very careful not to lose that. It is extraordinarily valuable. In the northern zone only yesterday we had supers of the larger facilities across the northern zone meet here in Townsville. We meet every couple of months, again to look at how we can better coordinate our care. It is all about provision of care. It has got nothing to do with which bits of paper to shuffle.

And finally you touched on in your evidence the fact that

within the system that you have established at Townsville, that the clinicians have a say, being head of the various institutes, and a say in the running of the hospital. Have you in your first statement set out at paragraphs 24 and following how it is that that system works - and the system where they have some autonomy in relation to the running of the individual institute but a say in management committees?-- Yes, that's right.

Yes. Thank you, Commissioners.

COMMISSIONER: Ms Gallagher seems to have abandoned us. Mr Devlin, is it convenient for you to go next?

MR DEVLIN: Yes, thank you.

CROSS-EXAMINATION:

MR DEVLIN: Dr Johnson, Ralph Devlin is my name. I am counsel who represents the Medical Board of Queensland?-- Mr Devlin.

I just wanted to go through a couple of issues about Dr Berg, if I may. At paragraph 9 of your statement you say this: "At the time", that is to say at the time that Dr Allen raised concerns about Dr Berg with you, "at the time there was a division within the psychiatry ranks regarding Vincent Berg and at least two consultants supported him." Now, is that a reference to - well, perhaps you could tell me: who are the consultants who supported Dr Berg?-- There was - in the-----

Perhaps I can assist you. At the end of your number 1 exhibit you have got two references?-- I do. One of those was from Dr Brian Boettcher who was consultant psychiatrist and Director of Medical Health. The other was Dr Barend Vorster, overseas-trained psychiatrist who came to us from South Africa.

Yes?-- The other reference which is attached to AJJ1 is from Dr Leon Petchkovsky, who wrote in reference to his previous contact with Dr Berg the year prior to having written this letter.

All right. Now, you have exhibited two of those. You probably have not seen a reference from Dr Vorster, have you?-- I may well have seen it. Dr Vorster was supportive of Dr Berg.

Would you accept that the two references that you do attach as part of exhibit 1 to your 91 paragraph statement, those two references by Dr Boettcher and Dr Petchkovsky from the Gold Coast District Health Service, are very glowing as to his experience and very accepting of the qualifications he claimed to have?-- I wonder how they might feel about those references now.

Well, I am just going to explore that with you. See, I have the benefit of having the Medical Board's file, are you with me? Well, did you know, for example, that this Dr Berg claimed to have been persecuted by the Russian authorities pre glasnost?-- Yes, I was aware of that, yes.

Now, did you know, for example, that when the Australian Medical Council got this advice from the university in Russia that the documents were forged, that Dr Berg then made a very, very spirited defence of his position. Did you know that?-- No, certainly didn't.

So that Dr Berg put on the record with all the various authorities, for example, that as a refugee he has certain rights under international law - whether this be right or wrong - but as a refugee under various treaties that deal with refugees, that they're to be assessed afresh in the country they come to when they claim persecution, because what's said about them from the other country might necessarily be deliberately false. Did you know that?-- I think that's a great line for comment.

Well, what I am getting to, though, is that the - you at the coalface took what came from the university on its face value, that is you took it to be true that the documents were forged?-- Absolutely.

Can I take it that was your position and remains so?-- It was, it is and it was backed up by the collateral evidence that the doctor was clearly not competent to practise.

COMMISSIONER: Doctor, Mr Devlin has put to you that you didn't know a lot of these things, but you weren't told anything about this by the Medical Board?-- No, the Board did not communicate with us at all.

Well, I am not sure what the point is in asking the witness whether he knew of things when your client didn't tell him.

MR DEVLIN: Yes, I was really getting to the position that he took up; that is that the information coming from Russia was necessarily reliant.

COMMISSIONER: Well, you relied on what you were told by the Australian College, though, didn't you?-- I did in November of that year, had been related to the Medical Board in January of that year.

You didn't contact the university directly?-- No, I didn't.

You got correspondence from the college?-- That's right.

Yes.

MR DEVLIN: What then was the force of the references that other professional staff had given about this Dr Berg? That is Dr Boettcher and Dr Vorster in particular who were in your area. What use did you feel you could make of that? Were those opinions flawed in some way?-- Yes. Dr Vorster himself presented significant performance management issues and was eventually terminated from his appointment.

I see?-- Dr Boettcher left us for other employment, but certainly there was issues that had also been raised with him. I do not regard their opinions very highly.

Thank you. So that explains why Dr Allen's assessment was the one that you went with most strongly?-- Absolutely.

Thank you?-- I have no personal knowledge of Dr Petchovsky, but I understand that was relating to a period as an observer, and I believe that he may have taken at face value some of the issues that had been presented to him. I don't hold any ill-feeling towards him at all, nor do I regard him any less for having written that reference. However, the two local ones that were written I had reason to not regard with the same value as Dr Allen's.

Thank you.

COMMISSIONER: As Mr Devlin puts the question to you it sounds, though, as if it's Dr Allen versus three other doctors. Were there other local doctors supporting Dr Allen?-- Most definitely. I recall distinctly issues being raised by Dr Sharon Boyes, Dr Sheila Parke, almost all of the mental health team. From my own discussions with Dr Berg I found him disordered and somewhat erratic. There was a substantial amount of evidence to corroborate views that Dr Allen has maintained.

MR DEVLIN: Can I just take you to one other aspect of this. There is a document on the Board's file - I don't know whether you've seen this before, but this seems to be an assessment by Dr John Allen after contact with the referee at that time who was this Dr Petchovsky from the Gold Coast. Are you aware of that early assessment in September of '99?-- That would pre-date his employment.

Correct. Just before his employment?-- I haven't any recollection of having seen that, but it would not be uncommon to - if there's been supporting evidence to put - to support registration, then that may well be on the file.

Well, I just want to read one part of that from the document. It's under the hand of Dr John Allen, but it's about what was to happen in the future with Dr Berg as of September '99. He writes, "Dr Petchovsky therefore gave an unreserved recommendation in support of Dr Berg starting training" - this is the Gold Coast fellow - "He agreed that first year training was appropriate and that the first year exam would be a useful way of gauging Dr Berg's progress." Did that ever happen then in the period, to your knowledge, the first year of his

employment?-- I'd suggest that whilst he was brought into the training program, his level of competence was such that there was no way it would be appropriate for him to have sat any exams.

So to your knowledge a first year exam was never completed?-- I'm not aware of a first year exam ever having been conducted. It may well have been scheduled for a time during which Dr Berg was on stress leave or after his termination.

So that if the Medical Board came to the conclusion that Dr Berg's claimed qualifications could not be substantiated either way, you certainly were not made aware of that?-- Correct.

You made observations, though, as to his competency?-- Correct.

And you dealt with that by not renewing him?-- Correct.

And would you in that - well, you say you think you would ordinarily make some form of informal contact with the Medical Board about somebody who you viewed as incompetent. You're nodding?-- Yes. Sorry, yes, you can't hear my nods.

Is there a reason why it would not be more formal than that, like a letter explaining the situation from your point of view as the person, as it were, in charge of this person?-- At times I have written to the Board. At other times I have phoned because I know that the Board actually maintains files. Where I'm looking for the Board to undertake a specific action-----

No, it's for advice, I presume?-- Well, at times I will ring to provide advice, at times I will ring to seek advice. Now, I know that the Board maintains file notes, and when I've previously made inquiries, the advice that I had received was that, "If you contact us then we will be able to record that there has been an issue so that that can then be followed up directly with you should the practitioner reply for registration."

COMMISSIONER: Mr Devlin, the question you asked - I'm not sure now if it was the last question or the question before, but it involved the proposition that the Board hadn't been able to determine one way or the other. The only thing I've seen emanating from the Medical Board is Exhibit 3 to Mr Whelan's affidavit, a letter signed by the then chairman, Dr Toft, in January 2003 where Dr Toft says unequivocally, "It is regretted that Townsville Health Service District were not notified when the Board became aware that Mr Berg did not hold recognised qualifications to enable him to be registered to undertake post-graduate training in psychiatry." That seems like a quite emphatic acceptance by the Board that that was the case.

MR DEVLIN: Yes. Unfortunately, due to a mix-up in Brisbane, the Commission doesn't yet have the assistance of the Board's

file. As of January 2002, which of course is before Dr Toft's letter, but January 2002, the Board issued a Certificate of Good Standing saying this: "The Board has not been able to verify the qualification on which Dr Berg's registration was granted." So there's a time continuum over which the Board took a particular view, rightly or wrongly, and then that letter expresses a view more strongly at a later point in time.

COMMISSIONER: Well, what extra information came to light over that period of 12 months to convince the Board by January 2003 that Mr Berg did not hold recognised qualifications to enable him to be registered?

MR DEVLIN: I hope to be able to distill all that into an affidavit for your assistance.

COMMISSIONER: Thank you.

MR DEVLIN: Thank you, doctor. Sorry, my question really was this: the effect of your evidence is that you really can't recollect either way whether you contacted the Board in this particular instance, correct?-- That's correct. I regard that, in retrospect, as a mistake. In this issue I should have written to the Board. I think there's a number of things that go to whether or not you put in writing your concerns about a particular practitioner. Will this matter be discoverable? What's my legal standing for doing this? It is a particularly vexed issue, and some form of protection would be valued, I think, by my colleagues as medical superintendents.

Well, would one of the things that informed what happened here - that is, for example, your decision not to put it in writing - we know that for a fact, don't we?-- I can't find anything on the file, so I have to accept that.

All right. Well, there's nothing on the Board's file. Perhaps that assists you. But would one of the things that informed whatever you did choose to do or not to do be that after you took over and were in a better position to observe, this fellow Berg exhibited a very heightened sense of self-entitlement in the sense that when he was challenged, he went off on sick leave and then invoked various measures against the hospital?-- It was a highly charged environment, and I guess the correspondence is often - comes back to haunt you in later times, and in these sort of matters it is actually quite difficult to work out exactly who you should be writing to, what you should be telling them. I have on occasions written to the Medical Board, I have on occasions referred matters to the Medical Board. It is my normal practice to contact the Medical Board when I have significant concerns, as I indicated earlier.

Can I ask you this then in fairness to you: is it possible that the concerns weren't that significant until the information came to light long after - some months after you had terminated him? Is there a little bit of hindsight here,

that at the time the concerns weren't quite so great as to justify contacting the Board?-- The concerns at the time were sufficient that we certainly did not want to renew his employment contract.

That's taken as read, yes?-- Were they sufficient to say categorically that this man was incompetent, should never be allowed to practise anywhere else again? Well, that was certainly my feeling, but did I have sufficient on file to be able to back that? Did I have an investigation? No. What I had was a series of open issues and a decision not to continue with employment.

In your evidence-in-chief you used the phrase "variance of practice"?-- Yes.

What did that encapsulate from your point of view?-- Many areas of clinical practice have a wide range of acceptable practices.

Yes?-- For instance, in treating a respiratory ailment some practitioners may err on the side of early prescription of antibiotics and others will wait until they have a definitive organism. There's - acceptable standard of clinical practice encapsulates a range of potential approaches to care. In psychiatry this is even perhaps more difficult than in other areas.

Yes?-- There are some fairly widely divergent thoughts on psychiatry. I think - to reflect back to Ward 10B here in Townsville, therapeutic community experiment, practice in psychiatry has over time been very, very substantially varied. So for somebody to be at odds with other practitioners is not that uncommon. For them to be significantly at odds and for them to act beyond the level of their authority and area of responsibility is a significant concern. The fact that Dr - I keep calling him Dr Berg - the fact that Berg actually had different ideas was not so much the concern as the fact that he chose to act on those ideas beyond his level of authority.

And the reality was for you, that on the one side was Dr Allen's strong views with which you aligned yourself and sympathised, and for that reason didn't renew him, and on the other side were at least three psychiatrists who to your knowledge, whatever you thought of them, had gone on the record with these glowing testimonials for him?-- That's correct.

That would have been relevant too, wouldn't it?-- Yes.

Thank you. Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Devlin. Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: John Allen for the Queensland Nurses' Union. Just two topics. The first one, credentialling and privileging of overseas trained doctors by Queensland Health-----

COMMISSIONER: Mr Allen, I'm sorry to interrupt you. Maybe one of the Inquiry staff could go and see if they can find Ms Gallagher and see-----

MR ANDREWS: Ms Gallagher indicated to me to the effect that as a result of the comprehensive answers that had been given, she no longer had questions to ask.

COMMISSIONER: I appreciate that. Thank you, Mr Andrews. Go ahead, Mr Allen.

MR ALLEN: The issue of credentialling and privileging of overseas trained doctors was a very significant one in the investigation you undertook of the conduct of Dr Izak Maree, which you refer to in paragraph 71 of your larger statement?-- Yes, that's correct.

And you were one of two investigators who investigated the conduct of Dr Maree, a South African trained doctor who had been appointed as the medical superintendent of the Charters Towers Hospital?-- Yes, that's correct.

And amongst your findings you found that Dr Maree, through negligent action, may have contributed to the death of a patient under anaesthetic?-- Yes, that's correct.

Now, the issues in relation to his credentialling and privileging included the fact that he hadn't been through a formal process of assessing clinical privileges?-- Yes, that's correct.

And indeed you undertook a bit of an examination yourself of his clinical practice in regards to anaesthetics by asking him to explain how he'd operate the particular anaesthetic apparatus?-- Yes, that's correct. When we looked at his record at the Charters Towers Hospital, it was clear that he'd delivered - I believe it was three previous anaesthetics prior to the anaesthetic on Miss Sabadina which had the fatal outcome. When we looked at the clinical records from those anaesthetics and when we spoke with Dr Maree about those, it was clear that there had been issues that should perhaps have raised a level of concern in him. For instance, alarms were ringing, he would silence those. He had issues with connections, if I recall correctly. We developed sufficient concern that we thought we'd just get him to walk us through how he approaches an anaesthetic. So we asked him to-----

Perhaps we don't need to go through all the detail, but how long did that process take, the practical demonstration of his skills?-- I would say half an hour to three-quarters of an

hour.

All right. As a result of that it became apparent that he had some real knowledge deficits in relation to that particular apparatus?-- Very significant knowledge deficits. He didn't recognise the significance of the carbon dioxide reading. He didn't recognise that that was in fact a feature of the monitoring devices. He had issues with management of the ventilator, didn't know how to adjust the volumes, nor the rate of the ventilator. He had issues with drug dosages, some very significant and basic concerns that one would expect to identify and address fairly easily.

Why hadn't someone gone through that 30 minute process before he was appointed to that position?-- It's very easy to look back on this and say it should have occurred. It certainly should have, and now it does. We learned from this process. Perhaps it would be relevant - as I think this case highlights a very significant difficulty - if I was to go back over his appointment process. Dr Maree was appointed by a panel comprising the outgoing Medical Superintendent, the District Manager and the Human Resources Manager of the Charters Towers district. They conducted an indepth interview and then they did extensive referee checking.

He had glowing references too, didn't he?-- Well, he did, and as part of the investigation we actually contacted the referees and conducted an indepth reference check with the knowledge that there had been problems. I have to say that he would have gained a position in any facility of the type around the country. He had a very good CV. He worked in a country where we have a good reputation for quality practitioners, and his references were not just good, they were outstanding. What we have put in place since then - that rang real alarm bells for us because there hadn't been a failure in his appointment process, and previously we'd come to rely on that sort of process to be fairly robust and to be able to provide us with a reasonable degree of assurance. The privileging process that was in place at the time allowed practitioners to exercise the privileges they were expecting to be granted prior to the formal consideration by the Rural Credentialling Committee. That's now been changed, and now practitioners in the northern zone who are going out to work in smaller facilities are only granted privileges in general practice until such time as there has been a formal check on their qualifications and experience by the Rural Credentialling Committee. Where there is any doubt - and that certainly occurs where you have practitioners coming from overseas who do not have, for instance, the advanced diploma in obstetrics or the advanced diploma in anaesthetics that you might obtain in Australia and that provide a very solid degree of assurance, then if they come from overseas we will put them through the major centre, have them assessed for a week or two weeks, or however long it takes across the breadth of clinical disciplines they're expecting to practise in in order to at least get a baseline level of comfort with their skills. This has led to us refusing privileges to at least two or three practitioners over the last couple of years.

All right. So does that flow from one of your recommendations, which was that consideration be given to review of the appointment and clinical privileging processes for senior medical staff in the northern zone?-- Yes, that's correct.

All right. I notice that one of the recommendations was that your report be submitted to the Medical Board of Queensland for further consideration and action as deemed appropriate by that body. Was that meant to be some type of investigation into Dr Maree possibly, or was that a more general forwarding of information?-- This is specifically in reference to the discussion with Mr Devlin before. An example where we felt there was very clear evidence that there was a gap in clinical practice standards and perhaps professional ethics that the Medical Board should consider and be aware of, perhaps make other jurisdictions aware of it. Certainly Dr Maree was no longer practising in Queensland, but we felt it was relevant that South African authorities, for instance, might be made aware of the concerns.

COMMISSIONER: Mr Allen, that report by Dr Johnson and Dr Farlow hasn't become an exhibit as yet, has it?

MR ALLEN: It is. It's Exhibit 56, Commissioner.

COMMISSIONER: I'm sorry. I was just going to pick up on some of the conclusions. You might recall, doctor, that in paragraph 6.4 on page 65 you expressed the conclusion that, "The appointment process of senior medical staff from overseas has numerous risks associated with establishing levels of clinical competence relative to the Australian experience", and over on the next page, "That the orientation process for Dr Maree was inadequate to identify his actual level of skills or to provide him with adequate knowledge of the Australian system for him to function independently." Certainly with the benefit of hindsight those remarks seem to be a pretty clear wake-up call for the sort of things that happened in Bundaberg 12 months later?-- I accept your position on that, Commissioner. I think the senior medical staff we're referring to in this regard - a particularly difficult group - is those without specialist qualifications. It's far easier to make an assessment of a practitioner coming from overseas if they have the relevant certification from the overseas authority - for instance, from one of the specialty boards in the United States or the Royal College of Surgeons or some such other recognised authority. Where we run into particular difficulties is where we have the non-specialist practitioner who exercises procedural skills. That group is far more difficult for us as we don't have, I guess, the certification from a recognised authority that they've passed hurdles that we might consider appropriate. So, for instance, in the case of Dr Maree, his anaesthetic qualification was essentially one - and I'd have to go back to confer with - to look at his CV, but my recollection is he had no diploma or specific qualification, it was rather more that he had extensive experience in delivering - I think it was in the order of 500

anaesthetics a year for the last few years. Now, that's where you run into major issues, where there's - we find that across a range of facilities where we have a requirement to have procedural practice from non-specialist practitioners.

I accept what you say entirely, doctor, but I was looking at this in a more general level. We've heard, from the incident with Berg and the wake-up call that that provided in relation to overseas medical practitioners coming to Australia with forged - or fraudulent qualifications, we have your report - coincidentally about the same time - in relation to Dr Maree - without putting too fine a point on it - killing a patient through apparent negligence. We know that the audit report in relation to Berg was shelved and never saw the light of day. It's the same with this one, isn't it? This was shelved and-----?-- Commissioner, I think that would be unfair to Mr Meehan, the zonal manager of northern zone. The actions that - this was a report commissioned by the zonal manager.

Of course?-- He acted on the report and has implemented the recommendations of the report by and large across the northern zone.

But presumably it went to Charlotte Street?-- Oh, I believe it certainly did go to Charlotte Street, and I have no knowledge of what happened with it from there.

But it apparently found a cupboard somewhere in the basement to gather dust?-- Perhaps.

It's certainly looking as if there were alarm bells sounding all over the place before Patel arrived in Bundaberg, and I don't mean this at all as criticism of the northern zonal manager, but someone in Charlotte Street should have heard those alarm bells ringing?-- Commissioner, I have another investigation report which is submitted with my supplementary statement which details another investigation into an issue in Doomadgee with other overseas trained practitioners. I think the truth is the way in which we bring overseas practitioners into the country, the level of support that they're provided, the ongoing peer review, is still below the standard that I'd like to see. It's very hard - for instance, in the case of the Doomadgee case, the practitioners that were lobbed into Doomadgee, both UK trained - I think one was Irish, but both from good training backgrounds, were unable to perform to the standard that they normally would because they weren't orientated to the area, had difficulties in understanding the local cultural norms. It's, I think, a system that's in some respects setting people up to fail. So yes, there has been some issues raised. I'd have to say I regard the fact that these issues were identified and subjected to such rigorous scrutiny to be at least some measure of comfort that we were prepared to look at the issues. What happened subsequently with reports and recommendations is perhaps a more difficult issue.

I guess, doctor, I was thinking back to some evidence you gave this morning, particularly in the context of Dr Myers where

you made the point that we've perhaps gone too far the other way and the recent changes are too rigorous and are going to prevent us attracting good overseas trained doctors into Queensland, but incidents like that involving Berg, this one involving Maree, and of course Dr Patel in Bundaberg certainly suggest to me that we can never be too rigorous in protecting Queensland patients from either fraudulent or incompetent overseas trained doctor?-- Again, Commissioner, I would highlight this is not simply an issue of overseas trained doctors. I have had a number of incidents where I've needed to manage the performance of Australian trained doctors.

Yes?-- Can I say the proportion of Australian trained doctors who perform greater or less than those from overseas? No, I can't say that, Commissioner, because I believe the way in which we have introduced overseas trained practitioners into the country has often left them with insufficient support, with insufficient orientation and understanding of our local systems to be able to perform to the level that they might otherwise be able to achieve. So I think to some extent it's not the overseas trained practitioners letting us down; it might be us letting them down.

That's as may be, Doctor, but with Australian trained doctors, firstly, you don't have the potential for people to falsify or conceal their registration history as occurred with Berg and as apparently occurred with Patel. So that's one problem you don't have with overseas trained - with Australian doctors as compared with overseas trained. The other difference is that the sorts of issues you identified with Doomadgee and with Maree, and I'm sure in other cases, with acclimatisation to Australian clinical practices aren't a problem for the local graduate as compared with the overseas graduate. Now, I accept it is probably as hard for someone to move from Hobart or Melbourne to Doomadgee as it is for someone to move from London or New York to move to Doomadgee but at least people will know things like the local protocol for handling a tuberculosis situation, which is one of the things I've been reading, they'll be familiar with the equipment, the protocol, the procedures, the command lines, all of those cultural features that are part of our Australian medical system. And that's why when you get wake-up calls like Berg and like Maree, it seems - "disappointing" is probably too slight a word but disappointing that something wasn't done about it at the time and before Patel turned up in Bundaberg?-- I can't argue with that, Commissioner. I think I went to significant links to address these matters, partly to provide some of that wake-up call.

Thank you.

MR ALLEN: Because the matters which-----

COMMISSIONER: I'm sorry, Mr Allen, Sir Llew had a question. Just that he's concealed by the screen.

D COMMISSIONER EDWARDS: I'm just wondering whether you have a view relative to sending a Queensland or Australian trained doctor as we do in their second year and perhaps third year, but it seems from the reading that we have done and the evidence we've received that the problem has been unfortunately, and this is no reflection on the very good overseas trained doctors, but we seem to have been putting overseas trained doctor with little check on their training and their capabilities into situations where tragedies have happened. Have you a view on whether when we are considering appointments of overseas doctors, that there is some mechanism by which that assessment could be done as is the assessment done by more senior doctors of Australian graduates in the hospitals where they are being trained?-- Sir Llew, I think

your question comes in two parts. One is is it appropriate for us to be sending relatively junior Australian trained practitioners out bush as it were and the next really relates to the safety-----

Is it appropriate, I take it for granted it is, but they seemed to have had reasonable training to understand the system and to evacuate patients where necessary, or are we getting the wrong impression?-- Gee, Sir Llew, I think you might be getting the wrong end of the stick on that one. I have deep concerns about sending junior Australian trained practitioners out to work in independent practice in remote areas.

COMMISSIONER: I should warn you, Doctor, you're answering a question from a man who today, which is his 70th birthday, is recalling being sent out to Cunnamulla on his first day out of medical school to take over as the only doctor in the very remote hospital. So I think-----?-- And I'm sure Sir Llew would not want us to go back to that, Commissioner.

I think you and Sir Llew are on the same wavelength about the difficulties young doctors face in the country but how do we translate that experience to overseas trained doctors?-- To pick up on that again, Commissioner, I'm sorry to labour the point, but we never used to that in New South Wales. We didn't have to send junior doctors out to relieve in those sorts of positions. This is something that's unique in my experience to Queensland. How that's evolved I don't pretend to understand, but the reality is we're sending junior Australian trained doctors out into positions that I think really, in today's environment, we should be re-evaluating. Now, how do we do that safely for overseas trained practitioners? Well, I'd have to say in many respects many of the overseas trained practitioners that we have coming through are more rounded in their clinical practice than some of the junior Australian trained doctors that we're sending out. That said, the process that we use in Townsville before we send somebody country relieving, which is where we move them around the countryside, is we actually have them do - we assess whether they've got a good term of emergency department behind them, we try to offer them an emergency life support or pre-hospital trauma life support course to establish their level of comfort and skills, we try and orientate them to the northern zone environment, we introduce them to our clinical proposals and we try to make that process as safe as possible. Now, that's a practice that we've evolved over the last five years, certainly that I've been in Townsville. I know it was process that was being evolved prior to my commencement but I believe we have made some significant ground in trying to address some of those issues. So we do have a little bit of science around that now and I believe we're doing that far better, particularly in terms of relieving. For the formal appointments, as I said before, we actually do bring them through a major centre and I can only speak for the northern zone because it is a policy we have adopted in the northern zone.

I think, Doctor, the other thing that has to be faced at some stage, and this may not be the stage to face it, is whether the sophistication of the modern medical system allows us to cling to the idea of having hospitals in towns of 1500 or 2,000 people in remote parts of the state, and I know that that's a very politically contentious issue because those people have votes along with everyone else, but maybe the time is approaching when we have to bite the bullet and say our system can't justify having a so-called hospital in a particular outback town and what we need there is, for example, a nursing clinic with the resources to bring in the flying doctor service or the ambulance, or whatever, as needed?-- I would have to agree with that, Commissioner. I think there's a couple of things that go with that. One is to ensure that we have an appropriate mechanism to train, if it's to be a nurse practitioner, then to have them equipped to fulfil such a role. We need to have evacuation mechanisms sorted out to such an extent that we can reliably retrieve people when we're quiet. Now, we're getting far, far better at that and the clinical coordination of services has evolved enormously in years. There is, just in recent weeks, a statewide clinical coordination of services which I think will provide far greater level of coordination of the available resources for air medical retrievals. That said, when you start to wind back services that are available to be provided on site in those sorts of areas, we may need to actually increase the amount of resource for retrieval. I think that's a logical follow-on. I'd have to say that the model that's been in place for years with solo medical practitioners working as a medical superintendent with right to private practice in small communities is, I would suggest, almost a dangerously outdated concept. They are required to work 22 days straight followed by six days off. Now, they may or may not be called out much overnight but they are absolutely at the mercy of their community for, you know, three weeks straight. I don't believe that in this day and age that's a safe model of care for us to pursue. It's extraordinary if - to recruit to because people now expect to have at least some sort of life. You know, whilst it's very rewarding living and working as an important part of a rural community, I think that's really taking it too far.

And it's outdated in another sense. If you take a town like Cunnamulla or Aramac, or what could be any number of examples, when hospitals were established in those towns in the 1930s, it was the best part of a day's trip from that town to the nearest hospital. Now it's probably an hour on the bitumen and much quicker by aerial recovery if necessary. It just strikes me in that we're inviting trouble by continuing to expect any doctor, let alone one who is a few years out of medical school, to provide all of the medical services that can be expected at a hospital in a country town like that?-- I would agree with you, Commissioner. I think isolation brings with it a number of risks, not the least of which is maintaining currency of practice. The skills maintenance for those practitioners is a significant issue. We are still faced with the tyranny of distance and whilst, certainly, the road connections have improved and the air connections have

improved, the Townsville Hospital sits as the tertiary referral centre for an area some one and a half times the size of France. We have enormous distances to cover and we do need to look at perhaps reducing the number of small places that we - that we maintain, perhaps consolidating some of those so that you might have two or three practitioners in a centre. This has enormous flow-on effects for the community. You know, people will choose to live where they can gain access to health care. That's one of the major determinants for a community. Now, to remove a community's doctor is a very, very significant step. Certainly, it's not only political in terms of wanting to hang on to your doctors; political in terms of wanting to hang on to one of the important parts of the fabric of the community.

And there is another side to the coin. One has to accept that in some towns of that sort of size that I'm talking about, the 1500 to 3,000 population, they would be unable to attract and maintain a GP unless that person was also offered the income and support of being superintendent at the hospital. So-----?-- Yes, that's right. The hospital superintendent position may - basically, it provides them with a retainer if you like.

Yes. Or a subsidy?-- A subsidy to provide access to public emergency service to keep the general practitioner in the town, that's right.

I'm sorry, Mr Allen.

MR ALLEN: Thank you, Commissioner. Doctor, when in your investigation report into Dr Maree you commented that, "due consideration must be given to the process of appointment, clinical privileges and supervision from the provincial centres to minimise the risks of such events being repeated", obviously the circumstances grounding that concern wouldn't have been limited to the northern zone?-- That's correct.

Do you know if those sort of conditions were passed higher up the chain beyond zonal level?-- I understand that the report was provided in its entirety up the management chain to the General Manager Health Services and was considered at that level. It is my understanding that the response was, "These issues will be addressed through a quality improvement enhancement project, so, you know, feel free to implement in an interim way whatever you wish in the northern zone", however, a state - it would not be considered for statewide application at this point. That is my understanding.

And that understanding came from whom?-- From my discussions with the Northern Zone Manager, Mr Terry Meehan.

Who was the General Manager Health Services at that time?-- It would either have been Dr John Youngman or Dr Steve Buckland. I think at the time it was Dr John Youngman. In fact, I'm certain it was him.

Okay. And this process that was going to address those

concerns statewide, what happened with that as far as you're aware?-- Well, I don't think it's effectively addressed the issues. The federal government provided funding to the states to conduct quality improvement activities through the Australian health care agreement. Queensland at that time was investing those funds in what were called QIMP projects, quality improvement enhancement projects. One of those was credentials and clinical privileging. Now, I am aware that that produced a guideline policy document about clinical privileges but I'm not aware that this issue was specifically addressed in them.

I see. All right. Now, it was addressed, though, in the northern zone because of your report into Dr Maree?-- That's - that's correct.

And-----?-- We discussed the findings of this report amongst the Medical Superintendents in the northern zone. We had open forum discussion about that I believe at a Medical Superintendents meeting in Cairns and subsequently the Northern Zone Rural Credentialing Committee, which is run by Dr Farlow, co-ordinated this report as it was seen to be within our ability to implement the recommendations.

Okay. If you could look at this document on the visualiser perhaps, can I suggest we will see eventually on the second page but may not see it now that it is dated 27th of June 2001. It is a memo to the District Managers of the Northern Zone from the Accident Emergency Manager?-- Yes, that's correct.

And does this appear to be really annunciating the response in the northern zone from your report into relation to Dr Maree?-- That's correct.

And if we see those three points down the bottom, there's really a practice which is being set out?-- That's correct.

That all rural hospital medical staff of medical superintendents, senior medical officer, et cetera, are to have credentials assessed and clinical privileges awarded by the zonal committee?-- That's correct.

Preferably prior to appointment?-- Yes.

But if not possible prior to appointment, then non-specialist medical practitioners are not to provide clinical services in anaesthetics, procedural obstetrics or procedural surgery until they are awarded relevant privileges?-- That's correct.

Would that policy, if implemented perhaps in a central zone, have required someone such as Dr Patel, who held himself out as being a specialist surgeon but was not Australian qualified as a specialist, would that have applied to him or would that have only been limited to someone who was not claiming to be a specialist surgeon?-- Well, there's-----

COMMISSIONER: Well, it does refer to Senior Medical Officer.

I think it's worth-----?-- Yes. In the northern zone, Mount Isa, for instance, uses the Townsville credentialing committee to consider all of its senior medical practitioners, whether they claim specialist's status or not, and that is probably a more effective mechanism for reviewing those who are ostensibly practising as a specialist.

MR ALLEN: Okay. So Dr Patel was appointed initially as a Senior Medical Officer Surgery but claimed to have overseas qualifications, specialists' qualifications in surgery?-- If he was appointed to that sort of role in Mount Isa, he would have been credentialed through the Townsville committee.

In accordance with the policy stated here?-- It's slightly at variance in that what is being referred to as a rural hospital in this regard, a hospital such as Atherton, Proserpine, Mareeba, Charters Towers, those sorts of facilities. Mount Isa is different in that it is holding itself out to provide specialists' services whereas the rural hospitals in general can be characterised by holding themselves out to provide services by rural generalists. It's a subtle distinction but it's an important one because the rural credentialing committee is staffed by expert rural practitioners. Now, they are more familiar with the assessment criteria of the joint committees run between the College of General Practitioners, ACRRAM and, for instance, College of Obstetrics, gynaecology or anaesthetics. So there is a specific body of knowledge that they can bring to bear. Where somebody is holding themselves out to practise at a specialist's level, then that is better assessed at a specialists credentialing body such as the Townsville Hospital. That's why we consider applications from the Mount Isa Hospital.

I see. Okay.

COMMISSIONER: Is Mackay in the northern zone?-- Yes, it is. It runs its own credentialing process.

But it would be roughly equivalent in size to Bundaberg I imagine?-- I'm unaware of the specific bed numbers or what have you but, yes, I'd say that would be reasonable.

And, similarly, for someone to be appointed as Senior Medical Officer in Surgery or Director of Surgery would now - would under this policy, or the equivalent policy, require a credentialing process to be gone through?-- Yes, that's correct and, again, the process would normally be as it is in Townsville: an interim award of clinical privileges followed by a formal credentialing process.

Yes?-- Now, maintaining credentialing is in fact quite a difficult undertaking and it's quite involved. My colleague in Mackay is reporting to me that it is quite difficult for him to maintain a credentialing committee with sufficient skills and experience to be able to conduct that function. That's why I've taken over the responsibility for doing that in Mount Isa and it may be that down the track we do - do the same for Mackay. Cairns has a greater level of critical mass

so is more able to perform that function. Now, that's - that's still an open issue and my colleague in Mackay and I will advance that over the next wee while but we certainly did take over that function from Mount Isa because they weren't able to mount an effective committee to provide the level of scrutiny, you know, that's required. I'm unaware of the situation in Bundaberg to know whether they would be able to mount an effective credentialing committee.

But if they couldn't, it would surely be possible to get the back-up needed from Brisbane or even from Rockhampton or from Maryborough?-- Certainly. I have - there is no technical difficulty for me to provide the support to Mount Isa to do their credentialing.

In fact, you don't have to be physically present in Mount Isa; you just need to see the papers?-- No, that's right. The papers come to us and the Director of Medical Services from Mount Isa comes to us and we do the consideration and processing.

If you keep talking like this, Doctor, you might end up doing the credentialing for all of Queensland?-- Thanks very much. That's a task I'd rather not have.

MR ALLEN: Doctor, just touching on something you mentioned there, you mentioned earlier in your evidence that in relation to the second part of the current credentialing policy, that the formal process would often include bringing on representatives of colleges where appropriate?-- Yes.

Now, you don't understand it to be or have been an element of Queensland Health policy that the credentialing and privileging process can't proceed unless the colleges formally approve a member of that committee?-- I re-read the policy the other day. I don't believe it says that.

No. So the fact that the colleges may not be willing to cooperate in a swift manner in providing a representative should not prevent a responsible medical superintendent from undertaking some credentialing and privileging process in relation to a new appointee?-- I think that's fair comment. I mean, I saw recently a formal letter from the College of Surgeons saying that they will not provide a college representative to credentialing committees, however, there are surgeons who attend; we may draw on their skills and experience. But I'm not going to get hung up on whether a college wants to put in an official representative. We've got very senior, very sensible people who are able to provide a level of scrutiny that's appropriate. Now, on my core committee I've got - mentioned before about the network of senior clinicians that we have in Townsville. We're extremely fortunate to have senior members of colleges, some are senior committee members of colleges. Now, frankly, it doesn't bother me if they're not formally representing their college. I like it to be so but if the college is not wanting to nominate them and not wanting to nominate anybody else as their representative, I'm not going to get hung up on that.

No?-- I think that the important matter is that appropriate scrutiny is applied and that we have people of sufficient seniority and expertise to do that scrutiny.

Yes, thank you, Doctor. I'll tender that memorandum from Terry Meehan to District Managers Northern Zone dated the 27th of June 2001.

COMMISSIONER: Thank you. That memorandum regarding credentialing and clinical privileges in the northern zone will be Exhibit 240.

ADMITTED AND MARKED "EXHIBIT 240"

MR ALLEN: A second and final topic, Doctor. You mentioned earlier in your evidence the problem experienced in your hospital and no doubt statewide of access block and its impact on being able to get through elective surgery lists and upon the provision of health care generally I would expect. Now, is access block where you have an influx of patients, perhaps in the emergency department, who are then kept waiting there for admission to a ward longer than is clinically desirable?-- Perhaps if I can offer the formal definition and I may get this slightly wrong but access block is defined as when you have a patient who is determined to be requiring admission to hospital; if they have a length of stay in the emergency department of eight hours or greater, then that is by definition access block. Now, in Townsville we have been battling with access block now for nearly four or five years. When I first arrived here it was common to have most days in the emergency department under 100 patient presentations per day. Now our average is closer, and in a five-year span, to 150 patients per day. Now, medical admissions to hospital jumped by some 30 per cent in one year last year. So our services have been significantly stretched. At the same time we've brought in a large number of innovations to try and improve what we call bed management, which is essentially making sure that patients don't spend longer in hospital than they need to and if they get care in the most effective and timely manner that they can so that their length of stay in hospital is minimised. Now, we believe that we have run just about every efficiency out of the system that we possibly can here in Townsville and we find ourselves significantly short of beds still. It's not uncommon for us to have 20 patients lined up in the corridor of the emergency department of a morning waiting for admission to the hospital. Now, that's a circumstance that the emergency staff have raised very significant concerns about as a patient safety issue.

Now, that's - when that's put up against the issue of elective surgery and providing care to those who need it in a programmed manner, we have a competition for a limited resource that forces decisions that we would rather not have foisted upon us.

Choose between cancelling an elective surgery list or keeping patients on trolleys in the Emergency Department for eight hours or more, decisions such as that?-- That's right. I mean, on a number of occasions we have had patients lined up in the Emergency Department corridor for periods of - or in the Emergency Department itself for periods of over 24 hours.

COMMISSIONER: Doctor, why has there been this increase? Is it expanding population or ageing population? Is there some explanation for what you described as a significant increase in emergency numbers?-- Commissioner, you would be disappointed if I said this was a simple situation, of course it is complex and multifactorial. We have at the same time seen growth in demand for our services in the Townsville Hospital there has been demand of growth in the private sector as well. So it is not a matter of private insurance levels or the private hospitals not carrying their weight. They do so. They provide a very significant part of the care in our community. Our population has expanded enormously in recent years and continues to grow. And that's a wonderful thing. It brings with it great economic benefits and makes it a wonderful place to live and work, but it also does put significant strain on our infrastructure. The hospital is only fairly new. When it was built, the expectation was that the beds that were available there would be sufficient, to use the expression future-proof the hospital for years to come. I think I myself was led into believing that. The reality has become very apparent over the last couple of years that we simply don't have a hospital big enough to cater for current demand let alone expected growth in demand in coming years, and there is an urgent requirement to look at significant increase in capital investment to build a larger facility to put more beds on. That's kind of hard to swallow when you consider the facility we have is magnificent. It is a superb state-of-the-art facility. I am proud to take people around there and it is extremely disappointing to see that it has proven to be too small so early in its life.

Doctor, one of the things that has frankly staggered me, because I came to this inquiry without any medical background, is that rebuilding has led to actual reductions in numbers at major hospitals, like the RBH and the PA in Brisbane?-- That didn't happen here, Commissioner.

I was going to ask, you didn't reduce the numbers?-- No, we didn't, and I have to really say that my predecessors and past district manager here really fought the good fight, the staff fought the good fight. We didn't get a reduction in our bed stock here. Now, that's almost unheard of in hospital redevelopments - not only within Queensland but around the world. The reality is we don't get as hung up on bed numbers now as we used to, but there are some patients who require a bed. I think there was a slightly tongue in cheek suggestion put up by a facilitator of a Health 2020 conference a couple of years ago suggesting that if we looked at the trends in bed numbers across Queensland, the last hospital bed in Queensland would close in the year 2063, I think it was, but incidentally on that day there would be 17,000 patients looking for access

to that bed.

Yes?-- You know, yes there has been a trend downwards in bed numbers. Is that a bad thing? Not necessarily. I think the reality is technology has reduced our dependency on beds, we have changed the paradigm with which we look at delivery of care. That said, there is no getting over the fact that some patients still require a bed and we just don't have enough in the system at the moment.

D COMMISSIONER EDWARDS: Has private bed availability increased as well in this region?-- Sir Llew, I would not be able to provide an authoritative answer to that. Certainly there has been significant development. In the private hospital sector here in Townsville there has been enormous investment, particularly by the Mater Hospital with new clinical blocks. I can't imagine that that didn't incorporate new beds but I have no specifics that I can offer you.

COMMISSIONER: I take it the Mater in Townsville, unlike the Mater in Brisbane, is a purely private hospital?-- Yes, that's correct, but it provides an enormous range of services, quite extraordinary cardiac surgery, neurosurgery. It really is a state-of-the-art private hospital facility. We're very fortunate.

MR ALLEN: Doctor, you mentioned the obvious concerns about patient safety in relation to this traffic jam of patients in the Emergency Department but it also raises real issues in relation to the professional responsibility of medical staff, both doctors and nurses, and you would be aware that those situations, when they become extreme, cause real concern on the part of doctors and nurses as to what might happen to them if something happens to a patient?-- I can understand where you are coming from. I think I can only speak for our environment. We understand as an executive team in the Townsville Hospital that there is extraordinary pressure on those staff and that they do an extremely good job in very difficult circumstances. If the suggestion is that they may be individually held to account for failures in care which are a system issue, I would reject that. I think in Townsville we have taken a very clear approach to identifying systems issues and trying to address them as systems issues rather than individual accountability issues.

But you don't control what action the Medical Board might take in relation to a doctor or the Queensland Nursing Council in relation to a nurse?-- No, I certainly don't control that, but in my experience the Medical Board doesn't normally consider the sorts of issues that would arise out of an overcrowded Emergency Department, those sort of issues would tend to get raised to the hospital to address. The sorts of issues that in my experience the Medical Board is interested in, where practitioners don't demonstrate due professional care, where they perhaps behave inappropriately. Now, that's not the situation for our staff. They're behaving very appropriately doing the best they can in difficult circumstances. I am not aware of any reports to the

registration authorities about conduct of individual practitioners in that situation.

Okay. Well, we've heard some evidence, for example in relation to a situation that arose at Caloundra in relation to action taken against a doctor and, indeed, investigation of a nurse regarding a fatal outcome for a patient who presented to the Emergency Department, and, indeed, it seems that work pressures were a real issue in relation to that doctor. The fact of the matter is if a doctor makes a mistake because of being overworked, being too tired to properly perform their duties, then any type of enlightened or considerate attitude on your part won't stop the Medical Board dealing with them, will it?-- Look, I have enormous difficulty with the concept of someone being held to account for a mistake. We all make mistakes every day. I can't recall the last day that I didn't make a mistake. The only difference is where I make the mistake and the context in which I make the mistake that alters the outcome. Now, I think we need to very clearly understand that our very valued practitioners actually are turning up to do a good day of work, and for them to be reported to the Medical Board for unprofessional conduct or Nursing Council for unprofessional conduct, I think really requires something more than them simply making a mistake. It requires a breach of professional conduct, a breach of professional discipline that goes beyond simply making an honest mistake in an environment where that mistake is going to result in an adverse outcome.

Thank you, doctor. You mentioned bed management. That's, in this sort of gridlock situation of access block, even included things such as putting adults in children's wards, trying to scrounge a bed here and there to address the problem?-- Adults in children's wards is something we regard as an extreme last resort. I can recall only a couple of incidents in the last five years where we have even considered doing that and generally we have been able to avoid it.

COMMISSIONER: But even the fact you have considered it shows how desperate you have been at times?-- Commissioner, I can't pretend to be other than desperate about this at times. You know, the reality is the first question that we ask when we get into work in the morning is, "How is the hospital?", and that means how many patients are waiting in the Emergency Department and what's - what are we likely to be able to achieve today.

And I am sure it is not uncommon to have surgical patients in medical wards, or orthopaedic patients in surgical wards, or whatever?-- That's absolutely the case. The truth that we know is that patients who are outside of the ward that would normally look after that type of patient - called outliers - will tend to have poorer access to sort of specialist support that they require. We know that they can tend to get lost in the system and we're investing a lot of time and energy in trying to work out how to prevent that from occurring. But when you run at occupancies of greater than 90 or 95 per cent, that means that you actually do have to look at putting

patients in mixed wards, it does mean you have outliers, and it reflects on a system that's operating beyond its efficient capacity.

MR ALLEN: Doctor, when talking about a shortage of beds, it is not always the case it is a shortage of the physical object, the actual mattress, it is a shortage of funded beds?-- It actually goes even beyond that. You know, this is an issue that I have tried on many occasions to make clear for the media because people will see an empty bed and say, "But there is a bed." There are many things that go towards making a bed a functional device for patient care, not the least of which is adequate nursing support.

That's a major factor, isn't it, as to how many beds-----?-- It is absolutely one of the critical factors. You know, the physical bed is only a very small part of the story. There needs to be the funds to be able to put the staff on, to make that bed a safe place for patient care, and there needs to be the availability of those staff. I mean, I have spoken a lot today about the shortage of medical manpower in Australia and globally. That's reflected in a similar situation, as I understand it, nursing staffing across the country and, indeed, internationally.

Although, Queensland seems worse than the other States in that respect, as with doctors?-- Again, I can only speak with some degree of authority on the medical side of them, but I believe that to be the case also with the nursing staff.

So the shortage of nurses really has a direct relationship to the unavailability of beds?-- Well, chicken or egg. Is it the bed and the funding for the bed that drags the nurses in, or is it the fact we can't get the nurses that means we can't open the bed. I think a starting point would be to say we need to establish additional beds, we need to fund them adequately and recruit nurses to fill those. Now, when - you have basically got to get the alignment of the planets to make this work. It is the availability of the nursing staff, it is the availability of the physical resource and the space to put the physical resource.

COMMISSIONER: And the availability of the funds to pay for the-----?-- And the availability of the funds, Commissioner. Unless you get the alignment of those, you have little room to move. The reality is, you know, sometimes you need the commitment of funds and the commitment to create the extra beds before you can recruit the staff to those beds.

MR ALLEN: The problem is at the moment there is a bare-bones roster of nursing staff. There is no sort of slack in the system so that you can call in extra nurses in times of access block, open up some more beds, address the situation of patient need?-- I am not quite sure that I agree with that entirely. I am not an expert in nursing rostering, however I do know that we do try to structure our nursing staff to accommodate expected surges in activity. We have what's called, perhaps laughingly in Townsville, the winter bed

strategy where we do look at trying to ensure that every available physical resource has appropriate human resource to staff it, but I have to say-----

COMMISSIONER: I think you're at cross-purposes. I don't think - I think Mr Allen is accepting that you have appropriate margins for error, but the point is that you have got no surplus over that margin for error to open up extra beds?-- Well, that's correct, Commissioner, but - and I think the - just to finish off the point, I think you were suggesting a bare-bones roster. We have huge gaps in our rosters at times reported to me where we have a number of shifts that aren't covered because we can't attract the staff. So I am not sure that we're deliberately trying to staff down. Certainly there is a formula that identifies the number of nursing staff expected to be required on any given shift. That was a formula that was largely derived in Townsville and has been applied elsewhere across the State, the concept, and that was done in conjunction with the unions and was the subject of ongoing negotiation. I am not party to that but I would have to say, from my experience in private hospitals, that we certainly ran far leaner on staff in the private hospitals than we do in the public system.

MR ALLEN: But the reality is in Townsville Hospital, for example, that when there are these times of increased need, this situation of access block, it is addressed by nurses working over time, double shifts, working through breaks, coming in on rostered days off?-- That's correct.

Not taking leave - sorry, nurses who go on leave not being replaced?-- Absolutely. You know, at times I will get a call late at night from the doctors in the Emergency Department saying that they're overloaded, you know, "There is a problem. What can you do?" I will phone the nursing resource coordinator, find she is in the middle of trying to negotiate to get extra staff, to get people to stay back late, perhaps open additional beds. You know, it is, I would say, a daily management issue.

It hardly makes Queensland Health an attractive employer for nurses?-- I couldn't disagree with that.

And I suppose the ultimate thing is there needs to be more funding?-- Well, some of these things I think come from a commitment. You have to be able to make - where I have seen systems be able to effectively change over time has been a commitment at a political level to have a standard. For instance, Victoria a few years ago came out with a standard for nursing practice. I think it was something in the order of there should be no more than four patients per nurse per shift. I am being rather simplistic but in the end it outlined a standard that could then be applied.

COMMISSIONER: A bit like class size standards in the education system?-- Yes, yes. And provided, perhaps, a time-frame over which we needed to manage to get to that point. But it outlined a target for what should be

achievable. In the United Kingdom some years ago there was a push for safe hours for medical practitioners, so over a series of years the European community had decreed there will be a reduction in the maximum allowable hours for medical practitioners. Now, that's seen the European community suck up huge numbers of doctors into their system, and because that's been a priority, because that's been an endorsed and funded target, they have actually made ground to achieve that. Now, I believe that that's the sort of commitment that we need to be looking for to establish this is the standard that people can expect, and then we need to go about identifying the steps to get there. Now, we have got some opportunities that are available to us on the medical side that are almost once in a lifetime opportunities with new medical graduates coming through, but to keep those medical graduates we need to create a safe, attractive and comfortable environment where people will want to come and work in or finds it challenging and satisfying work. At the moment I don't think we've done enough to establish those sorts of career paths. Again, I can only speak for the doctors but the same may well apply for the nursing.

MR ALLEN: Are you suggesting a system where the quality of care should actually determine the budget rather than the budget determining the quality of care?-- We obviously have an issue of resources, and there is a limit to how much resource can be applied to health care. There is an unlimited capacity to spend that resource, and I think from my perspective we need to be targeting that resource to providing safe and effective care, determining what it is that we do and doing that well. I can assure you that without extending our tax base or finding some other creative means for bringing revenue into public covers, we could spend an entire gross domestic product on health and still be looking for more. I think we do need to determine to an extent what it is that we're - we expect to do, to find some parameters around how that would be done safely and effectively, and build the safety and effectiveness measures into the performance accountability for executives such as myself, so that we're not just held accountable for the bottom line but also held accountable for the safe and effective provision of services.

Could I put it this way: that at the corporate level there should be more of a focus upon quality of care than mere budgetary considerations?-- I wouldn't argue with that.

Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Allen. Mr Boddice, any re-examination?

MR BODDICE: No, thank you, Commissioner.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Regrettably I have got one small issue.

RE-EXAMINATION:

MR ANDREWS: Doctor, Dr Myers has not been granted any privileges yet, that is correct?-- That is correct.

Dr Rosato applied in early May 2005 to you for clinical privileges for Dr Myers. Do you recall that?-- He made a recommendation to me for the award of clinical privileges. I don't have the letter in front of me but it was something of the order of general adult neurosurgery and tumour surgery.

Before sending that letter to you, you discussed with Dr Rosato the clinical privileges that he ought to apply for for Dr Myers and you suggested to him that he ought to apply for general adult neurosurgery, including spinal surgery and tumour surgery?-- No, I didn't suggest to him that he should do that, I asked him what he felt he was capable of doing. As the Clinical Director of Neurosurgery, I was relying on his assessment, and I made that clear, to advise me as to what Dr Myers was capable of safely performing, I asked him specifically to think about issues around clipping cerebral aneurisms and currency with clinical practice across the range of potential emergency neurosurgery that he might confront.

There would be nothing improper, would there, for a person in your position to be suggesting to Dr Rosato that he consider three particular areas as ones to apply for when applying to you?-- I was asking for his recommendation. I believe that there may have been a discussion where he gave me his verbal recommendation, and I would have asked him to put that in writing.

I have no further questions.

COMMISSIONER: Thank you, Mr Andrews. Doctor, it has been a very long day but an extraordinarily valuable one for this inquiry and for us individually. We thank you for your time. We realise what an imposition it is on such a busy job as you have, but we hope that we will ultimately be able to deliver on some recommendations to assist the health care system in Queensland, therefore that it will be worth your time to have been here today. But we certainly appreciate your attendance and evidence. You are excused from further attendance?-- Thank you, Commissioner.

WITNESS EXCUSED.

COMMISSIONER: Ladies and gentlemen we might now take a 10 or 15 minute break and if it is convenient to everyone, then

continue through till about 7 o'clock.

MR ANDREWS: The plans have changed slightly, Commissioner.

COMMISSIONER: Yes, Mr Andrews.

MR ANDREWS: The third witness for the day, Mr Gallagher, has been told that he need not attend further today and he will return tomorrow at 4 o'clock to try his luck.

COMMISSIONER: Yes.

MR ANDREWS: Dr Myers is the only witness I propose to call today and I imagine that I would be with him for about 10 minutes, and I know that one senior counsel for Queensland Health hopes to take a flight tonight.

MR BODDICE: I have to return to Brisbane but I see that Mr Fitzpatrick has come in time, so that won't be a problem from my point of view.

MR ANDREWS: I can take longer in the circumstances.

COMMISSIONER: Is it convenient-----

MR BODDICE: We know Mr Andrews' estimates.

COMMISSIONER: Yes. You mean how accurate they are, of course.

MR BODDICE: Absolutely.

COMMISSIONER: Is it convenient then to have a 10 or 15 minute break and it looks like we will be finished well short of 7 p.m.

MR ANDREWS: Correct.

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 4.28 P.M.

THE COMMISSION RESUMED AT 5.46 P.M.

COMMISSIONER: Thank you, Mr Andrews. Mr Fitzpatrick, you weren't here this morning but I decided in the ballroom we should dispense to stand up when we begin and conclude. It just seems to be inappropriate here.

MR FITZPATRICK: Thank you, Commissioner. I'll remember that.

COMMISSIONER: Thank you.

MR ANDREWS: Commissioner, I call Dr Donald Louis Myers.

MR FITZPATRICK: If the Commission pleases, I act for Dr Myers.

COMMISSIONER: Thank you, Mr Fitzpatrick.

DONALD LOUIS MYERS, SWORN AND EXAMINED:

COMMISSIONER: Doctor, please make yourself comfortable. Do you have any objection to your evidence being video recorded or photographed?-- None at all, sir.

Thank you. Doctor, may I say before you begin your evidence that on behalf of the Commission of Inquiry I actually feel an acute embarrassment that you have been brought into these proceedings. It has been made perfectly clear that there is no criticism whatsoever of your role in the fact that you got your locum position here in Townsville, no doubt at all, regarding your qualifications and experience. Some concerns have been raised regarding the transparency of the procedure and that is the only matter of concern or interest to us and, indeed, I would simply like to join with Dr Allen, Dr Johnson and others from whom we have heard evidence or received statements in hoping that you will decide to make Townsville a permanent part of your life?-- Thank you, sir.

Mr Andrews?

MR ANDREWS: Doctor, you've prepared a statement which I see is dated the 29th of July 2005?-- Yes, I have.

I see that in my copy you're described in the first line as Dr Donald Louise Myers. I assume that it's L-O-U-I-S?-- That would be correct, thank you.

And in every other respect are the facts recited in the statement true to the best of your knowledge?-- Yes, sir, they are.

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

I tender it.

COMMISSIONER: Thank you. The statement will be Exhibit 241.

ADMITTED AND MARKED "EXHIBIT 241"

MR ANDREWS: Doctor, I notice in paragraph 2 you observe that you completed the undergraduate and postgraduate degrees in an accelerated training program in five and a half years. I assume that that was rather than eight years?-- That's correct.

Should I take that as a testament to the amount of work you did at the time?-- No. That's a matter of advanced testing and having the opportunity to be in an advanced - a special program. There were very few people that were accepted in

that program.

COMMISSIONER: Are you being modest, doctor? I imagine it would have been also more onerous for the participant in the program?-- Yes, it was. We were a double overload during college.

MR ANDREWS: You were at some stage a Director of Neurosurgery, Intensive Care Unit. When was that?-- That's correct. I was Director of the Neurosurgery, Intensive Care Unit at Jefferson Hospital in 1980 through '85.

And I'm curious, your retirement from continental United States in 2001 you say was caused because the costs of running a neurosurgery practice had climbed to the stage where the income from the practice was less than its cost. Is that-----?-- That's correct. There is a crisis in American medicine and this - what happened to my practice is a typical example of that. The Pennsylvania area is hard hit. Philadelphia is second from the top in terms of malpractice cost and second from the bottom in terms of overall reimbursement. So there's a number of neurosurgeons and a whole number of physicians that left the area at about the same period of time. There's a shift going on in American medicine.

You came to Townsville with your wife in January 2005 to interview for this position - for a position at the hospital?-- That's correct.

How many discussions did you have with Dr Rosato?-- In January when we were here I had probably at least a half a dozen different discussions with him at different points in time, but we had continuing interaction. I was in the hospital every day and spent some time with him almost every day.

And how many discussions with Dr Guazzo?-- One. I had perhaps one or two telephone conversations trying to set things up and then sitting with him for about an hour to an hour and a half having a discussion in person.

When you accepted a position at Townsville what was your understanding at the time you accepted it, as to whether you would be supervised or not?-- My understanding was that I would be supervised in the community of neurosurgeons here; that there would be an oversight of my activities.

What made you believe that you would be supervised? A conversation, an expectation, a letter?-- I would think that primarily it was an expectation, but conversations would presume that you were interacting with other surgeons, that there were other people directly available, that I would never be by myself. I was under the presumption that I would be supervised.

And in your opinion how long would it be appropriate for supervision of you to continue?-- I would think that would

depend upon the number of cases I was exposed to, my performance, the opinion of the people that were supervising me.

And the rate of exposure to cases that you've been having to date, does that help you form a judgment about how long it should be before you ought to be performing surgery unsupervised?-- I'm not - could you re-state that question perhaps for me?

I imagine you've been observing cases since you've been in Townsville?-- Yes, I have. I've been participating as an assistant and working with the surgeons on cases.

Has that been to some extent refreshing your skills?-- Yes, it has on the one hand. On the other hand, as a surgeon you need to actually do cases in order to demonstrate your skills and demonstrate your ability and to allow other people to see what you can do.

When do you expect the college to have considered your application?-- My understanding was that they would be able to respond with some evaluation on paper of my credentials from four to six weeks from a point which they receive, what should have been about three weeks ago, two or three weeks ago, and at that point there may be some ability to move forward for me. I'm not certain of that.

And to this stage all work you have done has been under supervision?-- Yes, that's correct.

I have no further questions.

COMMISSIONER: Thank you, Mr Andrews. Doctor, I want to ask you a question which will really only gratify my curiosity rather than anything else, but, no doubt, whilst practising under supervision you've also had the opportunity to observe clinical practice by other neurosurgeons in Townsville?-- That's correct.

Are you able to make any comparison between the standard of neurosurgical practice that you've observed in Townsville and that which you are used to in the United States?-- It's staying in the same, that is to say that the care that I see here is of the - equal of any high level neurosurgical practice that I am aware of and I've seen a number of practices in the States.

Thank you for that, doctor.

D COMMISSIONER VIDER: I have one further question to that. Are the cases similar?-- That's difficult. Let me respond. What happens in the States - Philadelphia where I'm from - usually there's a group of eight or 10 neurosurgeons that will hang together, that will join together and one of them will specialise in one thing and the other will specialise in something else and six of them may be at one hospital and two of them may be at another and the Children's hospital may be

over there, so the practice gets so highly specialised in the different areas and it is hard to perceive what a general practice is when you are functioning in a metropolitan area like Philadelphia on the one hand. On the other hand, I'm functioning in the Virgin Islands now and we can't even begin to diagnose some of what we're seeing here, taking care of here now. We don't have arteriography, we don't have aneurysm clips, we don't have spine plates. There's many things that we don't have there, so while I'm seeing a general practice I'm seeing maybe trauma and tumours there.

COMMISSIONER: Doctor, how do the facilities of the Townsville Hospital compare to those which you are used to in the United States?-- They're almost precisely analogous. When I walked into the Intensive Care Unit the first time I saw it I was stunned because I haven't been in the Jefferson Hospital for a number of years since I left Philadelphia and it is almost like - I felt like I was almost walking back into the same clinics, modern medical environment. It was an inspiration. The hospital is first rate. It truly is. State of the art.

D COMMISSIONER EDWARDS: You say that the Medical Board has licensed you to practice neurosurgery, but you are awaiting the college to get approval for the possibility of a fellowship?-- I should perhaps - it's my lack of understanding of your nomenclature that makes me - I am licensed to practice as a senior medical officer and whether that is as a neurosurgeon, whether - exactly how that relates to neurosurgery I will leave it up to other people to better define that for me what my exact role is in terms of the Medical Board. Suffice to say, I am registered with the Queensland Medical Board.

COMMISSIONER: Thank you, doctor. Mr Fitzpatrick, do you have any further evidence-in-chief?

MR FITZPATRICK: I just wanted to ask the doctor one question.

COMMISSIONER: Yes.

MR FITZPATRICK: If it please the Commission. Doctor, you spoke about your current mode of practice at the Townsville Hospital and, in particular, that you work there under supervision of the two neurosurgeons who are permanently on the staff there. Was that a situation that came about as a result of the initiative of the Townsville Hospital or was it something that you suggested to them that you'd be comfortable with?-- My understanding - my - the feeling that I have is that it was at the suggestion of the Townsville Hospital, that this was their approach to this situation and I have been under the supervision of Reno Rosato. I have worked with Mr Guazzo as well, but technically I am under Mr Rosato's supervision.

Was it part of your understanding that that was one of the means by which the management of the hospital could assure themselves about your compatibility to work the area and care for the patients and so on?-- That and the issues with

registration, the issues with specialists' qualifications. I believe it was felt best not to put me in a situation where I would be unsupervised, that it could - whatever might happen it would be better if I were not placed in a situation at this particular point in time.

COMMISSIONER: Do I have the impression, doctor, that you yourself were grateful for the opportunity to update your skills by means of that supervision?-- You hit the nail on the head, sir. It is a special privilege and a special treat for me as a practising neurosurgeon to be able to work with these fellows here, see how things are done, ask them questions, ask them some of the tough questions about - not just how would you manage this patient, but what if we saw this, how would you take it at the next level; what if you saw this and that, what would you do next. So it's a multi stage process of becoming acquainted with the way practice is done here so it's a special privilege to be able to do this.

I'm going to ask another question based more on curiosity than anything else, but coming from an American system where there are no Government funded public hospitals as we have in Queensland do you identify any particular differences in culture or in practice at the hospital as compared with the system you were used to in the United States?-- I haven't been here long enough to perceive that and the question's interesting because in Philadelphia I often saw patients in my office that needed surgery with some degree of urgency but had no coverage. I couldn't bring them in the hospital unless I broke the rules and declared them emergency. There was no way to take care of them. As they walked out of my office I knew that they were stumbling around and there was no way I could help them and I found that more frustrating. I found that morally reprehensible that a system like ours couldn't come to better solutions for these people. In contrast in the Virgin Islands the hospital there has a mandate to take care of all covers. I do a clinic at that hospital and I see everyone that comes into that clinic regardless of their ability to pay and I'm allowed to admit them regardless of their ability to pay, so your question really - your question of me is interesting. It requires a stratified, complex answer because I'm seeing the best of all different worlds. To cut to the core of the issue, I'm inspired by the health system you have here because you are able to - not only you are able to, but everybody is working to provide excellent first care health - health delivery to all individuals. It's a right of all individuals here and although your taxes are obviously a little higher than the United States I'm also stunned at the level of care you can provide because I don't think we could do that in the States.

Mr Fitzpatrick?

MR FITZPATRICK: Yes, thank you, Commissioner. That's all I have.

COMMISSIONER: Mr Devlin, do you have any questions?

MR DEVLIN: No, thank you.

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: I assume there won't be any re-examination.

MR ANDREWS: No, Commissioner.

COMMISSIONER: Doctor, thank you for your time. We do appreciate you coming in to give evidence. You're excused from further attendance?-- Thank you, sir.

WITNESS EXCUSED

COMMISSIONER: Thank you. We will now adjourn - what time in the morning would suit everyone? Should we go for 9.30 again?

MR ANDREWS: Yes, please.

COMMISSIONER: Mr Andrews, you're confident that we're running to schedule more or less?

MR ANDREWS: Yes. I expect that Dr Johnson was far and away the longest witness.

MR DEVLIN: For what it's worth, we agree with that assessment.

COMMISSIONER: Is everyone else happy with 9.30 tomorrow? So be it then. We'll adjourn until 9.30 tomorrow morning.

THE COMMISSION ADJOURNED AT 6.05 P.M. TILL 9.30 A.M. THE FOLLOWING DAY