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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 05/08/200

..DAY 35

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THE COMMISSION RESUMED AT 10.03 A.M.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: Good morning, Commissioner. Commissioner, it is proposed today to call two witnesses. I understand that we're sitting these hours, 10 till 12, then 3 till 5.

COMMISSIONER: That's correct, yes.

MR ATKINSON: The intention of counsel assisting was to call a Dr Geoffrey Alan de Lacy, and then if there is time available in the day we hope to call Glen Tathem, who, of course, is a witness who has been lingering, if you like. The man who ran the Ethical Awareness course.

COMMISSIONER: Of course we will do our best.

MR ATKINSON: Before I call Dr de Lacy, can I say these things: that Dr de Lacy has been very difficult to convene with because he has a very busy practice in Bundaberg, and in addition he is seeing many of the patients of Dr Patel pursuant to an arrangement with Queensland Health.

He is being called because he has seen some 150 of those former Patel patients, and it is hoped that he can explain what he has seen in the course of that exercise.

Various parties have approached me and explained that because we don't have all 150 patient files at this stage, it is really not possible to test the evidence and to cross-examine Dr de Lacy at length.

COMMISSIONER: Yes.

MR ATKINSON: And certainly we haven't been keen to press Queensland Health to give us all of those hundreds of thousands of pages at this stage when we don't know as yet which patients are of interest to the parties.

COMMISSIONER: Yes.

MR ATKINSON: It is proposed then, Commissioner, that he give his evidence-in-chief. If parties do intend to cross-examine and if they are interested in particular patient files having regard to his evidence-in-chief, then he may be cross-examined at a later time when we have to hand the patient notes for each patient.

COMMISSIONER: Whilst in an ordinary Court of law people are discouraged from splitting their cross-examination, I would also invite counsel at the Bar table if they wish to commence cross-examination on any issues on which they already feel they have sufficient instructions, they would be welcome to do so, whilst reserving their right to postpone any further cross-examination until we've seen the files. That way,

having Dr de Lacy here will make the maximum use of his time whilst he is present.

MR ATKINSON: I should say, Commissioner, I have felt out some of the parties on that option and for the most part people have said they would prefer to cross-examine in one tranche.

COMMISSIONER: And I accept that's quite sensible. I have in mind, for example, reading through the statement this morning, there are - there are some remarks that might be thought to be critical of Dr Keating and that Mr Diehm might wish to take the opportunity to deal with those now. And I am not insisting that you do so by any means, Mr Diehm, but I will give you that opportunity if you wish to avail yourself.

MR DIEHM: I will see how it goes, I think will be my approach of it, Commissioner, if you don't mind.

COMMISSIONER: Thank you, Mr Diehm.

MR ATKINSON: I should say, Commissioner, that also raises a looming issue, which is with Dr Woodruff there is some 221 patients and there may be some logistical difficulties in working out for which of those patients the parties require the patient files so that they can test Dr Woodruff's evidence.

COMMISSIONER: Yes.

MR ATKINSON: Commissioner, the second issue I wanted to raise is that we haven't completed the task yet of coding the patients to which Dr de Lacy refers. That involves, obviously, reconciling those patients who are referred to in the evidence to date or in Dr Woodruff's report to make sure that people don't get two coded numbers. I propose that, Commissioner, you just repeat your earlier order that witness names are suppressed.

COMMISSIONER: Yes.

MR ATKINSON: Patient names, and I will make sure that today or by Monday we have a code which incorporates Dr de Lacy's patients.

COMMISSIONER: All right. I am afraid this will put a bit of an onus on the representatives of the media present here. Since we don't have code numbers for all of the patients, in the course of evidence today those names may be used. Can I stress to the press and media the importance of ensuring that any recordings, video recordings or tape recordings, that go to air are carefully checked to ensure that inappropriate names aren't included in any broadcasts. Hopefully for the print media it will be a little easier because they write their own script rather than broadcasting proceedings in this inquiry, but I will direct that patient names mentioned in Dr de Lacy's evidence, other than patient names that have already specifically been made the subject of directions releasing them from suppression orders, not be mentioned in

any broadcast or publication outside these proceedings.

MR ATKINSON: Thank you, Commissioner. Do the Commissioners have copies of Dr de Lacy's statement?

COMMISSIONER: We do, thank you.

MR ATKINSON: With the attachments?

COMMISSIONER: Yes.

MR ATKINSON: Perhaps the last thing I should mention then,. Dr de Lacy has been known socially to me for many years, as with other counsel.

COMMISSIONER: Yes.

MR ATKINSON: I call-----

COMMISSIONER: Ms Gallagher?

MS GALLAGHER: If the Commission pleases, I seek leave to appear on behalf of Dr de Lacy.

COMMISSIONER: Such leave is granted.

MS GALLAGHER: Thank you.

GEOFFREY ALAN DE LACY, SWORN AND EXAMINED:

MR ATKINSON: Witness, is your name Geoffrey Alan de Lacy?-- It is.

You are a surgeon?-- I am.

You work at the Mater Hospital in Bundaberg?-- I do.

You have rooms there and you do all your surgery at the Mater?-- I am also a VMO at the Bundaberg Base Hospital and work at the breast clinic based at the Bundaberg Base Hospital, but the bulk of my work is done at the Mater Hospital in Bundaberg.

COMMISSIONER: Mr Atkinson, I should have asked whether Dr de Lacy has any objection to his evidence being video recorded or photographed?-- None.

Thank you, doctor.

MR ATKINSON: And if you don't mind, Dr de Lacy, could you keep your voice up?-- Sure.

Now, you graduated in 1987 with honours from the University of Queensland?-- Yes.

You obtained a Fellowship with the Royal Australian College of Surgeons in 1997?-- I did.

You have worked as a Director of the QEII Hospital in Brisbane?-- The Surgery Department at the QEII, yes.

Sorry, Director of the Surgical Department?-- Yeah.

And you have worked over the last five years in a number of regional areas, Maryborough, Hervey Bay, Broken Hill, Gosford and Griffith?-- I have.

You have worked as a senior lecturer in medicine at the University of Queensland?-- In surgery.

Within the Department of Surgery at the university?-- Yes.

You have been an examiner for the Australian Medical Council?-- I have.

Just with that last task, can you explain what's involved in being an examiner for the AMC?-- We assess foreign graduates. I specifically assess them in surgery to make sure that they are fit to practise in Australia.

When you say you assess them, does that involve paperwork or does that involve looking over their shoulders, if you like, as they do surgery?-- That's viva exam and assessing written material. So it is face-to-face assessment of the individual doctors.

The viva exam in fact involves watching them do surgery?-- No, it is asking them questions and getting answers. No specific assessment in theory itself.

Doctor, in 1998 or 1999, that's when you were the Director of the Surgical Department at the QEII Hospital?-- Yeah.

I just have one question about that. You had only been a fellow for about one year when you became the director?-- Yes.

Is that unusual?-- It is actually common in metropolitan hospitals for that arrangement to occur. There is a career path which is - goes from fellowship through Director of Surgery in a big metropolitan hospital, to establishing private practice and going back to that same hospital as a visiting medical officer. When I was director there, most of the other surgeons that I was directing had been previously directors at the same hospital.

Does that not make it difficult to supervise people who are more senior than you?-- Sometimes, yes.

Doctor, apart from your practice at the Mater Hospital, have you come into contact with - or maybe through that practice have you come into contact with former patients of Dr Patel?--

In April this year I was approached by the Mater Hospital, and then independently by the Bundaberg Base Hospital, and asked if I would be prepared to provide second opinions and sort of continuing surgical care for the ex-patients of Jayant Patel who had a problem with his care.

So there were the two things: second opinions and follow-up surgical care?-- At that stage Dr Patel had just left the hospital and all of this - the subsequent problems were evolving. There were at that stage just two staff surgeons at the Bundaberg Base Hospital. Dr Patel was one, he had left, and the other one was - expressed a desire to leave.

That's Dr Gaffield?-- Dr Gaffield. There were few other surgeons in town, and I agreed to help and look after them if I could. At that-----

Could I just explore that arrangement, doctor? Is it the case that Queensland Health made an arrangement with the Mater and they in turn made an arrangement with you?-- That's right, yeah.

And the people who came to you for a second opinion-----?-- Mmm.

-----or came to you for follow-up surgery, the fees were paid by Queensland Health?-- That's right.

And what was the sieve, if you like? Which patients could come and see you?-- As I understand it, all of the patients were sent a letter outlining their options, and this was all subsequent to the arrangement. It was really done sort of on the run, as it were. There were a lot of unhappy patients and a lot of people that needed to be seen straight away. So I started seeing people, and as I was seeing them, the arrangements were being sort of finalised. The final outcome was that every patient who was - who'd had any contact with Dr Patel was sent a letter by Queensland Health and outlining some options, one of which was to see me in my private rooms which is situated at the Mater.

In a sense, anyone who had been a patient of Dr Patel, it seems, was entitled to approach you?-- That's right.

And they would have the fees paid by Queensland Health?-- They were paid directly - yeah, they were paid to the Mater and I was subsequently reimbursed.

So you could expect that what you saw was something of a fair cross-section of Dr Patel's patients?-- I think so. Some of those patients certainly didn't want to go back to the Base Hospital under any circumstances, and perhaps that's fair but I think there would be some selection bias, I think, in those that saw me. But when we started this arrangement I remember commenting that I wasn't sure whether we were going to see five or 500 patients, and it has certainly been closer to, you know, the latter mark. So after seeing a couple of hundred of them, I think it is probably a fair cross-section of his

ex-patients, yeah.

Now, when people are sent these letters, you understand, is this right, that there are three doctors they can choose?-- Yes.

Barry O'Loughlin?-- Yes.

Dr Michael O'Rourke?-- Yes.

But he is only on a five month contract?-- Yes.

And yourself?-- I think the arrangement is they can either see Michael O'Rourke, who is a senior staff surgeon from the Mater Hospital in Brisbane who has agreed to come up and help at Bundaberg for five months; seeing Barry O'Loughlin, who has a similar position at the Royal Brisbane Hospital; a series of locums that have come up to help him; or myself.

Right. You mentioned that at the outset you weren't sure how many you were going to see?-- Yeah.

COMMISSIONER: Of those three that you mention-----?-- Yes.

-----are you the only one who is external to the Base Hospital?-- Yes.

And that probably suggests why a lot of patients would have preferred to see you at the Mater rather than going back to the Base Hospital?-- Yes, some of them have certainly expressed that to me, that's correct, yeah.

D COMMISSIONER EDWARDS: And you had no difficulty getting files from the hospital to look at those - when you see those patients?-- When - I was first approached by one of the administrators from the Mater Hospital and asked whether they - in my opinion they thought this was going to be feasible, and the only provisos that I put on this process was that I had access to the Base Hospital notes. They are fairly jealously guarded - I mean for good medical reasons, actually. If the notes leave the hospital and that patient happens to be admitted for another reason while the notes are outside the hospital, it can really influence their medical care adversely. So that was a big deal. And the current arrangement we have got is that I can confine myself to seeing these patients on Friday, and a person comes from the Base Hospital with all the files and then goes back with all the files at the end of Friday consulting. And I also ask to see the hardcopies of their X-rays, which are also hard to get that for the same reason.

From the files you have seen, they do appear all intact?-- Do you mean have they been adulterated in any way?

I mean, in your opinion do you think all information that was provided, what should have been in the file was in the file?-- Within - generally, yes.

Thank you?-- There are inevitably some things that get misfiled, or bits of paper that are lost but they - similar medical files seen in other public hospitals, yeah.

Thank you.

MR ATKINSON: So when you reviewed each patient, doctor, I understand you had to hand the radiology?-- Mmm.

Any pathological - pathology results?-- Yes.

You would have examined the patient?-- Yes.

Taken a history? And you had all the records, in terms of things like discharge notes or transfer notes?-- I wanted to be able to provide exactly the same care as Dr O'Loughlin or Dr O'Rourke who would have access to those files and X-rays.

You mentioned, Dr de Lacy, that at the outset you didn't know how large the job was that you were taking?-- Mmm.

How soon did you find out?-- The next day.

What happened?-- Basically, I was - well, a patient was referred to me by one of the GPs the next day who needed an urgent operation that evening, and so it started immediately, and that particular operation, which was an incisional hernia was - had a complication that I hadn't seen before. Patient had a successful operation, they left without problems, but I had an inkling from the word go it was going to be an unusual circumstances. Certainly has been that for the last couple of months.

When you say the operation was an incisional hernia?-- Yes.

You mean the operation that had been done prior to your involvement?-- That particular case - I haven't actually got her notes with me - wasn't one of the ones I planned to talk about specifically - but she had had an incisional hernia repaired by Dr Patel and it had recurred, and she presented with a bowel obstruction, which can happen as a consequence of a recurrent hernia and all of which was standard. These are things we see all the time. On reoperating on her, however, the - his technique of hernia repair was unique, not something I had ever seen before.

We don't know much about hernia techniques at all. If you can make that a bit more graphic for us?-- One of the - one of the things which we try hard to avoid doing in these operations is damaging any of the contiguous and anatomical structures. Specifically in that operation, the small bowel, which can be involved in the hernia, is the one that is most commonly injured, and that can certainly happen. A stitch used to repair the hernia can pass through the small bowel. I have seen that a number of times. I have definitely not seen the stitch passed through 20 loops of the small bowel, which I did that day.

Right. Now, since that first patient, you have seen more than 150 former patients of Patel?-- I have, yeah.

And for each of them, is this right, doctor, you have provided something of a second opinion to the general practitioner?-- Yes.

And I didn't plan to tender it just yet, but you have provided that set of 150 second opinions to the Commission staff?-- I allocated half an hour to see a new patient. I tried to treat them exactly the same way I treated a new referral, a new private referral, and generated a letter which went back to the GP, as I would for a private referral, and a copy of that to the records of Bundaberg Base. After seeing a couple of these patients, certainly well before I had finished my first day of consulting, I suspected that I would probably have to sit here at some stage and that these would end up being public records. So I have tried to - while not making, you know, formal medico-legal reports, the letters that have gone back to the GPs are more complete than they would normally be. So there is more detail in all of these than is strictly necessary just for their medical care.

As you say, doctor, they are not medico-legal reports in the sense of reaching a view as to whether or not optimal care was provided?-- No, I saw my role as looking after these patients and tried to sort of confine myself to that, to help navigate through, you know, what's become increasingly murky waters with the patients. They have often asked my opinion about legal matters and various other things and I have just tried to confine myself to what's in their best medical interests. I think that's reflected in the letters.

How comfortable do you feel in providing - in your ability to provide a reliable opinion about the standard of surgery provided to the patients you have seen?-- One of the other caveats that I have - that I asked the Bundaberg Base Hospital to assure me about before we - before I took this on was that I was allowed to on-refer any of these patients who had problems outside my area of expertise to any other specialists I felt was necessary. And so of those 150 patients, many of them have been seen by other specialists. Dr Patel and I were both general surgeons, both primarily do gastrointestinal surgery, and those other areas in which he operated sort of outside my field, I have got expert opinions from other specialists. So in answer to your question, pretty good position to make the assessment about his competence within general surgery, I think.

COMMISSIONER: Dr de Lacy, would I be right in assuming that in instances where you felt they were outside your personal expertise, it would be right to infer that they were therefore outside Dr Patel's expertise as a general surgeon of a similar area of practice?-- In general that's correct, I think. There is - everyone has special interests and the rubric of general surgery is a difficult one to define specifically.

Of course?-- But in general that's correct, what you just

said.

When you talk about references to other specialists, are these mainly subspecialties, vascular surgeons?-- Neurologists, orthopaedic surgeons, ENT surgeons, vascular surgeons, plastic surgeons. I think I have referred far and wide.

Yes.

MR ATKINSON: I guess in terms of the match-up, if you like, doctor, between yourself and Dr Patel, your stationery I think says you have a special interest in laparoscopic and endoscopic procedures. But Dr Patel, in your experience did he confine himself?-- No, he didn't. Part of the issues, or part of the difficulties arose, in my opinion, due to him operating outside his area of expertise.

We will come back to that. But I guess what I wanted to ask you - what I was getting at with an earlier question is this: doing the job retrospectively that you have?-- Yes.

Would you accept that to some extent you are hampered; you have got patients who might have unreliable memories or you have got records that might not disclose exactly who was given the treatment at a particular time? Are there difficulties in piecing together what happened previously?-- Well, there certainly have been. I have only seen the survivors for a start.

COMMISSIONER: Yes?-- I - these are patients that, similar to other patients that I have seen, in that they have, as Mr Atkinson's outlined, bad memories, they see the doctors when they are anxious, they have had bad results, which can happen and does happen to every surgeon, sometimes angry, they don't hear what they are told, they don't remember what they are told. But that actually goes for every patient I have ever seen, publicly, privately, whether they have been seen by Dr Patel or operated on by Dr Patel or not. Having said that, he's - these - I have tried to put together these letters I have generated for the GPs with as much sort of reliant - relying, rather, on the hard evidence if I can. Histology reports, X-ray reports, the details that have been transcribed into the notes by other hands than Dr Patel's and have come to a conclusion based on that.

And also, of course, your own observation of the-----?-- What they have told me and my examination and often the results of my operations.

You see, doctor, this is of critical importance to us. There has been a report, as you would be aware, prepared by Dr Woodruff based almost totally on what can be gleaned from the clinical notes, and a number of people have already made the point to us in their evidence that what you derive from the clinical notes is never the full picture, even if they are the best clinical notes in the world. But in this case we have the added problem that it is at least suggested that Dr Patel was less than scrupulous in documenting procedures,

particularly when something went wrong. Bearing that in mind, my tentative view is that the sort of evidence you are able to give based on, not only clinical notes but talking to the patient, observing the patient, reviewing the scans or radiology reports, whatever, whilst it may not be perfect is the closest we're ever going to get to the truth?-- Well, I mean, I think so, too. I mean, often - you know, ultimately when these patients have come for reoperation, the hard facts, specifically what's in front of me on the operating theatre table, certainly don't tally up with Dr Patel's notes.

Let's just go back to the example you gave a moment ago of the patient with the small bowel-----?-- Yes.

-----being sutured when the hernia was repaired. There's no way anyone would pick that up from looking at the file?-- No. The - that operation read, you know, closure of anterior abdominal in a standard way. Now, complications occur because surgeons aren't aware that they've made a mistake during the operation and I don't know that that necessarily represents in the falsification of notes or anything. What it represents in my experience is the most ham-fisted attempt at repairing a hernia I'd ever seen, and on a number of other occasions, and, I mean, I know that I'm - these are conclusions that I've drawn, not sort of hard facts, although I'll be happy to supply those to you if it's going to help. You know, his - it's hard to imagine how he could possibly have had these complications without knowing them. They aren't the standard kinds of things that I've seen in seven years of practice or that I've heard described by people who've had much more experience than me. It's certainly possible to catch up a loop of bowel during closure of an abdomen. I've found it impossible to envisage how you could go through the bowel with every stitch and not notice unless you were looking out the window, you know, rather than at the patient, and there have been a lot of other examples of the sort of errors of that magnitude.

I wonder if we could talk about some generalities before Mr Atkinson takes us into the detail. Some of the comments we've heard from people who are in the same operating theatre as Dr Patel when he was operating suggest, firstly, that he wasn't careful to get a good field of vision of the organ that he was operating on. Were the problems that you identified consistent with that sort of failure?-- Not only that kind of failure but certainly that type of failure. I was in the operating theatre with him only once and so the point that Mr Atkinson made about the difficulties of making these judgments retrospectively, I really couldn't comment on his surgical technique, only his surgical outcomes.

Yes. Similarly, it's been suggested, again by people who were in the operating theatre, that he was quite rough or brusque in moving aside other organs when operating. Are there any indicia from the surgical outcomes that you've observed that would corroborate or reinforce that proposition?-- Any - any number of them. Any number of examples of that. Injuries to the liver, spleen, rectum, bladder, ureter, pretty well every abdominal organ, which were operative accidents and many of them - many of them. I can make the inference that he must have been a rough operator but it's - as I said, I never saw him operate apart from that one case.

There's also been a lot of commentary, particularly from nursing staff, about his closure techniques and the fact that there were an excessive number of dehiscences-----?-- Yes.

-----and of wound infections. Again, was there anything in your observations that sheds light on that proposition?--

Well, using the small bowel as your - as the tissue to close the abdomen is generally - results in a bad outcome. I've had to operate on a lot of his hernias.

Yes?-- And I haven't got a number for you but many, 10, 20, 30 perhaps, and out of the 150 patients that I've seen so far. As a principle, it would be nice to think that you never had one of those in your career. It's certainly possible to envisage, if you assess the patients perfectly and performed, you know, perfect operations on them, never to have, you know, a dehiscence. It's not common in surgery. One of the points that I'd like to make if I could was that I'm not certain that the magnitude of his errors, the number of problems that he's had, the number of deaths that he's had has ever been sort of appropriately compared to what we might have expected him to have, and these things aren't just things that happened to an average, general surgeon, at all. They're not 10 times what you might expect. They're more like 100 times what you might expect. He's had I've heard reports of 87 deaths or something over that period. If you're lucky, you might have had none, none. If you were unlucky, you might have had four or five, not 80. And equally, with these patients-----

MR ATKINSON: I'll just stop you there, Doctor. To be fair-----?-- Yes.

-----from what Dr Woodruff's done in terms of clinical audits?-- Yes.

He started with 87 or 88 deaths where Patel had some involvement?-- Yes.

He distilled them down to about eight where he considered that unacceptable levels of care had caused the death or had contributed to the deaths. So perhaps that's a better statistic to work from, the eight rather than the 87. Do you still maintain that that's outside the range of - that's well outside the range of what a general surgeon might expect as opposed to, say, a neurosurgeon?-- We do the same kinds of operations Dr Patel and I. I mean, I'm looking through his 150 operations. They're not grossly different from the ones that I do or, you know, other peers. And an elective death, that is a patient who's been - walks into your office with a problem, you know, when you've got time to assess the patient, time to assess the problem, to make the decision whether they should be operated on by you at this institution, have you got all of the supporting structures in place that's necessary to care for them, when you're faced with that situation and the patient dies, it's a disaster, and it's also rare.

You have time, I guess, to work up the patient?-- Yeah, that's right.

So if they have comorbidities, renal problems or cardio problems?-- Yeah.

You have time either to work it up so that that problem won't impact upon the surgery?-- Yeah.

Or, alternatively, to send them somewhere where there's oncologists or nephrologists who can assist?-- Exactly.

And that's why you say that a death from an elective patient is more disturbing?-- A disaster.

COMMISSIONER: Doctor, we've also had a lot of evidence which has been critical of the number of very complex procedures such as oesophagectomies and Whipple's procedures undertaken by Dr Patel?-- Yes.

Particularly when they weren't situations of the utmost urgency?-- Yes.

Where there was no need to operate that day rather than wait 48 or 72 hours so the patient could be transferred to Brisbane. What are your views regarding the appropriateness of performing operations of that complexity at the Bundaberg Base Hospital?-- Well, I think it's inappropriate. I haven't seen any of his Whipple's procedures, I'm not sure if anyone of them survived. If they did, they haven't seen me.

MR ATKINSON: You've seen one oesophagectomy?-- I've seen - there's been at least one survivor from his oesophagectomies who had a terrible time and sort of, to quote, wished he was dead. And quite a lot of the ileocolic and anastomoses, which I understand was one of the other specific procedures which he was prohibited from doing in the States, a lot of those patients have survived but have had major complications. Is it feasible to do them in the Bundaberg Base Hospital as I understand the structure there; no, really, it isn't. Whipple's and oesophagectomies; certainly not.

COMMISSIONER: The indications we've had in evidence so far is that you really need three conditions to undertake those sort of procedures. You need, firstly, a hospital with the resources and support facilities, ICU and other specialists and so on. That's one requirement?-- That's right.

Secondly, you need a surgeon with the appropriate skill and expertise?-- Yes.

And thirdly, you need a sufficient turnover in that sort of procedure so the surgeon keeps his skills up-to-date?-- Yes.

The suggestion we've had is that all three of those conditions were missing from Bundaberg Base Hospital when Dr Patel was performing these procedures?-- That's certainly true. And I formed the opinion, I mean, there is even a more basic problem with that with the care that these people have got or haven't got in that one of the essential preconditions to operating anywhere on anybody is that you judge the outcomes, you judge whether the patient survived and has been, you know, happy with their care rather than just whether the procedure was performed or not. And in talking to a lot of these patients, that was - that was certainly an essential bit that was

missing. That the final outcome here was to operate on the patients, not to judge whether they were - whether it was a successful operation or not. I know that sounds absurd but that's what has been going on there for the last two years.

Well, I take the force of what you say and another way of perhaps putting the same thing is that a number of the complaints we've received have been along the lines that Patel saw surgery as the first or best option without necessarily considering other things. One example that comes to mind is a very ill man in his 70s on whom an oesophagectomy was performed?-- Yes.

He had a cancer, he had a life expectancy of something like six or 12 months without the procedure and the medical department at Bundaberg Base Hospital wanted to refer him for palliative care and treatment in Brisbane but Patel decided instead to whip out the oesophagus. Again, from your review, are there indications of a failure to consider non-operative procedures rather than performing operations?-- He saw operations as an end themselves, not as a - not as a way of treating patients, not as a way of improving their health in my opinion. I'm not sure if that patient is the survivor who I've seen-----

MR ATKINSON: No. I should help you both.

COMMISSIONER: I was referring to Mr Kemps, who died?-- Yes.

MR ATKINSON: Whereas the patient that Dr de Lacy saw is coded as P1, a man called P16.

COMMISSIONER: Yes?-- Yes, who had a very similar situation or was in a similar situation which you'd described. He was non-assessed pre-operatively for his cardiorespiratory status. Had some operative misadventure, you know, bled from his spleen requiring a splenectomy. Had prolonged periods spent in intensive care but survived.

MR ATKINSON: That patient, Doctor, and I'm sorry to interrupt, he's interesting,P16. He is the 72-year-old pensioner?-- Yes.

He illustrates some of the things you said in that he has what you describe as a stormy post-operative course?-- Yes.

And he had his spleen inadvertently injured?-- Yes.

And then removed in the course of surgery. I understand you will speak later about patient selection but do you say that he was a good choice for an oesophagectomy?-- Well, to be honest, most of the patients who require these procedures are old, frail smokers with - with by definition a lot of other comorbid problems, heart and lung problems. They're always difficult procedures. But in his particular case, no, he was a bad choice and he had - the operation was performed badly. Specifically, the - another organ injured and removed, the spleen. That's not part of the operation. And a part of the

operation which is if not critical and certainly important, pyloroplasty - it's allowing the stomach which is used as the tube to replace the oesophagus to drain properly. If that part of the operation is omitted, they get terrible reflux, and it was omitted and he's got terrible reflux. You don't improve these people's length of life. You do the procedure only to improve their quality of life so they can swallow for the last year of their life, and he can't swallow because of his reflux. That's a typical story.

He's not happy with his quality of life?-- No, he's not.

I understand from what you say that a good surgeon is getting feedback from the patient to work out whether in the future, if you like, that operation is warranted?-- From the patients, from his peers, from the rest of the medical community.

COMMISSIONER: Doctor, again just going back to generalities for a moment, I think it would be fair to assume that like most professions, certainly the legal profession is an example of this, there are a range of skills and qualities amongst practitioners from the very best to the, frankly, mediocre, but one hopes that everyone is at least competent in their job and I imagine that there are surgeons, some surgeons that you would regard more highly than others?-- Mmm.

But within that spectrum, are we talking about, from your observations, Patel being at the low end of an acceptable degree of competence or something worse than that?-- Far worse than that. Far worse. Far worse. I've looked after complications in the last four months that I've never seen before. I've had an opportunity to sort of assess his decision making both pre-operatively, intra-operatively and post-operatively and it was terrible.

Sir Llew?

D COMMISSIONER EDWARDS: No.

D COMMISSIONER VIDER: Just a question of the patients that are coming back to you who have been seen originally by Dr Patel?-- Yes.

And the elective procedure was to do a specific thing?-- Yes.

And then complications occurred that resulted in further surgery?-- Yes.

Are they aware of the additional surgery that they might have had done, or are you picking that up only from the notes and that's the first they know about it?-- There's been a lot of miscommunication, if that's an answer to your question. That also happens in other patients other than just Dr Patel's patients but there's certainly a lot of that, people not aware of what's been done or what's been removed or how it's been, you know, put back together again.

Yes?-- And some of these people are an itinerant, illiterate alcoholic 400 kilometres west of Rockhampton who lives in a truck with his dog who doesn't know exactly what he's had done. It's not a particularly unusual circumstance but it is unusual that it's - the number of them who are unsure.

The other thing is we have had evidence presented to us from relatives of the deceased?-- Yes.

And it would appear from their relating of events that they really are unsure at times of the clinical path. I accept what you say-----?-- Yes.

-----that at these times people don't often hear what is being said, but have you had any requests from relatives seeking to come and see you just to have the clinical path of their relatives' treatment explained to them?-- Relatives and patients. No relatives of the deceased have seen me.

No?-- Just the survivors.

COMMISSIONER: I suppose that's because the funding arrangement that Queensland Health has put in place with the Mater doesn't extend to deceased patients, for obvious reasons?-- I'm a surgeon looking after these people. I think that's actually the primary reason, if they're referred to me with - with problems, at least seeking to have what they've had done by Dr Patel checked, but usually with some sort of a symptom, some problem. And I've treated them as I treat any other patients. As I said before, some of them have asked me questions which are completely outside the sort of doctor/patient relationship but I try to keep away from that if I could and just provide surgical care. If they've got a complication, then try and fix it. If they've been sort of inadequately informed about their operation and don't know what's going on, "Do I have cancer?", "Am I supposed to be followed up?", "Should I be getting colonoscopies every year or should I forget about it?", then I give them that advice. It's the same kind of advice I give to other patients not Dr Patel patients.

Doctor, I have to say one of my ongoing concerns over the last three months is that there are these 80-odd patients who died?-- Yes.

We have the Woodruff report which is able to identify eight or so which that doctor regards as likely to be an outcome of poor patient care but another couple of dozen on top of that where he suggests that that's - possibly that it was the wrong operation in the wrong hospital or post-operative care was faulty, or whatever?-- Yes.

The result of that is that we do have some dozens of families in and around Bundaberg who've lost a loved one and really don't have closure in those circumstances. They don't know whether it was, in a sense, natural causes or bad luck or whether there was some error. I'm just wondering whether you would consider it feasible, not for medico-legal purposes or

anything like that but just to give families closure, for Queensland Health to put in place some sort of arrangement to allow those families to have a consultation with a surgeon like yourself or Dr O'Rourke or Dr O'Loughlin just to discuss what appears on the patient file so that those families have the comfort of knowing that the loss of a loved one was hopefully unavoidable but if there was - was a risk of some problem, then to take that up in a formal medico-legal way at a later point in time?-- Do I think that's feasible what you've just suggested?

Yes?-- I've often been put in a difficult situation where a patient has come as well to have their - to have their what's been done by Dr Patel checked.

Yes?-- And they're happy with their care, they had no problem and they feel well now but their care has been terrible-----

Yes?-- -----in looking through their notes. Terrible care doesn't necessarily result in terrible outcomes. It just results in an increased likelihood of those outcomes being terrible. And, for example, with patients who had cancer removed, they either will or will not have their cancer back in five years and you can generate a statistical risk of that happening. They certainly don't have symptoms of cancer at the moment but because of what Dr Patel has done or not done, they have got an increased risk of their cancer coming back in five years. They're happy, they had no problems and they feel well and I've got to try and navigate through that. It's - I can envisage similar difficulties with the patients who've actually died. And we aren't generally expert at counselling patients. We get a lot of practice because of what we do but I think that that - it could be very difficult to do effectively. Certainly for those patients that have received the gold standard care of and you can say, "Look, this is just one of those things. It's terrible but there is nothing that anybody could have done", that would certainly be a comfort to them. In my experience with the 150 patients that I've seen, that's not going to be able to be said very often.

I see. Thank you for that.

MR ATKINSON: There are certainly patients you've seen, Doctor, where you have agreed with the treatment path adopted by Dr Patel?-- Yes.

And there are people who have come to see you because they thought, "Well, Patel was my treater. Maybe something's wrong", and you've been able to re-assure them and send them away?-- Yes.

Doctor, just to return to the issue the Commissioner raised of oesophagectomies and you also spoke about Whipple's procedures and the Commissioner-----

COMMISSIONER: I think I did actually.

MR ATKINSON: Well, you both did. I mean, is it the case that

medicine or surgery, both of them have moved on a bit, in that 10 years ago people would do Whipple's procedures and oesophagectomies in regional areas but now there's more of a propensity to refer them to tertiary hospitals?-- I mean, I can't speak with any sort of authority there, I wasn't sort of a practising consultant 10 years ago and, certainly, I have practised in the country. Those are notorious operations. They're ones that general surgeons have been fearful of, you know, since they were invented and I would think that probably the converse is true: the results of those particular procedures are better now than they were before. Ten years ago I would have thought that almost all of them would have been done in a metropolitan centre by people specialising in only those operations and now with better support available and - that that kind of - that that gets diffused out into the smaller centres, but not as small as Bundaberg.

Can I ask you on some particular issues. The Commissioner raised the issue of closures and closure techniques?-- Yes.

And there has been some evidence and some discussion about Dr Patel using a mass closure technique instead of layer upon layer?-- Yes.

Can you say which technique you observed?-- Text books are written about the technique of closing abdomens. That's what, you know, we do with our spare time. And it's - it varies depending on the situation. One of the things - a point that I've noticed, however, is that he didn't like to use prosthetic mesh for hernia repairs. That's a sterile, flexible, flyscreen like material that's used to close defects in the abdomen or elsewhere in a way that - so there's no tension on the tissues and it's generally the gold standard for dealing with these problems. This is - it's an example the - of a gold standard, which he didn't adhere to. But this particular one results in a lot of problems for the patients. What Mr Atkinson was referring to isn't quite sort of - I mean, there's not a big difference between a mass closure and a layered closure. I use mass closures. Most people who close abdomens the first time round use mass closures. What that specifically means is a needle passes through all the layers of the abdominal wall apart from the skin and sewn together. A layered closure is sort of a more old-fashioned type of closure but also useful and is still performed by lots of surgeons. Either of them can be effective as long as the rules are adhered to. I mean, I could go through the rules if you want me to but that means nothing. But he didn't adhere to the rules.

In his closure technique?-- In his closure technique. And the evidence that he didn't adhere to is the outcomes, and the outcomes are burst abdomens and incisional hernias. Those are the consequences of poor closure technique or - sorry, and another one, or operating on the wrong kind of people. Some people, if they're on certain kinds of medications or have certain illnesses, will not heal and you can predict that. And - so he made all of those mistakes and the outcomes of these incision hernias were burst abdomens.

COMMISSIONER: Doctor, what you said about the reluctance or the non-use of-----?-- Mesh.

-----the synthetic mesh?-- Yes.

Some witnesses have suggested that Dr Patel didn't appear to be up-to-date in some areas of his medical knowledge. For example, he was prescribing antibiotics and pain relief that seemed to be 10 years' out of date. Did you see indications of that sort of lack of current knowledge in the things you observed?-- Many. Do you want me to give you details? Again they're technical ones.

Well, examples anyway?-- An example is a very common operation performed by surgeons is a removal of the gallbladder. It's done by - 10 or 15 years ago it was done by a big cut underneath the right ribcage but it's done by keyhole laparoscopic cholecystectomy, removing the gallbladder and the stones contained in it. An addendum to that operation, whether it's done via a big cut or whether it's done via a little cut, is injecting some fluid, which shows up on the X-ray, into the duct connecting the liver to the intestines called the common bile duct and that's what the gallbladder hangs off.

That's the cholangiogram?-- That's it, an operative cholangiogram. It's an injection of the fluid. The reason we do that is because a stone that has formed in the gallbladder can go into that duct and sometimes block that duct causing serious illness. That can be a life-threatening problem.

So the general teaching, the gold standard is that at the time of the operation is addendum to the operation, an operative cholangiogram is performed. Technically, it's a little bit more difficult than simply just removing the gall bladder and so it was not done. It's - there would be other surgeons in Australia I would think who still do not do them, but the vast majority do it as a matter of course and he didn't, and that's also resulted in any number of problems and, I mean, to make this concrete, I'm not sure, I don't want it to sound like a medical lecture, the outcome is a 40 year old woman who ends up with serious pancreatitis secondary to this gall stone and is now a diabetic and has no pancreatic - we call it - exocrine function, the two functions of the pancreas which is to produce insulin and hormones into the blood and to produce pancreatic juice into the intestine. Neither of them is now functioning, hence she is now rendered a diabetic and a serious diabetic and doesn't absorb her food properly and that's a consequence of not performing that operation, not only a consequence but it's a consequence of not recognising the pancreatitis or treating it for six months afterwards and there's any number of examples of these.

So the initial question was many examples of where Patel's medical knowledge seems to be a bit out of date and one of them, I understand doctor, is that in the course of the lap cholies he wouldn't do cholangiograms?-- No.

And certainly in your reports, for instance, the patient Dan is one-----?-- Yes.

-----of a number where you explain the absence of the cholangiogram?-- Yes.

Are there other types of examples of your view that Dr Patel's knowledge was a little dated?-- I mean, in most of the cases that I've seen, there's been some evidence of that. Again, it's technical, it's all technical, removing low rectal cancers, not doing a total mesorectal incision, that the idea comes from literature that's been published in the last 10 years it's now thought of as an important part of treating rectal cancer and he didn't do it.

COMMISSIONER: And I guess these are the types of patients you were talking about earlier who may have no current indications of any adverse outcome from the surgery but are now at risk of potentially fatal complications in years to come as a result of poor surgery?-- That's certainly true, yes.

MR ATKINSON: Doctor, if I can just keep you on a general a little longer before we descend. What one of the other issues that you addressed fleetingly was wound dehiscence and you said that in a perfect life?-- Yes.

Or even in the good life a surgeon could get through his career without seeing more than perhaps a couple of examples?-- That's right.

All right. Do you - can you say what incidence of wound

dehiscence you saw in the Patel patients and whether you're in a position to say it's outside the range of bad luck?-- I haven't got an exact number of the ones that I've operated on already, but I would think that it would be 20 perhaps that I've already operated on in the last four months.

And you didn't see the wound dehiscences, you saw the words in the records?-- Yes, and the wound dehiscence results in an incisional hernia, so wound dehiscence is what happens at the time when the wound gives way. If both the abdominal wall and the skin gives way, then the, you know, intestines are on the bed, are visible, that's called a burst abdomen. Usually that doesn't happen, the skin closure stays together and the anterior abdominal walls, the muscles burst and that results in a defect with a hernia.

And that's when you see patients with things pushing out through their abdomen?-- Yes.

And sometimes I understand there's a third option where you have a superficial wound dehiscence where the skin's opened up?-- Mmm.

But the abdominal wall has maintained the integrity?-- Same word but very different clinical situation, that's common and not serious.

Right. So do you find that there's three types of wound dehiscence?-- There are at least three but three situations where the word - the first two is a major problem and the third is general and minor.

COMMISSIONER: We've received a number of complaints, one of the matters that I'd like to take you, complaints about patients undergoing surgical treatment with Dr Patel with either no or grossly insufficient anaesthesia. One witness, for example, described having a piece of flesh the size of a matchbox cut out of his upper arm or shoulder without anaesthetic. Is there any reason why that should be happening?-- I haven't seen that patient.

No?-- But I've heard those sorts of complaints made about other surgeons than Dr Patel and the local anaesthetic procedures are more difficult than are - more difficult to control than perhaps you'd imagine, and people have, you know, different thresholds to pain, they require different amounts of local anaesthetic. Sometimes the disease process itself makes it difficult to anaesthetise the area. All of those things are relevant and would have - the detail would be important, and without seeing the patient or his notes, I couldn't really - but I've certainly heard that complaint voiced about other aspects of his care, that it hurt, but in the patients that I have seen.

Doctor, I'll be honest with you, when I heard the first allegation of that nature, I was skeptical?-- Mmm.

Because for all the reasons you mention-----?-- Yes.

-----quite candidly, but the number of times we've heard similar things and heard of patients being physically held down-----?-- Yes.

-----whilst surgery proceeded, I fully understand that sometimes local anaesthetic is not as effective as you'd expect it to be?-- Mmm.

But when it gets to the stage of the patient screaming and have to be physically suppressed, I guess that's the stage at which a competent surgeon puts down the scalpel and takes whatever steps are necessary to address the pain?-- That would be reasonable, I'd certainly do that myself.

D COMMISSIONER VIDER: I just wanted to not stay with that particular topic but just to ask a general question: you're now practising in a non-metropolitan area?-- Yes.

Do you expect the scope of surgery that you undertake to be the same as you would do in Brisbane?-- No, I expect it to be less for a - or for exactly the same reasons that I would expect the scope of surgery to be less performed by Dr Patel. The infrastructure is less. I've done Whipple's procedures, I don't do Whipple's procedures in Bundaberg. I've done oesophagectomies and I don't do oesophagectomies in Bundaberg, and lots of other examples.

And so therefore, the remoteness, if you like, of the location-----?-- Mmm.

-----won't dictate the nature of the work that you do, given the fact that patients present and you're it?-- I'm sorry, could you repeat that?

I'm talking about patients that might come-----?-- Yeah.

-----for whatever reason, and it's something that you might normally not do in a metropolitan area, but there isn't anybody else around. For example, we heard Dr Patel told another staff specialist when he first arrived when the specialist asked him what he did and he said, "I do everything."?-- Yeah.

Now, as it's unfolded, it would appear that he does; he doesn't have any difficulty opening your thorax?-- Mmm.

Or doing orthopaedics or whatever you like - I'm not quite imagining that it goes that far - but I'm just asking the general question does the isolation at times mean that you would move outside what would be your normal scope of practice?-- Acutely, for acute problems.

Yes?-- Yes, for elective problems it works the other way.

Yes?-- If you, you know, if you're the only surgeon available, then sometimes you have to drill a bird hole and practice neurosurgery-----

Yes?-- -----because there's nobody else there and the patient's inevitably going to die if you don't, they're easy decisions to make, but with electives, it's exactly the opposite. If you have time or there's a better place for it to be done better, then you can refer on and that's the way that I think most people practice outside the metropolitan centres.

Yes.

D COMMISSIONER EDWARDS: And be expected to practice?-- And be expected to practice, that's right, yes.

COMMISSIONER: Doctor, I also wanted to ask something that's not directly Patel-related, but one of the things that the starting point for all of this problem is, of course, Dr Patel only went to Bundaberg because it was designated as an Area of Need?-- Yes.

And yet what we hear is that at the present time - and I don't wish to embarrass you by saying this - but you've got an exceptional impressive CV, we've got Dr Thiele there, Dr Anderson there?-- Mmm.

In the past we've had Dr Charles Nankivell, Dr Sam Baker.

MR ATKINSON: Miach.

COMMISSIONER: I'm sorry?

MR ATKINSON: Miach.

COMMISSIONER: Yes, and that's just in surgery and in medicine and other areas there are some extremely impressive medical practitioners; you've got two private hospitals that presumably only continue to function because they make money, otherwise they wouldn't be there. It just strikes me as more and more bizarre that a town that has the good fortune to attract so many outstanding medical practitioners, nonetheless gets labelled as an Area of Need and ends up with someone like Jayant Patel?-- Are you asking my opinion-----

Yes?-- -----about the Area of Need legislation?

Well, about its application to - as a basis for bringing Patel to Bundaberg?-- Its outcome, the fruits of it, if you like, are a cheap service and that's it, and if you're in the position, as I understand the hospital administrators have been put in for the last 10 years of being given a fixed budget and being asked to provide a service and be assessed by certain benchmarks and not others, then that's what you do, and if you can get a service more cheaply, and you're assessed according to the number of patients that you operate on, not on their results, then I guess that's what you do. I'm not really in a position - I mean, again, I'm sure the detail is relevant and I don't have access to any of them, but I know that that's worked out in Bundaberg and it hasn't been to

anybody's benefit which is why we're here, but that's my opinion.

Well, let me put it to you this way, and again, at the risk of embarrassing you, doctor: from what I've read from your CV, you are a surgeon that any hospital in Australia, public or private would be delighted to have looking after its patients, and yet we read that you offered your services as a VMO and you were knocked back. From what I've seen, it's the same story again and again, that highly competent surgeons, surgeons like Dr Thiele were available in Bundaberg but a decision was made not to access their services as VMOs rather than to have a staff doctor. Am I making some mistake in that? Is there something wrong in that impression?-- No, those are the facts. How the decision was come to, I didn't make the decision, you'd have to ask those people that did, but that was certainly how it transpired.

Mr Atkinson, we might take a 10 minute break if that's convenient.

THE COMMISSION ADJOURNED AT 11.12 A.M.

THE COMMISSION RESUMED AT 11.39 A.M.

GEOFFREY ALAN DE LACY, CONTINUING EXAMINATION-IN-CHIEF:

MR ATKINSON: Thank you, Commissioner. Dr de Lacy, before the break we were addressing some general matters. Another matter that we've heard a little bit of is anastomotic leakage?-- Yes.

Can you say whether or not there was a high prevalence of that amongst the cases that you saw?-- There were certainly a lot of them, just with the caveat that I have only seen 200 out of all of the patients he has operated on. There were certainly many examples of anastomotic leakage.

COMMISSIONER: Can you explain precisely what that is?-- When a segment of a hollow tube is removed - a typical example is a bit of large bowel that contains a bowel cancer, two ends have got to be joined together again to re-establish the continuity of the gastrointestinal tract. The join is, in technical terms, called anastomosis. It is a key part of the operation. As long as the patient has been appropriately assessed as being fit for the anaesthetic, how they do post-operative with their outcome is determined largely by whether that join heals or leaks. If it leaks, the contents of that tube, in this case the bowel, spills out into the rest of the abdomen, with peritonitis and death if they don't have another operation.

And such a leakage is an indicator of poor surgical technique?-- The College of Surgeons publishes a list of clinical indicators. For general surgery, one of them is anastomotic leakage. Another one is prevalence of venous thrombosis and pulmonary embolus, and they're markers of whether the service is appropriate. They are available. Most hospitals use them as a way of identifying whether there are problems. I am not sure whether Bundaberg Base Hospital use them or not but it is an indicator of poor service, and certainly there were many examples in Dr Patel's patients.

In the case of Patel's patients, was it a matter of poor technique or was it also a matter of choosing the wrong patients?-- Both.

And in terms of poor technique, were you able to identify what went wrong, or what the technical error or technique error was?-- Difficult in retrospect. Almost all of these patients have been reoperated on by Dr Patel to save their life. You need to reoperate on these people within the first, you know, week after it happens or they die. So by the time I have seen them, the survivors, some months afterwards, they've had numerous operations in almost every case and very difficult to determine what happened at that first operation. Something happened, the outcome was bad. There are a number of conditions which lead to these problems. That's actually the

technical part of doing the operations. For example, the two ends of the bowel - the segment's been removed, the two ends of the bowel that have to be joined together again have to have an adequate blood supply, under no tension so they don't spring apart. They shouldn't contain cancer, you know, have - be done in an area of irradiated tissue, and there are many other sort of rules that you follow to get good outcomes. One or more of these rules were broken. If the outcomes were wrong, exactly what was done, very hard to determine.

I guess a surgeon necessarily has some insight into what his strengths and weaknesses are, or her strengths and weaknesses, and if you have a repeated problem like that, you get advice, or you go back to the textbooks, or you read the latest papers to find out what the preferred techniques are. But from your evidence, it sounds as if these things just continued to happen without any attempt to improve quality?-- It is presupposed on the idea that you judge your outcomes. I didn't see any evidence that he judged his outcomes at all. If there was a problem - this is completely hearsay - I certainly never spoke to him about this - then it was inadequate suture material, or the practising in a third world hospital, which is how he described Bundaberg Base Hospital, or something else, some other issue, some reason, the patient had done something wrong, or whatever. He didn't judge the outcomes. And I suspect, you know, from talking to a lot of these patients and assessing his work, that he never had judged the outcomes he had, having these problems certainly in the States, it seems for 10 or 20 years, and he spent his whole career not fixing up these fairly basic problems because they weren't his problems, they were somebody else's problems.

But, for example, anastomotic leakage-----?-- Yes.

-----you mention that in most instances he reoperated on the patient?-- Mmm.

So he must have known that something was going wrong?-- Anastomoses do leak, and in advising the patient or giving them the option to have an operation or not to have an operation, you can quote statistics to them of the chance of that happening and it is determined by the details of the case. To give you an example, if you have to do - if you have to join up the rectum very close to the anal canal, the closer you are to the anal canal the greater the risk of leakage. If it is within a certain number of centimetres from the anal canal, then the risk of leakage is so great that the general advice is that you add another piece to the operation which is called a diverting ileostomy, a temporary bag to divert the faecal stream away from that join to give that time to heal and then subsequently get rid of the bag at another operation in three months. Anastomoses do leak in the best hands. They don't all leak. And certainly the leak - the number of leaks that I have seen would be, you know, grossly excessive.

MR ATKINSON: There is two questions there, doctor: the Commissioner's question, I guess, is really this, with respect: that you say that he didn't follow up his patients

well - Patel?-- Yes.

But certainly the number of times he reoperated, for instance when the anastomosis had gone wrong?-- Yes.

There is some evidence there of follow-up?-- Yes.

I guess the leakage is specially important because if you have the contents of the bowel leaking, then people are going to die from infection pretty quickly?-- I mean, it is obvious there is a problem when an anastomosis leaks.

How can you tell?-- The patient has the signs and symptoms of peritonitis usually. They are certainly desperately unwell and it is obvious to everybody - all of the nurses, the junior doctors, and the doctors in charge of their care, that there is something drastically wrong. It is not always possible to identify that it is a leaking anastomosis immediately because that's - you are aware that can happen, it is certainly always - you are always - it is in the forefront of your mind.

And then-----

D COMMISSIONER VIDER: And given your statement in paragraph 14 of the conduct of the morbidity and mortality committees-----?-- Yes.

-----and Dr Patel's input at those meetings-----?-- Yes.

-----you wouldn't have had any indication there of the clinical outcomes of the procedures. So none of this would ever have come to light from his own telling of the story?-- Well, I attended those for about eight months, I think. The last half of 2003 and the first couple of months of 2004. I didn't see any of these patients presented, for example.

No?-- And they weren't - their function is to provide an auditing tool to identify exactly these sorts of problems, but how they were run under Dr Patel was very different, and it was more like a teaching session for the junior doctors, an opportunity for him to demonstrate his knowledge of surgery. So there were no adverse effects or adverse outcomes reported that I remember at all.

No.

D COMMISSIONER EDWARDS: Following up Deputy Commissioner Vider's comments, on reading - I don't make any comments on your notes, but looking at some of the charts we have had an opportunity to browse through - and I must say I am very rusty on the way operations are written up these days - but it seems he was very inconsistent in the comments that he made as to what went on in operations. From your experience was that-----?-- Very consistent?

-----his approach?-- Did you say consistent?

Very inconsistent? You would almost wonder what he did in the

operation, except somebody else had written the operation?-- As a general comment the operation - the operation notes were transcribed by one of the junior doctors.

In most of these cases they were in his writing?-- The ones that were in his writing were - well, when we're taught how to do those things, the principle is that it is so that another surgeon can take over the care of your patient.

Correct?-- That's the principle that underlies it, and you provide as much clinical detail as is necessary for somebody else who hasn't done the operation to take over the care of that patient. I have been in that situation on 200 occasions and operated on many of them and they have not been - they haven't fulfilled the purpose that they were, you know, originally envisaged for. I have found them useless. Sometimes it is - there is a - there is a standard way of writing up an operation note and I could rattle them off for you, done them so many times before. That's the standard operation. What's actually essential when you write them up is what's individual about that patient. Not that you did, you know, the standard laparocholecystomy, but what this laparocholecystomy was like in this patient, and that's actually the critical bits, rather than saying A, B, C, D, E, F, G. His notes tended to be of a general nature rather than specific nature and not useful when I have had to reoperate on them.

Thank you.

D COMMISSIONER VIDER: And not particularised, which would fit in with the notion that the surgical procedure became a statistic?-- Yes.

Not something done on a patient that had to have an outcome- that was meant to have a good outcome for the patient's life?-- That's the conclusion that I drew-----

Yes?-- -----from reading them as well.

COMMISSIONER: We've also heard the suggestion that his notes were sometimes bowdlerised in the sense that he would, for example, nick a spleen in the course of procedure and the only record of that in the notes would be that he performed a splenectomy as if that had been intended from day one?-- Yes.

Did you see indications of that, of notes being written up in a way that downplayed or discarded errors?-- No indication of the operative blood loss, but the stickers in the chart of the blood transfused immediately afterwards, that sort of thing.

Yes?-- Lots.

MR ATKINSON: Dr Woodruff will give an example of a record where it is almost an oxymoron. On the one hand it was - the record says that the patient's emodynamically stable?-- Yes.

In the other hand, it says he is getting fusions of

adrenalin?-- Yes.

One possibility I would like to put to you to see if you agree is that Dr Patel doesn't appear on the records to be dishonest so much as to be seeing his own operations through rose-tinted glasses, and the example you give is one doctor - there is infusions of transfusions of blood and he understates what's happened?-- Well, he certainly is seeing them through rose-tinted glasses. A lot of the patients have given me a version of events that surrounded their consultation, which is at odds to what he wrote. Whether that - if they're right, then that would constitute sort of dishonesty as well. An example, risks and options explained to the patient, decision for mastectomy rather than breast conserving therapy, and the patient's recollection is booked for a mastectomy, no options given to them, that sort of thing. And that's all through, you know, his notes - not just the outpatient visits, but through his operation notes, and in some cases his post-operative follow-up notes as well.

And you readily conceded at the outset of your evidence, doctor, that sometimes patients get it wrong?-- Mmm.

I understand what you are saying from your statement is that a number of times you have noticed anomalies between the records and the patients' stories?-- Yes.

That's the only basis on which you suspect that sometimes Dr Patel wasn't entirely honest?-- Not the only basis but that's the primary basis. There were - I have tried to go back to the primary sources if I could, that part of the medical record which has got nothing to do with Dr Patel: the X-ray reports from the radiologist, separate doctors; the pathology reports, pathologists, separate doctors, often separate institution; sometimes the notes written by junior doctors that describe an abnormality perfectly but don't give it a name and it is at odds to what Dr Patel has written. There is a lot of examples of that.

COMMISSIONER: Doctor, I seem to recall being told - might have been by Mr Atkinson or it might have been by someone else - that when you were first asked to see these patients, you might have had the frame of mind that, candidly, many of us did at the beginning, that Patel was all about media beat-up and there wasn't anything too serious in it. Did you certainly approach this with an open mind from the outset?-- I think yes, I did. The two things have made the paper at that time were the Schapelle Corby case and the Dr Patel saga, and without any detailed knowledge I sort of made the assumption that it was going to be the same. I didn't know anything about the Schapelle Corby saga but I did assume, you are right, that at least some of the allegations that were sort of wildly flying around at that stage were bound to be sort of smoke without fire, just based on other experiences I had had. But I have got a different opinion now. My opinion now is that the real story of what was going on there was worse, that the number of patients was, you know, 10 to 100 times more than I thought there would be, and that the type of

complications that were allowed to sort of happen there were gross by comparison to what I was expecting.

MR ATKINSON: Doctor, before we speak about specific patients, can we speak a little about your relationship with Dr Patel? One of the things Commissioner Vider took you to is the M&M meetings which you describe in paragraph 14-----?-- Yes.

-----of your statement. You have worked at a number of major tertiary hospitals like the Princess Alexandra and also a number of regional hospitals?-- Yeah.

Is there a model that's generally accepted about how an M&M meeting should unfold?-- There is. Every death and all of the major adverse outcomes, a thumbnail sketch usually by the junior doctors with enough information to - to achieve its outcome which is to improve the service. It is supposed to be - I mean, they are actually somewhat fraught meetings, if it is an individual surgeon, you know, whose patient has done badly, which is an extremely difficult situation. But the college has made a point of insisting that you attend these because the service is improved by discussing these openly in a non sort of judgmental way, to improve your results. I have run them at QEII, I have participated in them at different places.

They are supposed to be a supportive environment, I understand, where people explain what they did and other practitioners say, "You might have considered this treatment"?-- Yeah, sometimes they can be, you know, robust debate as well, but the object is to improve the service, and that involves acknowledging that there has been a problem and that, you know, if you are not prepared to do that, then certainly you can't move the process forward at all and there was no - these were just - they had the name of morbidity and mortality meeting but that was all.

I understand there is at least two problems that you see now: one is that you have uncovered a whole lot of complications?-- Yeah.

But they were never the subject of M&M meetings that you went to?-- Yes.

But the other, and independent of what you know now, is the way they were conducted then?-- Dr Patel was the Director of Surgery. I mean, okay, there were only two surgeons, but he was the director, and which meant that he was in charge of how these things were dealt with. He set the tone for the meetings and the tone was that they were didactic exercises, an opportunity to discuss a particular subject, breast cancer or whatever, and not debate about patient outcomes.

Who else would be in attendance?-- It varied and there were lists we signed our names to.

Yes?-- But from 10 to 25 other people, other specialists from outside and other fields, all of the junior staff working in

surgery and basically whoever else wanted to attend. They were open.

One can understand that the junior staff, particularly perhaps those who were working every day with Dr Patel, might have been amenable or vulnerable to intimidation or to his forceful personality. The people who were coming from outside-----?-- Yeah.

-----were they more forthright in discussing things, or are you saying they just lacked any information to really have a proper informative debate?-- It - unless you were obliged to go to them to fulfil a College of Surgeons guideline - and there were other morbidity and mortality meetings held in private hospitals, for example - it just became a waste of time. That was certainly in my case, anyway. I can't really answer for any of the other people. I know the other surgeon on staff, Dr Gaffield, had an operating list either before or after, I can't remember. He was often either running in or out, and nobody else in the room was really in a position to make any judgments about his work and they weren't given the opportunity to anyway because the patients weren't discussed.

And what's supposed to happen in a sort of Jungian way, say, "Here is the mistake I made. How could I have done it better?" That's the model, is it?-- I am not sure exactly what you mean by Jungian way, but that's the model.

COMMISSIONER: I am glad you said that, doctor. I didn't understand that either. Did other local surgeons attend these meetings - other private surgeons, I mean?-- Occasionally.

Dr Gaffield-----?-- Again I stopped going to them in early 2004. The details would be available but I think occasionally, yeah.

Yes?-- Dr Kingston commonly, I think. Dr Anderson and Dr Moreny, perhaps not.

D COMMISSIONER EDWARDS: These are very important meetings in a hospital?-- They are, yeah, yeah.

Should this Commission consider the importance of those in some form relative to the outcome of the Bundaberg Hospital as a result, it appears to me, as a mere amateur, that the morbidity and mortality committee was really not working?-- It was subverted, in my opinion. I mean, it was the thrust of what he was trying to do, I think, was to try and make sure that his work was not audited. We certainly didn't know that he was the subject of numerous inquiries overseas, but he did. And a lot of these issues - the M&M meeting, the failure to transfer patients, his relationships or lack of relationships with other staff, were explainable, in my opinion, in any way by just a desire not to have his work checked for fear of this, I guess.

COMMISSIONER: Following up Sir Llew's point, it occurred to me that obviously it is different in a place like the Royal

Brisbane or the PA, but in a hospital the size of Bundaberg where there are only two surgeons on the staff and junior trainees and surgical section, it may be very desirable to have M&M committee meetings chaired by someone external to the hospital, to have the likes of a Dr Thiele or Dr Anderson or yourself at least guiding the discussion?-- There is an informal auditing process with every VMO as opposed to every staff surgeon. A staff surgeon is isolated. He doesn't have to recruit the patients, they walk through the door of outpatients, they have got nowhere else to go. If they come in on a certain day and he is on call, they are under his care, that's it. If they are referred to his outpatient session, they are looked after by him, that's it. Different for VMOs who have both the public and a private practice who aren't isolated to a - to the public hospital. They have also - they need to generate those patients, their income for their practice, by keeping their referees happy, the GPs.

Yes?-- Or they have no work.

And keeping the hospitals happy?-- Well, what I was going to go on to say is if they - if all of their anastomoses fall apart, if every wound incision ends up, with an initial hernia six weeks in intensive care, they get no referrals.

D COMMISSIONER EDWARDS: And keeping patients happy?-- Keeping patients happy. However, if you are in an isolated environment like a full-time staff surgeon, when the patients are referred to you anyway - I mean, it is public knowledge now, but certainly wasn't then, and even if it was, a lot of these patients - I mean, I have looked after patients who are illiterate and don't watch the television, and the convoluted ways they have got to me from their little shack in Cracow in western Queensland have been interesting. Even if this was public, they just turn up, they have got a problem, they have faith in the person in the white coat or the suit and tie, and take his advice. And there is - so the point I was making was that there is another form of auditing which happens, you know, in those towns for VMOs which does not happen for staff surgeons. If the primary form of auditing, which is these M&M meetings are subverted, then this happens.

COMMISSIONER: And I have been told outside these proceedings that at least in the private system, the other informal system of auditing is through the anaesthetists because surgeons always operate under the watchful eye of an anaesthetist?-- Yes.

And if you are getting things wrong on a regular basis-----?-- Theatre sisters as well.

Yes?-- Mmm. All of those things work in the private system. And being the public system you depend on the structures that are in place because the patients have no choice and the doctors referring their publicly insured patients to the Base have no choice either. They can't specifically in their referrals say, "Not to be operated on by Dr Patel", or direct them to a certain doctor. It is whoever is on that day.

Doctor, you have touched upon something that is obviously at the heart of this inquiry, because we have got to work out, amongst many other things, what went wrong, why the system broke down. It seems to me that the starting point is that Dr Patel was essentially under nobody's control, in a clinical sense? He had superiors in the hospital, Dr Keating as Director of Medical Services, Mr Leck as regional manager, but in a clinical decision-making sense, there was no Court of Appeal from Dr Patel?-- The Court of Appeal was only when he had to transfer patients. Then you have another surgeon, has the opportunity to do what I have been doing and to go through all of the medical records, it is necessary to look after the patients and so each time he transferred a patient it was - he was audited.

D COMMISSIONER EDWARDS: Or a very effective efficient morbidity and mortality committee?-- There are two public surgeons at the Bundaberg Base Hospital. That is the department. The number of VMOs that are more less involved, predominantly less involved. Hard to imagine - I mean, I think the point - an effective M&M meeting is essential and all surgeons are bound by that who are Fellows of the College, whether you are publicly or privately you are obliged to. But in this specific situation of Bundaberg Base Hospital, just with - it is such a small group, it could still fail. Two surgeons. But it would certainly be harder to come up with these kind of results for two years if it was working effectively.

COMMISSIONER: And particularly when the - if you view M&M committees as a sort of audit process, the added problem here is that the chair of the audit was the man whose results should have been audited.

D COMMISSIONER EDWARDS: Would it be worth considering that an external qualified person should chair those committees?-- I think that's a - I think that that would be a good idea.

If possible?-- If possible - practical problem, yes.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: Doctor, I understood you to say in those exchanges with the Commissioners that there are three ways that Patel, you suspect, stopped people from really checking his clinical competence?-- Mmm.

(1) the M&M meetings were something of a farce; (2) I understand he was - you have observed a reluctance to transfer patients?-- Yes.

And (3) he managed his relationships with other people. Is that a fair summary, before we go into them in some detail?-- If you mean managed them, he made it awkward for people who were in a position it audit his work to be around.

Yes?-- Certainly made it awkward for me as an individual, and

I have heard many stories from other people - it is all hearsay - other anaesthetists, et cetera - who expressed some sort of reservations about his work being shouted down or threatening to resign but I have no personal experience.

If we just return to the question of M&M meetings?-- Yep.

Do you agree with this concept: we have heard from a doctor who is now at Logan that M&M meetings can be difficult because people are coming in and out; is it the case that best practice in your view would require that the M&M meetings are quarantined so that people put aside time from their clinical workload?-- That - the outcome is that, you know, effective M&M meetings are important. There's actually a lot of medical literature in support of that. They take an hour at lunchtime or before or after work and, you know, part of the - would it work better if every staff surgeon was obliged to attend for all of that time? Ultimately, how it's going to work is that you're going to be stuck in theatre saving somebody's life, you know, at some point. Or, you know, are you going to be holding up anaesthetists, nurse, everybody else who are ready to go? I mean, there are practical issues. But as a general point, I think it's - you know, I couldn't agree more that there are - they're the most useful tool we've got to improve the system.

COMMISSIONER: At the very minimum though, in the public system surgeons should be given the opportunity to participate in these meetings otherwise and in their own time. They should be allowed an hour a week as a minimum to attend an M&M meeting when they're not expected to be doing other duties?-- That would be an improvement to the system I think.

MR ATKINSON: Conceivably, you mentioned the problem that it's a pretty small Department of Surgery at the Base and there's - that robust debate is not going to be easy to manage perhaps or sustainable. But conceivably, an M&M meeting could be integrated between the private and the public hospitals or between a regional hospital and a tertiary hospital?-- Again, they'd all be good ideas.

Now, in terms of transfers, it's your evidence, is it, that - well, forget about the motives for a moment. Your evidence is that there seemed to be a reluctance to transfer patients to tertiary centres?-- That's correct, yes.

Is that a trend that you suspect or you can see a clear pattern?-- The decision to transfer is complicated and - but a lot of the patients that I've seen in consultation have had stormy post-operative courses requiring prolonged stays in intensive care. Now, in retrospect, when everything is known about these people, it - it's easy and somewhat facile to say, "Okay, well, if we'd known all that then, we should have transferred them straightaway." And that's a problem that we all face trying to make prospective decisions. However, having said that, a lot of these people were kept, you know, extraordinarily long periods of time, and by comparison to other patients looked after by other surgeons at the same hospital, they were - yeah, there was a reluctance to transfer definitely.

We've heard from one patient who I notice is in your list, Trevor Halter?-- Yep.

And perhaps he's a good example, is he, Doctor? He goes in on the 20th of November. He seems to have some very awful complications - it's at page 52 of your paginated bundle, Commissioners - and he's not transferred till the 4th of December. So it's Trevor Halter?-- Let me - can I just have a moment to look through this?

Sure?-- I remember Trevor. In summary, his problem was that he was admitted electively for a laparoscopic cholecystectomy, something we have dealt with before. He could anticipate being in hospital one night and going home cured and if I saw him, I would tell him that he had a one in 1500 chance of having a major iatrogenic-----

COMMISSIONER: Would you mind spelling that for the reporter?-- I-A-T-R-O-G-E-N-I-C. Anyway, it means caused by the treatment. And they are injury to the other structures surrounding the gallbladder, which has to be injured to be removed. And - those other structures are the common bile duct, the liver, the first part of the intestine called the duodenum, they're the common ones. He - in his operation, he - there was uncontrolled blood loss. There's a problem which was described as bleeding from the cystic artery, the one supplying the gallbladder. He didn't have a normal post-operative course. He became extremely unwell. And in looking after those people, a lot of things can be the cause of that. But in his situation specifically, he had two subsequent major operations by Dr Patel, first to evacuate a blood clot from around the liver and the second time to drain an abscess, a big collection of pus from around the liver. He's actually a good case in point because the diagnosis in his case was that he'd had a common bile duct injury, which is not a bleed and not a collection of pus. Now, that diagnosis wasn't made until he was transferred to intensive care at the Royal Brisbane Hospital but, in retrospect, looking at his blood tests, it was obvious. He had a bilirubin of 80 to 100 which is four to five times normal and would have been obvious looking at the patient: he becomes yellow with a bilirubin over about 60. And that diagnosis wasn't made despite the fact there are chart entries in there every day for Dr Patel and the rest of the team. So he spent a number of days, I can't remember, perhaps 14 days, in intensive care having various things done but not having his problem fixed. He was then transferred to the Royal Brisbane Hospital where the diagnosis was made and the appropriate intervention, which is called an ERCP and stent, was performed by Dr Appleyard, I think, and the patient got better. There are a lot of problems with the care of that patient and it - he is one of - I mean, all of them are a little bit like that. I'm afraid there are a lot of big words like iatrogenic, but there are key issues that haven't been attended to: he did not have an operative cholangiogram and he should have; a cystic artery was injured and it shouldn't have been; when he had a post-operative complication, the diagnosis was not made; he had two operations which he didn't need to have; and he wasn't transferred in a - the - you know, a timely manner. When he was transferred, the right diagnosis was made, he got the

right procedure and he got better.

COMMISSIONER: Does Mr Halter have any ongoing disability or ongoing propensity to further illness as a result of the cause of treatment?-- He got perfect treatment at the Royal Brisbane. A stent was put in, which is a small plastic tube, into his common bile duct, which dangles out into the intestine. A note was made by the gastroenterologist who put that stent in to have it removed in three months. He got better, discharged back to the care of Bundaberg Base Hospital, did not have the stent removed, got ongoing infection in his common bile duct, which is what happens if you don't remove the stent, and came to me in that condition. Yes, he's got ongoing problems. I have seen 100 people who are basically the same as that. He is just a typical case. Not especially bad; just typical.

When you say he was returned to the Bundaberg Base Hospital, you mean to have the stent removed?-- For follow-up.

For follow-up. Was that returned under the care of Dr Patel?-- Yes.

MR ATKINSON: You say that he's not particularly bad but, Doctor, it's the case, isn't it, that Mr Halter could have died from complications before he went to the RBH?-- Certainly.

Just in terms of the terminology, can I clarify this: when you use the word the "iatrogenic"?-- Yes.

You mean it's caused by the treatment?-- Yes.

When you use the word "adverse outcome"?-- Yep.

That's a broad term that means it's not an outcome that's reasonably contemplated by the procedure?-- Iatrogenic illness is a specific phrase used when the patient has been made worse by the - as a consequence of the treatment. If a patient gets a rash, when they're given some antibiotics to treat an infection, which infection which may have been life-threatening, is appropriately treated by the antibiotics but they've suffered an iatrogenic illness because they've got a rash, it can be something trivial like that or it can be something terrible like this. "Adverse outcome" is a broad term. It just means - it means a poor outcome for whatever reason. If the patient decides that he wants to discharge himself in the middle of the night against medical advice because he has to go to the pub for a beer, that's an adverse outcome but not an iatrogenic illness.

But adverse outcome is still confined, isn't it, in the sense that if someone dies, that's not necessarily an adverse outcome unless it's-----?-- No, it's usually - it's an adverse outcome.

COMMISSIONER: It's possibly in a trauma case?-- Pardon me, sorry. No, in an elective procedure, it's an adverse outcome.

No, it's not necessarily - some people can make it live to hospital but they're unsalvageable for one reason or another and then if they die, then that's not considered an adverse outcome.

Indeed, and I don't want to put you on the spot here, Doctor, but we've had some discussion during the course of the evidence about death certificates and reports to the Coroner?-- Yes.

And one of the debates that apparently took place was Dr Patel declining to refer the death of Mr Kemps to the Coroner because of, in his view, the patient died from blood loss, therefore it wasn't an unexpected death. But would I be right in thinking that any death from elective surgery would have to be regarded as an unexpected death?-- Definitely. Mentioned at morbidity and mortality meetings and referred to the Coroner and dealt with in that way. That would be the standard practice.

In other words, you don't perform elective surgery if's expected to kill the patient?-- No, you don't.

MR ATKINSON: Now, Doctor, I was working my way through slowly those three ways that Dr Patel avoided, whether intentionally or not, scrutiny?-- Yes.

We spoke about transfers just then. The third one was his relationships and you spoke just before about your relationship with Dr Patel?-- Yep.

You didn't have a lot of social or professional interaction?-- No social interaction. Professionally, I was - I worked at the Bundaberg Base Hospital on - just on the after-hours roster. I did one weekend in six to help out with the on-call. No elected procedures there at all. So we often had - oh, we sometimes had cause to call each other to organise the roster. We didn't share any patients at all apart from, you know, a couple that are subject to the statement and, as I said, I just saw him operate once. So our professional contact at other times was confined to passing each other in the corridor and the morbidity and mortality meetings.

Is that normal in a regional area, that your professional contact with a fellow surgeon would be so confined?-- No, I - no, not at all. You know, I certainly got the feeling that he was isolating himself from the rest of the medical community. I think other people felt the same, expressed that to me.

But in empirical terms, what you can say is - is this right - that in other areas, in other regional areas, or in Bundaberg, you would have much more professional contact with a surgeon of his standing?-- Much more, yes, that's right.

COMMISSIONER: Can you compare it, for example, with the level of contact you had with Dr Gaffield?-- Well, I've had much

more contact with Dr Gaffield, much more. I mean, we have social contact and, you know, much - we're completely different.

MR ATKINSON: In a sense, Dr Gaffield is not really your opposite number if you like because he doesn't do the same general surgery that you and Dr Patel did?-- No, he was - he specialises in plastic surgery. He's a - so he was - we shared the occasional patient and he did participate in the general surgical on-call roster but otherwise it was separate.

Doctor, your statement suggests in paragraph 12 that there came a time when you made a decision to have less contact with, certainly, Dr Patel?-- Yes.

Can you just walk us through what happened and the facts of the matter that you set out in paragraph 12?-- Just let me refer to the statement for a minute to make sure we're talking about the same person.

It's the - yes, the bowel operation and-----?-- Yep. Not long after I arrived in late 2003, I operated on a patient called Phillip Minns privately and had a complication myself.

M-I-N-N-S?-- M-I-N-N-S, Phillip Minns. Prior to that I'd had a conversation with the Director of Medical Services, Dr Keating, as has been previously been brought up, who I - you know, I offered my services. What I would have liked to have done would have been to elective - operate in elective outpatients at the Base Hospital. It is a standard arrangement to have a combination of public and private. I was told at that stage that there were no free sessions or that, anyway, my services weren't required during the week-----

Who told you that?-- Dr Keating. But that, so as to have some sort of foothold in the hospital and take advantage of the facilities that they offered, specifically the intensive care, which at that stage wasn't offered by the private hospitals, I agreed to participate in an on-call roster. I mean, it's the most onerous part of the job really but - and it's usually done in association with, you know, regular operating lists at the hospital but in my case, not. So a month or two passed and I had a complication at one of the private hospitals which required ICU. This was an elderly man. He had a bowel operation. An excision of a cancer I think or diverticulitis disease, I can't remember the details exactly, and he became very unwell within the first 24 hours. I wanted to admit him to the intensive care at the Base Hospital and care for him then. I rang to organise that and I was told by Dr Patel that it was - he was the admitting surgical officer that day and that if I wanted the patient admitted to the hospital, that he would have to take care of the patient. You know, it was cumbersome and I didn't like the idea and I - but I subsequently spoke to Dr Keating, who confirmed that if the patient was going to be admitted to ICU, he would have to be looked after by Dr Patel. And the issue was that I'd spoken to Dr Patel about the case and I wanted him investigated and

observed in ICU and Dr Patel, without seeing the patient and after five minutes' conversation, decided that the patient must have had a leaking anastomosis, we've talked about it before, and that he was going to take the patient to theatre immediately to confirm this diagnosis. How it turned out, how it transpired was that the patient had to be transferred to ICU. Dr Patel did take the patient to the operating theatre. He re-opened and had a look. It was fine and, subsequently, the right diagnosis was that the patient had had a heart attack, post-operative heart attack, still an adverse outcome definitely, and ended up spending six weeks in intensive care. You know, a terrible outcome, certainly one that's on my conscience. The patient had a second laparotomy, that's a second operation, which was in my opinion unnecessary and the process was terrible. And after that, I just tried to limit my contact with Dr Patel completely and then Dr Keating.

Doctor, before that second laparotomy, which was essentially to look at your surgery to see whether there had been a leakage?-- Yep.

You advised against the surgery?-- I did.

Who did you advise?-- I advised Dr Patel, I advised Dr Keating and I advised the anaesthetist Dr Joyner that it was - who was also going to be looking after the patient in ICU.

All right. Well, did you advise those three individuals on mass or by separate conversations?-- No, separately.

Right. Well, the discussion with Dr Patel?-- Mmm.

Was it the same advice you gave in each instance?-- Yeah, I wanted the patient admitted and observed so that we could make a diagnosis. My contention - and it proved to be right but it may have been wrong, but anyway, it was - but if the patient had leaked, it wouldn't explain the signs and symptoms which he had, he was profoundly hypotensive, he was tachycardic, he was intensely unwell.

COMMISSIONER: Did the second laparotomy worsen the patient's condition in terms of the cardiac problems?-- Impossible to know since there's nothing - we can't compare it to what would have happened if he hadn't had the procedure. In general, yes, as a general comment, about unnecessary procedures, yes, and if the answer to that question was no they didn't make any difference, then we'd be doing them all the time.

Yes. Doctor, I'm afraid we're going to have to stop there, one of the Commissioners has a lunchtime meeting. Gentlemen, we'd like to make as much use as possible of Dr de Lacy's presence here, and so we're intending to resume at 2.30. It may be we may be a few minutes late, but if so, we'll be as close to 2.30 as possible. But we'll now adjourn.

THE COMMISSION ADJOURNED AT 12.30 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.45 P.M.

GEOFFREY ALAN DE LACY, CONTINUING EXAMINATION-IN-CHIEF:

MR ATKINSON: Dr de Lacy, prior to the break we were looking at.
Paragraph 12 of your statement, and I had asked you about your comments, that you gave advice prior to the second laparotomy?-- Yes.

And you explained that you gave that advice to Dr Patel to the anaesthetist and also to Dr Keating?-- Yes.

And I think you also explained that effectively, you gave very similar advice to those three people?-- Yes.

What was your advice then about why this operation wasn't really required?-- The patient had become shocked after an operation, there are a number of possible reasons why that might have happened. An unlikely one is that they've had an

anastomotic leak. That does result in shock eventually but usually that takes some time to evolve. A more likely scenario was the one that proved to be the final diagnosis which was that they had a post operative myocardial infarction, heart attack or a blood clot going to the lungs or a number of other potential causes for this same clinical scenario, and the advice I gave was that they needed to go to intensive care because regardless of what the cause of the problem was, the problem needed to be treated itself, the patient needed to be supported, their heart and lungs needed to be supported while we made our assessment, and so I was in favour of investigating them and operating later if necessary if it became obvious a leak was the problem. Dr Patel's opinion was different which was that we needed to exclude a leaking anastomosis immediately.

And that's the view that might be shared by other reasonable surgeons, do you think?-- Perhaps.

Right?-- So - it's a debatable point.

COMMISSIONER: Were there contraindications to a leaking anastomosis?-- Well, the way that we look at it is that there was no positive evidence that the anastomosis had leaked. In fact, it hadn't leaked.

Yes?-- But in a rapidly evolving scenario of someone who's having a post operative complication, is desperately unwell, it's sometimes difficult to know and so decisions are made based on what's likely or what's most serious. The appropriate management in that situation, in my opinion, was to admit them to ICU and to investigate them. Dr Patel disagreed.

This was a private patient of yours from-----?-- A private patient of mine. At that stage there was no private intensive care facility in Bundaberg.

Did the patient consent to the second procedure?-- The patient was in no condition to consent or not consent. He was unconscious.

But the patient had consented to your operating on him?-- Yes.

And presumably the consent form, as they usually do?-- Mmm.

Included provision for any follow-up treatment or procedure?-- Yes.

But the patient had never consented to be treated by a public doctor?-- No.

In a public hospital?-- No, he hadn't.

D COMMISSIONER EDWARDS: But you did admit him to a public system?-- Oh, I was - that does sometimes happen, certainly in these circumstances where in the smaller regional cities

there is no private intensive care.

I take all that?-- Mmm.

But my point is on the basis of which a intensive care in a public hospital unit, I find it difficult, and I'm totally sympathetic, I might add, but on the basis of the principles and correctness, you weren't a surgeon associated with the hospital at that stage?-- No, I was.

You were?-- I was credentialed.

Could you explain that position then?-- I was credentialed to work at the hospital to do a one in six on-call weekends, so that - but not to look after patients during the week.

Should it be expected that your patients should be admitted?-- That was the arrangement, that was certainly my understanding of the arrangement and certainly on those days when I was the admitting surgeon, if there was a patient who required intensive care - I can't recall an instance - then I would have been looking after them in Intensive Care. The issue on this particular day was that Dr Patel insisted on looking after the patient and sought administrative approval and was given it and against my will and-----

I accept your point?-- Mmm.

COMMISSIONER: Doctor, my flaw is that I tend to look at these things as a lawyer rather than a doctor, but from what you've told us, I even sort of started to wonder whether it wasn't an assault for someone to operate on the man without his permission, without the permission of his family and contrary to the advice of the surgeon under whose care the patient had consented to be treated?-- Operations are done without the consent of the patient or the family on occasion when the consent for one reason or another can't be obtained, specifically because the patient's unconscious, and it does happen regularly. This particular situation was not one that I'd encountered before in other hospitals that I'd worked at and I was extremely unhappy with it.

And it would certainly be a very rare thing for a patient who has trust and confidence in a particular surgeon to then be subjected to operative treatment by someone that the patient has never dealt with and contrary to the advice of his or her chosen surgeon?-- That's correct.

D COMMISSIONER VIDER: Doctor, was there any memorandum of understanding or anything loosely in forms of some sort of contract between the Mater and the Bundaberg Base Hospital for the Mater Hospital to access the Intensive Care Unit at Bundaberg Base Hospital if necessary?-- It was certainly the standard practice. Whether there was any documentary support I've got no idea, but patients were transferred backwards and forwards from the two private hospitals to the public hospital specifically for intensive care management and that had been going on for some time, and I believe certainly has gone on

subsequently.

Yes?-- It was just the specific issue in this case was who was looking after them and what was done.

Yes. And the other thing is am I right in saying that this patient was admitted to the Intensive Care Unit at the Bundaberg Base Hospital in a clinically unstable condition?-- Yes.

And the only assessment that was then made was by another surgeon and not by a physician?-- Certainly the assessment was made by the surgeon. I'm - all this happened within a space of hours and my contact was with the surgeon only. I actually went up to theatre and watched him perform the operation - it's the only time I've ever seen him operate - partly to convince myself that there was no actual surgical misadventure, but I'm not sure what other physicians were involved. There would certainly have been an intensive care doctor involved but I don't have all of those details at the tip of my tongue, I'm afraid.

Mmm.

COMMISSIONER: What was Dr Keating's explanation to you when you telephoned him and complained about your patient being taken over by Patel and, according to your statement, Dr Keating said that, "If the patient was at the Base Hospital, he would have to be under Dr Patel's care."?-- It was largely that as I've - as I've written down in the text of that statement, that Dr Patel was the admitting surgeon for the day and that if the patient was going to be admitted surgically that day, that he'd have to be under Dr Patel's care.

I have to say, doctor, I find this very disturbing. If I'm having a surgical procedure, which I have had occasion, I'd like to know who the surgeon is and check out whether it's someone I trust and I might get that right and I might get that wrong, but it's my choice-----?-- Mmm.

-----he sticks the knife into me. If a patient, particularly in the private system, has chosen to put his or her confidence in you, I just don't see how anyone in the world has the right to say that that patient is going to be operated on by Patel contrary to your advice. It might be different if there was a situation where it was something outside your competence and that a sub-specialist, a vascular surgeon or a colorectal surgeon or something like that was needed, but the idea that I as the patient can have myself taken out of your care and placed in the hands of someone else is something I find very disturbing?-- I was certainly disturbed by it that day.

MR ATKINSON: Doctor, you mentioned that conversation with Dr Keating where he said if the patient came to the Mater - sorry, to the Base, then Patel would be the treating surgeon. What was Dr Keating's response when you explained that in your view the second laparotomy should not proceed, at least at this stage?-- As I remember it, and it's - this is 2003, we

talked about administrative details only, which was that who was the treating surgeon and not what the specific, you know, treatment should or shouldn't be. I expressed my discontent with what was going on, definitely.

Mmm?-- But I've never had a clinical conversation with Dr Keating about any aspects of clinical care, just the administration of the service and we confined ourselves to that.

Now, your view was that there were no positive signs for an anastomotic leak?-- Yes.

And in any case the thing could wait and the patient could be observed in the ICU?-- Yes.

Dr Patel took a contrary view. You mentioned that the episode made you extremely unhappy?-- Yes.

Which aspect made you unhappy? I mean, his view wasn't one that was way outside the clinical range of reasonable responses; is that right?-- What made me unhappy was basically what Commissioner Morris has just outlined, that I felt responsible for this person's care. It is true that in the public system you are assigned to a particular surgeon, but it's extremely uncommon, even within the public system, once you've assumed the care of a patient that it's then transferred to another doctor, very rare. It's never happened to me before, for example, and the reason is not really a medical one but just a humanitarian one, you feel responsible for their outcome.

Mmm?-- And I wanted to be responsible for this person's outcome and I, you know, I wasn't allowed to, there was no alternative, he had to be transferred to Intensive Care, it wasn't as though he could have been flown to Brisbane, he wasn't in a fit condition and the rest followed.

Doctor, I glean from this episode and some others and your evidence, that you took the view that Dr Patel was unduly proactive and unduly keen to operate?-- Yes.

All right. Why is it good practice among surgeons to be conservative, reticent to operate, all things being equal?-- Because complications do occur in the best hands of surgery, because even when they don't occur, inevitably you wound people, you make incisions, spill blood, cause pain, and the assessment is that those inevitable consequences of the intervention is worth it, that there's going to be a - some good that comes out of this, and it's most surgeons I think would agree that the more pre-operative assessment that the patient has, the better or the harder the indication for an operation that you could come up with, the better the results, so we take the opposite view to Dr Patel and go slowly.

And can you elaborate a bit? You have seen evidence of Dr Patel being unduly keen to operate without working up the patient or without doing the proper pathology to make sure

that that's what's required; that's a trend?-- It is a trend, yes.

All right. Can you say a bit about it?-- His assessment of that particular patient, Mr Minns, took perhaps 10 minutes before the decision was come - was arrived at to operate. That's the one that I've got personal experience with first-hand prospectively. Retrospectively, looking through the chart notes, there's a lot of evidence that things that I would have done or that we were taught to do have - were not done. I can give you specific examples as we go through individual patients, but in general, pre-operative investigations to establish that the patient was fit for anaesthetic were regularly omitted which results in higher incidents of post-operative heart attack, post-operative respiratory compromise, and the facts are that that is what happened to these patients.

COMMISSIONER: Would that also be consistent with the claims we've heard of people having inadequate anaesthesia?-- Everything was rushed, it seems to me. For the reasons that why he was doing that, I'm not sure of, but it was rushed.

Yes.

D COMMISSIONER EDWARDS: Doctor, I'm not being difficult, please, but I find it very difficult to understand the position, and I understand your difficulty, but if it becomes a public patient, then the protocols of - right or wrong - the protocols have to be followed?-- Yes.

And the protocols would be that a doctor is allocated this patient who is in the system?-- Yes.

I have no difficulty with you being there and following all of this out, but I can also understand the rules of the Health Department - whether they're right or wrong - that those protocols be followed and the protocols would be that Dr Patel or somebody else nominated by Dr Keating would be the responsible surgeon?-- Yes.

You could take all the interest you wanted to and so forth. All I'm trying to get to the bottom, wasn't the system correct? It may have been wrong in outcome and wrong in your responsibilities and so forth, but it seems to me by reading your statement that the system allowed what was done and the outcomes were not good, but it was allowed to be done in accordance with the regulations and rules of the Health Department and hospital?-- That is certainly one view, that's the view that Dr Keating, I assume, took. The practical realities of my experience in the other hospitals that I've worked in is that that's not how it is administered.

I understand all that. All I want to know is were the protocols, in your opinion, followed, whether they're right or wrong protocols is something we'll debate and have a view on?-- Yes.

But I am having a difficulty that the rules should be changed day by day to suit a particular patient or suit a particular incident; I don't think that any system can actually operate like that?-- No, I think that was basically the substance of the argument that was - or part of it anyway - that was given to me at the time.

COMMISSIONER: But there would also be another dimension to this. I mean, I take the force totally of what Sir Llew says about the rules of the public system, but even within the rules, one would think that just as a matter of professional comedy or courtesy between one surgeon and another, it would have been an extraordinary thing for Dr Patel to operate on your patient, contrary to your views?-- It's - elsewhere, there is a common agreement amongst doctors, administrators and anyone else that's got anything to do with patients that the ultimate end point is to have a healthy patient at the end of the process and that the rules have applied to that end bent and occasionally broken to that end. At the PA, for example, at the QEII, that's not an uncommon experience to have a patient operated on, discharged, present within the next couple of days with a complication of that surgery that was not picked up in hospital and needed to be readmitted. Are they admitted under the surgeon of the day or the patient who just operated on them last week? Inevitably, it's the patient who just operated on them-----

Surgeon who just operated?-- -----because the surgeon wants to do that, to look after the patient. An administration in general understands that if the patient is happy and satisfied and healthy at the end of it.

There's a lot less trouble for everyone.

D COMMISSIONER EDWARDS: Doctor, I need to say I'm not disagreeing with your view at all but I am trying to get the view that whether the rules were broken technically by them - their taking action they did, it appears to me, my understanding, that they probably acted in accordance with the law, as wrong as it was, in principle?-- I'm not sure if it surprises you for me to say I've never actually seen those rules but I'm happy - I was unhappy with the situation extremely but I dare say that there were - well, I certainly have no evidence that they weren't applied anyway.

MR ATKINSON: Doctor, in paragraph 7 of your statement, you set out some headings of suboptimal care if you like?-- Yes.

Just before we go there, can I ask you this. Prior to the break you spoke about the fact that you have done 150 letters for former Patel patients to general practitioners?-- Yes.

On the other hand, you mentioned that you have seen maybe 200 former Patel patients. What's the basis for the discrepancy?-- I - well, that's a - I - every patient that I've seen as a new patient has at least one letter written about them on my first consultation. If I have had to see them subsequently, for each episode of care there is another letter that goes off to the GP and the Bundaberg Base Hospital. Those numbers, I did count them last Friday and there was 151 new patients who had been referred to me.

Through the Mater Hospital/Queensland Health arrangement?-- Yes, yes. Of those, they've had more than 100 procedures. Some of those have been colonoscopies and endoscopies. A lot of them have been corrective surgery. I haven't actually done the breakdown but I've certainly been operating on them every week for the last couple of months.

COMMISSIONER: I think Mr Atkinson was wondering why we have only got 151 items when there were something like 200 patients all-up?-- The letters that have been sent from my secretary are the initial consultation letters, the long letters.

Yes?-- Every time they've seen me post-operatively or that I've operated on them, or whatever, there are other letters. There's more documents.

Right.

MR ATKINSON: But are there more patients?-- No, there aren't more patients.

Just to cut to the chase, I had this query that you might see some Patel patients because they're referred to you not through the Queensland Health/Mater Hospital arrangement-----?-- Yes.

-----but because you're a general surgeon in Bundaberg and some people need follow up surgery and they say, "We'll go and see de Lacy across the town"?-- No, they've all been fixed and they're all aware of the funding arrangement. For example, I

don't charge them, they don't have to pay to see me. So we're aware of which are the Patel patients.

I was thinking - for instance, I don't see the patient Fleming here but I understand you've seen him?-- Ian was admitted acutely to the hospital rather than saw me in my rooms but there are documents relating to his care on - on my computer you're welcome to-----

All right. Yes, in terms of those patients, you have probably done over 100 procedures?-- Mmm-hmm.

And that includes, you say, both corrective procedures and-----?-- Diagnostic procedures.

And scoping, which would be diagnostic. Now, if we stick with that figure of 151, of them, how many can you say, you know, were - with reasonable certainty are people who've received, yes, substandard care?-- The majority of them.

More than - more than half then?-- Of the - after going through the whole process of checking, like, what they've had done to them I've found myself in a position of writing, "I agree with Dr Patel's assessment and that no harm has been done", on a number of occasions. Not that many. Ten perhaps.

Right?-- At a guess.

D COMMISSIONER VIDER: Ten out of 151?-- Yeah.

MR ATKINSON: But, Doctor, there's that old saying even a dwarf is as tall on the shoulders of a giant. It's easy to look back and say, "I can improve on what he's done"?-- Sure.

But that's a separate question from saying, "I think his standard of care was below acceptable"?-- I think that's an important distinction to make, but both true. I mean - there have been a lot of problems and he was providing an inadequate standard of care. Any surgeon looking after that patient group would have had some problems. The number and sometimes the quality of problems, the magnitude of problems, is - in my opinion were a long way removed from what's normal care.

COMMISSIONER: I'm sorry, Doctor, again, being a lawyer, I tend to see things perhaps in a more black and white way?-- Yes.

If you've got 151 cases and there are 10 where you - roughly 10 where you agreed with Patel's diagnosis and treatment, does that mean that there are 140 where there was suboptimal care or is there another category of care that was adequate but not the best?-- No, it's pretty black and white I think. It's, you know, suboptimal care in the majority of patients and no middle ground.

Well, from what you've said, the vast majority, something over 90 per cent of patients?-- Without - without physically going through the whole 150 and in the time that I had to prepare

this, which was limited, and - by, you know, the practice, I went through about half of them again in the last week and there weren't too many out of that group who were - who I was able just to simply to re-assure and say, you know, "No harm done. You've had good care and you don't need to worry about it anymore, you can put this behind you and don't mention his name again." I have said that. There are certainly some but it's a little difficult to come up with an exact number, but certainly the majority have been badly managed, mmm.

MR ATKINSON: And we use that word "suboptimal" but I understand what you're saying is that in the majority of cases, the standard of care falls below that of a reasonably competent surgeon in your view?-- Thoroughly.

Now, if I can go to those headings, there's four in paragraph 7?-- Yep.

The first one is inadequate assessment of the patients' presenting complaints, the second deals with surgical technique, the third one deals with post-operative care and the fourth one deals with inadequate follow-up. With the first one, inadequate assessment of the patients' presenting complaints, you set out in a schedule, I understand, patients who provide an easy example of that?-- Yes.

You have got there P371, P372, P373, P374, P375. I wonder if you could just do a thumbnail sketch of each of them?-- Sure. Could I just start with the classic one, it's number 2 on the list, P372, who is illustrative of a lot of these problems. I'll go through them all briefly. He's a 44-year-old computer programmer who presented on the 17th of December 2003 complaining of bleeding from the backside. He was, in summary, seen from the 17th of September 2003 to the 24th of August 2004 numerous times by Dr Patel and his junior staff. Dr Patel performed a number of procedures for banding of hemorrhoids, a rubber band placed around a protruding lump in the anal canal, on a number of occasions. There's a description in the notes written by junior doctors which describe an anal cancer and after a year of having his hemorrhoids treated, the diagnosis was finally made by another surgeon and he had his anal cancer removed. That's not good treatment. It's an example of failure to make a diagnosis.

COMMISSIONER: What are the implications for that patient with a 12-month delay in having his anal cancer diagnosed?-- Well, there may be none.

Yes?-- Or he may develop the spread of cancer which is incurable by best medicine, and time will tell. He knows that. There's a - it's not good but inadequate treatment doesn't always result in poor results and he may be fine.

But the important point at least for our purposes, it's no comfort to the patient, but that patient's life was put at risk by that failure?-- It was, yep.

MR ATKINSON: Then you talk about the patientP371?-- She

was a 59-year-old woman who presented to hospital with a serious problem. Again, PR bleed - or bleeding from the backside and pain on the right side of her abdomen. Numerous investigations were done and Dr Patel came to the conclusion that the patient had a diagnosis called ischaemic colitis, which is poor blood supply to the bowel. She had an operation which was - would have been appropriate for someone with ischaemic colitis but was not appropriate for someone with Crohn's disease, which is what she actually had. She had a very difficult post-operative course but survived. She has been left with most of her bowel having been removed and a join between the last portion of her small bowel and her rectum. That particular operation is specifically contraindicated in the diagnosis of Crohn's disease. The last part of your small bowel, it's something called the terminal ileum is the most commonly affected part of the bowel in Crohn's disease and is - there's evidence on histology, that is, what the resected specimen looked like under the microscope, that her terminal ileum was affected by Crohn's disease and it's been used to join with the rectum. That specific situation is bound to leak. We've talked about anastomotic leaks before. That's the situation where it tends to happen.

COMMISSIONER: Is such a leak particularly dangerous in the bowel region because it leads to greater risks of blood poisoning and infection?-- The consequences of peritonitis, which are death if not treated.

D COMMISSIONER EDWARDS: Her day-to-day lifestyle are very badly interfered with?-- Her day-to-day lifestyle is that she passed between 12 and 20 loose bowel motions per day and that she's - was 85 kilograms, she's now 56 kilos. All of these people have had those magnitude of problems.

MR ATKINSON: And the mistake, Doctor, in short was not to diagnose Crohn's disease at an earlier time by proper assessment?-- Exactly.

And you think a competent surgeon could do that? I mean, it's not that prevalent a disease, Crohn's disease?-- It's - all of these things are difficult but that's specifically why you're there to make those assessments. That's not, for example, an assessment that a GP is likely to make correctly but it is one that as a surgeon you're supposed to be able to make, and the reason is because it makes a lot of clinical difference to the patients. Small mistakes, small misdiagnoses are made all the time but the critical issues are supposed to be attended to and in this particular situation, a critical mistake was made due to misdiagnosis.

D COMMISSIONER EDWARDS: Is the specimen sent away for pathology?-- It was.

And it came back?-- As Crohn's disease. As Crohn's disease.

COMMISSIONER: Could that have been done pre-operatively?-- It's notoriously difficult to diagnose pre-operatively.

Yes?-- It's the whole clinical scenario, not just a specimen being sent away, that allows you to make the diagnosis. Looking back through the notes, again with the caveat that this is in retrospect, et cetera, it was never ischaemic colitis, it didn't have any of the real clinical features, but it also wasn't necessarily Crohn's from the word go either. It would have been a difficult diagnosis to make but having the opportunity to do the operation, to review all of the radiology, to have - you know, to pull it altogether, that definitely should have been made and the diagnosis should have been made because it was critical to her care to make the - to distinguish between the two because the operations are completely different.

And, in any event, the fact that it is a difficult diagnosis to make-----?-- Mmm.

-----is the very reason why you don't perform surgery which is contraindicated for one of those two conditions?-- Well, I mean, as it happens also, she had - she had an ileocolon anastomosis, which I understand he was specifically prohibited from doing in sort of other jurisdictions, but - and I - it's not hard to understand why, having looked at some of these patients, from my point of view. That was her story.

Yes.

MR ATKINSON: So that, the histology comes back after the operation?-- Mmm.

And it shows, particularly in combination, one would think, with the other symptoms, that she's got Crohn's disease?-- Yes, yes.

But that's not picked up even then?-- No.

I mean-----?-- It should have been picked up.

There might be debate about whether the doctor might have diagnosed Crohn's disease earlier?-- Yes.

But certainly after that, there is no mistake - there's no excuse?-- It's a matter of looking at the report and understanding what it means and accepting that the pre-operative diagnosis was wrong and changing your tact based on sort of new evidence.

And that didn't happen?-- Didn't happen.

The next one is the patient P373?-- Would you mind if I skipped over the detail, I just haven't got that?

Sure?-- But I could go on toP374.

Yes?—P374 was 57 years old, who was admitted for a laparoscopic cholecystectomy. On the 29th of June she had that; was discharged the same day. She came back two days

later with the disease that was characterised by abdominal distension, abdominal pain and vomiting. She was in hospital for seven days. The vomiting was severe enough for her to dislocate her jaw. No diagnosis was made. She was discharged. She came back in two days after that with a similar - similar syndrome, vomiting, dislocated jaw, abdominal pain and abdominal distension. The diagnosis of a small bowel hernia through one of the cuts that was used for the keyhole surgery was made. She was taken to theatre. The small bowel had become caught out through the small hole that's used for the keyhole access and was blocking the flow of flood and fluid through the small bowel, which is why she was in pain and distended and vomiting. That hernia was fixed by Dr Patel. She went home; the hernia has recurred. She's had to have another operation to fix the hernia. That's her story.

COMMISSIONER: And where is the failure to make the adequate assessment of the presenting-----?-- Diagnosing the fact that this - that she had a - the cause of her post-operative pain, vomiting and distension was an incisional hernia and dealing with it.

So it's the failure on this occasion occurred between the two operations?-- It did.

Yes?-- She had an appropriate operation for gallstones, again performed without an operative cholangiogram, but again that was just his practice, bad practice, but it was one that he did in all cases, and, yeah, not diagnosing the cause of her small bowel obstruction and the treatment.

MR ATKINSON: Would that be difficult to do?-- It's possible to have - I mean, all of the - every complication that I described has been described elsewhere. It's not - well, some of them are bizarre but most of them, for example this one, it's possible to make these mistakes.

And I guess, it wouldn't be - it would be something your mind would turn to the possibility, that the small intestine is caught-----?-- Sure.

-----in incisional hernias?-- Sure, one of the small possibilities you would just go through and exclude.

So you think that a reasonable surgeon would find that diagnosis-----?-- Well, I had operated on her to fix her recurrent hernia finally.

D COMMISSIONER VIDER: So this patient came in with a complication?-- Yes.

With persistent vomiting?-- Yes.

For seven days?-- Yes.

That's unresolved, then she's discharged?-- Yes, came back in two days, exactly the same syndrome: dislocated jaw, pain,

abdominal distension. Finally the diagnosis was made.

Thank you.

MR ATKINSON: The next one is P375?-- P375 is a 72-year-old woman who presented with a lump in her left armpit. A sample of that was taken by a needle and proved to be - proved to be a cancer of some description. Further tests were done on it and it was thought by the pathologists to represent metastatic melanoma. An operation was performed on her by Dr Patel to remove the lump and submit that for histology, that is, look at it under the microscope. It did in fact prove to be a metastatic melanoma, that is, melanoma that has moved from another site into the lymph - into the glands underneath the armpit. She was discharged. There are a couple of issues surrounding that which would entail poor care. I think the primary one, you probably don't have to be a doctor to understand, is where did it come from, which - where did this melanoma start.

You wanted to find the primary?-- The primary, actually, was sitting on her arm. I subsequently removed it. And at the - she wasn't offered any further care, no further follow-up and no what we call adjuvant treatment. There were features on the specimen submitted to the pathologist which would have led another surgeon to offer her at least the alternatives for radium treatment or even more specialised treatment, Interferon.

In lieu of surgery?-- No, as well as surgery.

Right. Can I ask you this, Doctor, you find the metastatic melanoma under your arm or the surgeon does?-- Yes.

How does a secondary develop into a primary? How do you know it's not a primary?-- Because it's in the lymph - because it's in a lymph node and the lymph nodes are small, round small structures which have drained tumour cells away from the primary. Melanoma starts in the skin or occasionally elsewhere, inside the mouth or the eye, but not in lymph nodes.

Right?-- So the fact that it presented in a lymph gland meant that it's come from somewhere else, and in this case from her left arm.

D COMMISSIONER EDWARDS: It was so obvious?-- It wasn't so obvious but it was there.

But it was a mole?-- Yes. It was - I mean, it was a pigmented skin lesion which we removed and proved to be the primary melanoma.

MR ATKINSON: So they're the two main features of the poor care: the failure to look for the primary-----?-- Yeah.

-----and also the-----?-- Failure to offer her any form of treatment. To give you - to give you an example of what I

think reasonable treatment is, I saw her a year after that had happened and she's looking fine. She has no specific problems. I examined her and found this pigmented skin lesion which we'd removed, it proved to be the primary. But that then now becomes quite a specialised and difficult decision to make and there are lots of potential ways forward from there, one of which is to do nothing, another of which is to give her radiotherapy under her arm, which has its own complications. Another one is to perform more surgery to remove all the lymph nodes under her arm, complex chemotherapy or even more complex treatments. It's quite specialised. However, Queensland has a major melanoma unit. There is a Dr Mark Smithers, who is a world expert in this, and numerous others. So I have referred her to the melanoma unit at the Princess Alexandra Hospital and was seen by Dr Smithers in liaison with radiotherapists and all of the other people who are involved in this care all the time and their final assessment was that if they'd seen her at the time, okay, perhaps radiotherapy, probably not Interferon because she's 73, but now that a year has passed, there is no point in doing that. But that's the process that I think is sort of appropriate for managing somebody like that.

Sorry, when you say there is now no point in doing that, is that because it is untreatable, in effect?-- No, there is no evidence she has got more melanoma. She may have been cured by Dr Patel.

Yes?-- But she hasn't got - well, let me rephrase that. She definitely was not cured by Dr Patel because the primary wasn't removed but that was a minor procedure.

Yes?-- It needed to be done, it needed to be diagnosed, but she may not have suffered long-term because of what was or wasn't done. But statistically her risk of having a melanoma come back within the next five years has increased, definitely.

The reality is that when Patel saw her she had what was probably a treatable melanoma?-- Yes.

She now has an untreatable melanoma. So, again, if one quantified the risk, she is-----?-- Has been adversely influenced by his care, certainly.

With the consequences that it is potentially fatal?-- Yes.

MR ATKINSON: Doctor, except for P373, which we will come back to, that's the end of paragraph (a)?-- Yes.

COMMISSIONER: Mr Atkinson, we might then just have a five minute break.

MR ATKINSON: Sure.

THE COMMISSION ADJOURNED AT 3.29 P.M.

THE COMMISSION RESUMED AT 3.35 P.M.

GEOFFREY ALAN DE LACY, CONTINUING EXAMINATION-IN-CHIEF:

MR ATKINSON: Doctor, I might move through the list a bit more swiftly. Under paragraph (b), "deficient surgical technique", and the first subheading is "removal of wrong organ", I understand that. Can you take me to the two examples of P175 and P377?-- P175 is a 76 year old man who had his thyroid removed for thyroid cancer. He was not offered radioiodine, which is the standard accessory treatment in that circumstance, but he was followed up at surgical outpatients by Dr Patel six months after his initial operation. There is a note in his chart written by one of the junior doctors to say that there was a mass in the right side of the root of his neck, just here. Provisional diagnosis at

the time was recurrent thyroid cancer. The note was he was booked to have that reexcised in the operating theatre. He proceeded to the operating theatre and had an operation done here and had-----

COMMISSIONER: You are pointing to under the chin line?-- Under the chin line, and had a lump removed, which on histology, under the microscope, proved to be a normal submandibular salivary gland, which is somewhat removed from the thyroid and also from the mass that the junior doctor had identified, which proved to be a recurrent cancer when I reviewed him, and the patient subsequently went on to further major surgery to remove the recurrent thyroid cancer - not by me, but by an ENT surgeon in Brisbane.

And, again, has the delay in dealing with the recurrence of the thyroid cancer put the patient at risk?-- Yes, it has.

MR ATKINSON: Doctor, one of the things that seems, from a layperson's view, concerning about that story is that the surgeon doesn't seem to have understood what the right submandibular gland looks like. Is that - am I oversimplifying things? I mean, should the doctor be taking it out?-- No, he shouldn't be. He operated in the wrong vicinity and took out the wrong organ, and, you know, it is terrible. I mean, in my opinion - I mean, my opinion is no different to all of your opinions, it is just the anatomy is a little clearer in my mind, but it is terrible.

He is looking for a mass, he finds a gland that's supposed to be there and he takes it out?-- Yeah.

Okay. Then the matter ofP377?-- Let me just find this.

COMMISSIONER: Page 66?-- Thanks.

MR ATKINSON: I have only paginated the Commissioner's bundles?-- Dorothy is a 49 year old woman who presented to the surgical outpatients department with nipple discharge. There are a lot of issues surrounding her care, but to summarise them, she was investigated by Dr Patel with what's called a ductogram, some X-ray - some fluid that shows up on X-rays instilled into the ducts that exit from the nipple, and the diagnosis of a papilloma, which is a growth of the inside of one of those ducts, was made. She proceeded to have an operation where that papilloma was supposed to be removed. She had a portion of her breast removed, unfortunately not the part that contained the papilloma. The histology report showed normal breast tissue and she was discharged. She continued to have discharge from her nipple. She presented to me to be reassured that her treatment had been adequate and she has had another breast operation and the papilloma has been removed.

I understand there is other examples there of the same type of problem?-- Mmm.

The next subheading is "missing tumours on diagnostic

procedures"?-- Yeah.

Could you just give us a sketch of P379 and P288?-- P379 is a particularly tragic case, and I haven't got his notes specifically in front of me here but I don't think I need them. He is an uncommon problem. He was flown to the Bundaberg Base Hospital severely anaemic and was investigated by the physicians at the Base and a cancer was found approximately that far inside his rectum.

COMMISSIONER: You are indicating, what, about five centimetres?-- Perhaps 10 to 15 centimetres. The instrument, the colonoscope, couldn't be passed beyond that tumour. He was referred to Dr Patel who performed an operation on him, and his notes read that there was a tumour found at the rectosigmoid junction, which is approximately that far inside, a little bit further, perhaps, and it was removed and anastomosis was performed. At that stage there was no evidence of spread of the tumour. He was referred for chemotherapy but declined, and during the follow-up process at surgical outpatients it was determined that the tumour had spread to his liver and lungs, which makes this unfortunately a fatal condition. He again came to see me to make sure that his treatment had been correct, performed another colonoscopy and there was the tumour still sitting in his rectum with the join approximately two centimetres above the tumour. It is an unusual situation. The man's had two tumours. The one that was diagnosed by the gastroenterologist and the one that was removed by Dr Patel were not the same tumour. It can happen in five per cent of cases.

MR ATKINSON: But they were there at the same time?-- They were there at the same time. The second one, the one that Dr Patel removed, was not diagnosed because the scope couldn't be passed through the lower one. It is an unusual circumstance, but because it occurs in five per cent of patients, the recommendation is that a full colonoscopy is done as soon as possible in exactly that circumstance. It was not done. The patient was clear of tumour as far as we can tell at the time of the original operation and now has incurable cancer.

The rectal tumour became metastatic?-- That's the assumption we work on, yeah.

And he has passed away now,P379?-- No, he is still alive.

COMMISSIONER: Without going into the gory details, was the operation to remove the tumour performed transanally or is it-----?-- No, via an incision in the abdomen.

Right?-- The first part of that operation is what we call a laparotomy, which is an assessment of the condition of the organs inside the abdomen; has the tumour spread to the liver, has it spread elsewhere, et cetera, are there more tumours in the bowel? In one in 20 people, the answer to that would be yes. So there is a formal process that we're taught to do and

which was, you know, not done.

MR ATKINSON: Then the matter ofP288?-- Similar. Similar. Again, an elderly man who had a large tumour diagnosed by other doctors. This was actually slightly more interesting in that the - he had a similar operation and an abdominal incision and a segment of bowel, the one containing the tumour, was removed. The specimen was sent to the pathologists in two bits. The first bit - which is unusual. Unusual enough for the pathologist to comment on it at the time, which is available in the notes. There was one segment of bowel which had the tumour extending to the margin of the resected specimen, which is significant. Whenever we see that, we are concerned that some tumour has been left behind, not clear margins. We try not to cut through the tumour, we try and remove the tumour and a cuff of normal tissue so we're sure to remove everything from the body. There was a second specimen sent to the pathologists, which was labelled as distal resection margin, which did not contain tumour. The notes from the pathologist read that they had contacted Dr Patel personally, because the specimen was so unusual, and he had reassured them that this extra bit of bowel that had been removed was distal to the tumour, was the bit that the tumour had abutted, so that what he was saying, in summary, was that, "Everything was fine, don't worry."

MR ATKINSON: It was the cuff?-- It was the cuff, yeah. The reality of his care subsequently, unfortunately, suggests that wasn't the case. His tumour has recurred at the join, has been removed colonoscopically by another doctor, and this man is currently undergoing work up to have it removed again. The inference being that Dr Patel has cut through the tumour. Poor care. Poor care.

Doctor, under the heading of "wound closure"?-- Yes.

Can you just speak briefly about P380 and P104?-- Do they have numbers attached to them?

No?-- I have got them.

D COMMISSIONER EDWARDS: Page 135 on ours.

MR ATKINSON: Your copy is paginated, doctor. Page 135?-- P380 is a 66 year old man who had an operation for gallstones via a cut under the ribcage. He had an injury to his liver and to the blood vessels supplying the gall bladder which required transfusion. He was a chronic smoker with known respiratory illness. He had no form of preoperative cardiorespiratory assessment, got into respiratory difficulties after the operation, was transferred to the intensive care. The notes in the chart say that he was progressing well, but what the patient told me was that he got his son to drive him to Logan Hospital, which is a four or five hour trip, was admitted there and treated for urinary retention, just not being able to pass urine, and a wound infection. Very unhappy patient and an example of the annotation in the notes being in variance to what the patient

tell me. He ended up with a large incisional hernia, one of many, and subsequently required repair. I don't mean to put everybody to sleep. It is a long litany of medical problems.

Not at all. You mention there, doctor, also-----

COMMISSIONER: I don't think anyone in the room is thinking of going to sleep at the moment.

MR ATKINSON: You talk there in the notes, doctor, about the cystic artery being inadvertently damaged?-- It is a complication of the operation. All of these things can happen. It is just they don't happen in every single patient. It is - I have looked after many patients that have had that description in the notes. I have formed the view that what's unequivocal is that the patient bled because they usually have to be transfused and that's recorded. The cause of their bleeding is usually recorded as an injury to the cystic artery because that's sort of a known and somewhat acceptable complication, but that it is - all that I can say for sure is that their bleeding required transfusion.

D COMMISSIONER EDWARDS: There is a possibility he may have damaged the common bile duct, I think you mentioned?-- Some of them have had - not this particular patient.

MR ATKINSON: Doctor, you mentioned also there a man called P104?-- Yeah.

I don't think we have a note of-----?-- P104 is a 63 year old man who had an operation many years ago for a growth in his bowel performed by another surgeon. He also ended up with a hernia following that surgery and was referred to Dr Patel in 2003 to have the hernia fixed. Dr Patel made his assessment at outpatients and his assessment was no hernia present. The GP who referred the patient disagreed, had an ultrasound performed which demonstrated the hernia and he was referred back to Dr Patel to have the hernia fixed. As is the case with most of these hernias that Dr Patel has operated on, the hernia has recurred, the man still has got the problem he presented with and needs to be fixed. He is awaiting repair.

Why does that come under the heading of poor wound closure?-- Dr Patel did operate on that man eventually to try and repair his hernia. As was his standard practice, he did not use mesh - prosthetic mesh repair, which would be the standard practice in Australia, and the hernia recurred.

Under the heading (c) "post operative management", there is a long list there. Can I ask you just to take us to P382, P383 and P230?-- P382 is a 59 year old man who had a hernia repair performed by Dr Patel. He is a tomato stacker and has a physical job.

COMMISSIONER: 214.

WITNESS: He had a day case procedure, discharged the same day, and subsequently found himself unable to walk. Couldn't

flex his hip and couldn't walk, which is a very unusual symptom to complain of after a normal hernia repair. He, in summary, proceeded to an operative exploration. I operated on him and he had had the mesh plug - the doctor had used mesh in this circumstance, but instead of putting it where it should have been put to repair the hernia, he had put it into the femoral nerve, which is the nerve that supplies the leg, and on removal of the mesh his symptoms went away. An unusual complication.

MR ATKINSON: That's something - you put it under the heading of "post-operative management", because that's something the doctor should spot through follow-up, is that right?-- There are a number of problems with the management of each of these patients. I have done more than a thousand hernias. Nobody has ever complained of not being able to walk after one. And it is an unusual complication, unusual symptom to complain of, and should have alerted, really, anybody that there was something amiss. Instead, he was discharged from further follow-up.

P383?-- P383 is a 59 year old woman who-----

Page 58?-- -----had a gastric band procedure for obesity many years ago. She complained of persistent pain in the upper abdomen and vomiting and was - had a diagnostic procedure performed by another doctor, an endoscopy - that's a look down into the stomach. She was diagnosed with the commonest complication of the gastric bands, that it had migrated into the stomach. The plastic cuff that's put around the top of the stomach to prevent you eating a lot can erode through into the stomach and the plastic is then visible on the inside when you look down into the inside stomach. She was referred to Dr Patel, had an operation and had the gastric band removed. Relatively complicated operation. You have to enter, make an incision in the stomach, remove the band and then sew up the wound in the stomach and then the wound in the abdominal wall. She had exactly the same symptoms after the procedure as she had before, and when I investigated her and performed an endoscopy, she had what's called an hourglass deformity of her stomach. The problem - the reason she was vomiting was that the band, in the process of eroding through into the stomach, had narrowed the mid-section of the stomach. He had done an operation, he had removed the band, but the narrowing was still there which was the cause of her symptoms. She was seen in outpatients, complained of exactly the same symptoms that she had prior to the procedure and was discharged. She needed quite complex repair to get rid of her symptoms, including removal of the distal half of her stomach, and another major operation.

How should you have removed that narrowing effect in the stomach?-- By removing all of the stomach distal, that's downstream-----

Yeah?-- -----from the narrowing. It is really - that's the simplest way of doing it. The issue with this patient, however, is that there are, I think, a number of ways to deal

with these problems. The best way depends on the details exactly. She is grossly obese, for example, and that makes a difference, but as a principle, if you are operating to relieve her symptoms and the symptoms are exactly the same as they were after the operation, then you've failed, and that should be clear when you follow them up as an outpatient, and that's the issue - the primary issue in her care.

P230, doctor - page 70?-- 70, sorry. George is a 76 year old man who is a chronic smoker with a lot of the problems of smoking. He has had a coronary artery bypass procedure, he has had part of his lung removed for a tumour, and the surgeon who performed that procedure on his lung noticed that he had bad reflux and suggested that he may qualify for an operation to cure his reflux. He was seen by Dr Patel in October 2004 and was, in summary, operated on by Dr Patel to cure his reflux. No preoperative investigations to assess his cardiorespiratory function were done. The patient was found blue and unconscious in the ward on the first day post-operatively but recovered and was discharged after a week or two only to be readmitted the next day under one of the physicians with severely compromised heart function, and now he's a respiratory cripple; can't walk because of shortness of breath, couldn't give me a proper history because he can't complete a sentence because of shortness of breath as a consequence of the operation. There is another issue surrounding his care which is that - what he told me certainly was that the operation that Dr Patel performed is an old-fashioned way of doing this operation. The operation is called a fundoplication. That used to be performed via a large cut in the abdomen. It is now performed via small incisions, keyhole surgery, which is a lot easier on the patient in many ways. The patient tells me that what he was told by Dr Patel was that he could get it done via the keyhole method in Brisbane but the waiting list was five years, or he could have it done via a large incision with Dr Patel, which was just as good as he could do it next week. The second part of that assertion was definitely correct. He had an operation the following week and he now can't walk or talk. The first part of it, which was there is a five year waiting list to have a laparoscopic fundoplication is definitely not correct. What would have happened if he had been referred, assessed and/or operated on is impossible to know, but it is hard to imagine having a worse result, short of death, than he has got.

COMMISSIONER: And he would have been much better off with his reflux than his present condition?-- His reflux is actually fine.

Yes?-- It's just the rest of him that's the problem.

But the operation that he had was only to treat the reflux?-- It was. He is now what, the sum total of his - or the result of his care is that his reflux is better and his breathing is much worse. You know, what would have happened if he had another form of operation by another surgeon in another institution, it's really impossible to know.

But if he had no operation at all?-- Yeah.

His lifestyle would be moderately better than it is now?-- Substantially better.

MR ATKINSON: Doctor, I've just received instructions who have suggested that Mr Halter might have recently passed away?-- He may well have, certainly some of these patients will have.

Can I ask you then to go to the heading of "Poor Follow-up"?-- Mmm.

And I just ask you to go to one patient there and that's P387?-- P387 I don't need the notes for. She was only one of the early patients who was referred to me. She again had had a laparoscopic cholecystectomy. Yet again there was a note to say that the gall bladder was perforated during its delivery through the anterior abdominal wall after it's been removed from the attachments inside, it's pulled out through one of these small holes. There was a note to say that the stones contained within the gall bladder had spilt - which can happen - that a search was made for them at the time of operation and this - they were removed and she was discharged. She represented to the hospital complaining of a wound infection and, in summary, by the time she got to me, the GP had identified that there was a 2.5 centimetre stone, that's one inch, that big, sitting in her anterior abdominal wall and which was the cause of her continuing wound infections and needed to be removed. It's a gross mistake to leave something like that inside.

Doctor, just over the page - well, just finish off on GAD 2, that list you've given us?-- Mmm.

You've taken us to some cases and I understand - or I've taken you to them?-- Mmm.

But I understand they're cases that are readily accessible, you've chosen those cases because they're the ones that speak most simply about poor care. But even this entire list, it's not exhaustive; is that right?-- In no way, they aren't necessarily the worst, they were what I had time to collect in the last week. There are certainly many other cases of this similar magnitude.

And you've explained already to the Commissioner your view of the scale of the problem?-- Mmm.

Having regard to this sample of 151 patients.

D COMMISSIONER VIDER: Mr Atkinson, can I just ask Dr de Lacy something? You've just given us an overview of the clinical case histories of these patients; what's their psychological state like?-- Variable. A lot of them are fine. They just want to be fixed and forget about it. I would think that's the majority of them. Some of them are dreadful. A lot of their relatives are dreadful and one or two are, you know, are worse than that, just, you know, in my opinion see this as an opportunity to jump on a bandwagon. The vast majority of them are surprisingly good about it and have been fixed or improved anyway one way or another with the appropriate treatment and are happy to leave it at that. Most - these are extremely technical issues.

Mmm?-- And it's hard enough to explain it to you all and much much more difficult to explain it to - and I'll use the same example I gave before - the illiterate itinerant alcoholic. They have been damaged and a lot of them are coping, they're pretty good, in summary.

COMMISSIONER: Mr Andrews, we were going to come to back to P373; is there some particular reason for keeping that one aside?

MR ATKINSON: I can do that Commissioner - call me Mr Atkinson.

COMMISSIONER: I'm sorry.

MR ATKINSON: Sorry Commissioner. Will you mind, doctor, just going back to that matter of P373?-- If you can direct me to a number, I'll do that.

Page 188?-- Lee is an otherwise well 37 year old spraypainter who presented to the Base Hospital in August 2004 with a swelling in his neck. The provisional diagnosis made by Dr Patel was an inflamed lymph node, lymphadenitis in technical language, and he was treated by incision and drainage, the same as you would with a big pimple. The patient was seen at least twice more by Dr Patel, had a formal operation in September that year to incise and drain this recurrent correction of infected fluid from his neck and finally had the diagnosis of a branchial cyst made which is something that can occur in the neck of a young man and give them those symptoms and signs, the diagnosis was actually made by Dr Gaffield. In summary, the patient was referred to an ENT surgeon in Bundaberg who excised the cyst rather than incised, that is, removed the whole thing rather than cut into it and, as I understand, he's made a good recovery.

Doctor, over the page, I'll just take you to one patient, it's a patient who has given evidence before the Commission, and that's Nancy Swanson, but that's over the page in your

statement rather than-----?-- Yeah.

-----in the collection, and that's at page 182 of your collection?-- Yep.

183, I think. 182?-- There are patterns which I've identified as, you know, looking through the - so many of these patients, and one of them is that Dr Patel didn't perform preoperative assessments to assess the fitness for an anaesthetic, in summary. There's a - I've made reference to it on a number of other cases that the consequence of that is that you've got an increased risk of having heart attacks or respiratory impairment after the operation, not that you necessarily will, but that the risk is increased, and this is another example of that. She's a 62 year old lady who has had multiple admissions for smoking-related illnesses, lung illnesses who was seen in Outpatients by Dr Patel, referred by one of the gastroenterologists on staff with multiple polyps, small benign growths on the inside of the large bowel. Dr Patel's assessment was that though there was no evidence, there was no absolute really convincing evidence of invasive cancer, that she would be best managed with removal of the majority of her large bowel and adjoin between the last part of the intestine, the terminal ileum and the rectum. He removed - he subsequently took her to the operating theatre, subsequently removed that segment, the histology of that resected segment showed that there was no cancer and she proceeded to have similar types of problems to a lot of these patients, the join leaked, she had an anastomotic leak, she required another operation and a bag which is what's often necessary in this circumstance. She had a post-operative heart attack which again is one of the things which can happen to smokers who have unassessed and have operations.

And she had a wound dehiscence too?-- She had a wound dehiscence as well.

Tell me doctor, with the preoperative assessment, does that put on call to the anaesthetist rather than the surgeon?-- In her case it's illustrative after she had her heart attack and she had that bag fashion, she had the another procedure to reverse the ileostomy, that's get rid of the bag, re-establish intestinal continuity. Now, before that operation, she did have cardiac, what I would call an appropriate cardiac assessment for an elderly smoker, which is called echocardiogram and a dopamine stress test, and that's - that would be a standard way of assessing somebody prior to an anastomotic who had these problems. Unfortunately, in this particular situation, the horse had bolted somewhat in that she'd already had a heart attack and it would have been much more appropriate to do it before her initial operation before a minor operation done subsequently.

D COMMISSIONER EDWARDS: In your report you say that the resected specimen was 71 centimetres long?-- Yes.

Would you like to comment on that type of resection?-- I've paid a lot of attention to the histology reports for exactly

that reason, because they're quantifiable and because they often don't necessarily tally with what Dr Patel has written down. People's colons, that's the large bowel, vary in length and an average length would be one to 1.5 metres. Removing something that's 71 centimetres is - does not, would not formally constitute a total colectomy but it is possible to have a short colon, but again, yes, the reason I included that in the letter was that it was a bit odd.

Did the pathology show the polyps that he said that were there?-- Yes.

Thank you.

COMMISSIONER: In both Mrs Swanson's letter and in a few of the others you use the abbreviation GORD?-- Gastro Oesophageal Reflux Disease.

Right.

MR ATKINSON: Doctor, can I leave the patients there and take you back to your statement, and I want to take you to paragraph 13 of your statement and I want to deal just briefly with an application you made for a university position?-- Yes.

Can I show you this document but don't look at it just yet if you don't mind, and I'll hand up copies for the Commissioners. Doctor, I understand that the position, just to shorten things is this: that in about September 2003, Professor Birks from the university approached you and suggested that there was a position as an academic in surgery at the university in Bundaberg and they were after a good candidate?-- Mmm.

And they wanted you to apply?-- That's right.

All right. And there's a letter you'll see before you, there is a letter that was actually gone to Dr Keating at the hospital rather than to you; did you receive a letter like that?-- I think so, it's a couple of years ago, but I certainly got the - I was aware of the gist of this, I think I did, I'm not sure if it's on file or not, but, mmm-hmm.

Now, the second, the next page contains a position description?-- Mmm.

And it's a half time position?-- Yep.

And you receive a salary of - the person who is successful receives a salary in the order of $80,000?-- Yeah.

Depending, interestingly, on whether or not they're a specialist in the relevant discipline?-- Yeah.

Then when one goes - you've seen that position description?-- I have.

All right. And then a number of pages over one sees the

selection criteria on the last page. Some are threshold or essential issues and some are desirable?-- Yeah.

Two of the threshold ones which immediately stand out are that you need to be a registrable fellowship of a learned college?-- Yes.

You of course had that?-- Mmm.

In 2003 you had it for six years?-- Yes.

Another is that you need to have knowledge and understanding of the challenges facing rural and regional Australia?-- Yes.

You'd had that because you'd worked for five years?-- I thought I was a good candidate for the position which is why I applied.

Right. There were only two applicants?-- Mmm.

Yourself and Dr Patel?-- Yeah.

And there were only three people on the selection panel?-- There may have been, I met Dr Keating and one other person, I'm not sure who that person was.

There may have been a Peter Bore I think his name was?-- Perhaps.

And perhaps Professor Birks as well?-- He'd retired at that stage, he certainly wasn't present in the interview.

All right. You went for the interview?-- Yes.

You made a presentation?-- Yes.

You didn't get the job?-- Correct.

All right. It's clear now, of course, that Dr Patel didn't have a fellowship?-- I didn't have any information about that at all.

No, and you're not aware of any discussions at the time?-- I certainly wasn't aware of any of those issues, that's for sure.

All right. And at that stage he'd been in the country six months?-- Yeah, I'll take your word for it, I'm not sure exactly when he arrived, mmm, but he had certainly not been on staff very long.

Were you told why you weren't successful?-- No.

Did you subsequently apply for the same position?-- After Dr Patel left the country, that is, earlier this year in April, I made inquiries again with the current Dean, a fellow called Steve Margolis, and asked him what the actual, what the situation was with teaching of surgical undergraduates, and he

referred me back to Dr Keating. We had an informal discussion if his office about the future of the teaching position but I mean, I was interested then and am still interested - well, actually I'm doing it now, I'm teaching undergraduates.

In the last paragraph of - last sentence of paragraph 13 you say that Dr Keating told you that, "If you were to be appointed, some arrangement would have to be made with the Base so that they did not lose money that they had been receiving."?-- That's correct.

Did you understand what that all meant?-- Well, I certainly - I inferred, based on a number of other things that I'd heard, and it was confirmed by Dr Keating at that meeting, that the money - that wage or that salary, rather, of $80,000 odd was paid to the Base Hospital and offset against Dr Patel's salary.

Because his temporary work visa only permitted him to work for the hospital so he couldn't be employed by the university?-- I'm not exactly sure what the details were but he didn't receive that money directly, the money was paid to the Bundaberg Base Hospital as a private surgeon. As a VMO, if I'd been appointed, that money would have come directly to me, not to the hospital.

Yes?-- And the - in the conversation that I had with Dr Keating in his office, which was of a very general nature I might say, about what is possible to happen in the very difficult circumstances of this whole thing blowing up, he made the point that an arrangement would have to be made so that the hospital didn't lose that money which they were currently getting from the University of Queensland.

Commissioner, I tender those documents.

COMMISSIONER: Yes. The correspondence from the University of Queensland of 15 September 2003 - before I come to Exhibit 253 - 252 will be the statement of Dr de Lacy and attachments.

ADMITTED AND MARKED "EXHIBIT 252"

COMMISSIONER: And then 253 will be the letter from Associate Professor Birks of the University of Queensland to Dr Keating of the Bundaberg Base Hospital of the 15th of September 2003 together with the attachments thereto.

ADMITTED AND MARKED "EXHIBIT 253"

MR ATKINSON: Thank you.

D COMMISSIONER EDWARDS: Commissioner, I am Chancellor of the University of Queensland, I have nothing to do with any appointments of this nature.

COMMISSIONER: Thank you.

MR ATKINSON: Doctor, before I make you available for cross-examination or let you go home, depending on how things play out, can I ask you some general questions?-- Yes.

The Commissioner asked you some questions earlier about the Area of Need policy?-- Yes.

Is it the case in your experience that there is trouble getting doctors to work in regional areas?-- Well, the short answer is yes. The long answer is that I've worked in a number of them and they're all faced with similar problems which is the competing for the services of specialists who can basically work wherever they want and failing to attract them because the paying conditions are uniform throughout Queensland Health no matter where you're working and the attractions of the big city verses the rural and regions, it's not confined to health, it's a problem with provision of services in those situations. The outcome is that these rural and regional parts of Queensland have to apply under an Area of Need scheme to get easier access to largely, and by no means only, inferior people, inferior personnel, a lot of them are fantastic, but a lot of the others are people who can't find work in other circumstances, and some of these things or some of these disasters follow, they're put in - the individual specialists or deemed specialists are put in the most difficult situations with no support. The medical administrators are caught in a - the bind of having to provide services that are, with a limited, very limited budget and it sort of results in these kinds of disasters, or at least the potential for these kinds of disasters to occur if there is a particular mix of personalities like there has been in Bundaberg.

COMMISSIONER: But doctor, accepting every word of what you just said, the fact of the matter is that Bundaberg has actually succeeded in attracting some exceptionally good Australian specialists of which you are one example, and I've mentioned earlier some of the others?-- Mmm.

But your services have been spermed by the hospital?-- Pretty much. That's the situation. When I first applied, I was told that those positions were filled and that another general surgeon was a low priority. I certainly formed the opinion that at that stage that there was a ticking box, a face in the frame and that that was what was - that that was largely all that was necessary, not only but they - there's a limited amount of money. I mean, let me say, I feel very sympathetic for the difficulties of administrators in these circumstances who are asked to rely on such nebulous qualities as a strength of character and honesty with no administrative or legislative support. I mean, they're in a difficult situation and these

things, in my opinion, are bound to happen and have happened in my experience to a much lesser extent in other rural and regional situations.

Doctor, my concern though is this, and in a sense we've already addressed this in an interim report, but it seems to me the situation you describe is the result of a misapplication or one might even say a perversion in the way in which to the Area of Need scheme is intended to operate?-- Yeah.

Because the scheme presupposes that there are not Australian-trained doctors available to work at the hospital, but from what I've heard, not only from you but from other surgeons who are available in Bundaberg, you were quite willing to make yourselves available to work at the hospital, you even volunteered to do so and you were turned away?-- That's - there were some special circumstances there apply to Bundaberg which do not apply to the rest of rural and regional Queensland, but the framework that that specific problem was built on was that the principle that Queensland Health has applied for many years is to push people into the peripheries by anchoring their provider numbers to a region or to confining their practice to one hospital only, the push principle, instead of making those places attractive to work in for, you know, not just locally trained people but good people who could work in the metropolitan circumstances if they wanted to but prefer to work in those, in regional Australia for a variety of reasons, the pull principle. And this is a very different way of sort of approaching the same problem, making the jobs attractive rather than accepting that the jobs are unattractive for a number of reasons and forcing people to go out there. Inevitably, you're going to generate people of the quality of Dr Patel.

Well, one of our Terms of Reference requires us to consider what can be done to attract more Australian-trained doctors to regional and rural areas throughout the State?-- Yes.

One of the points that has emerged, particularly from the evidence we heard in Townsville earlier this week, is that Queensland Health traditionally doesn't permit a hospital to advertise a position for a specialist to come to a particular locality to work as a VMO and to have a private practice as well?-- Yes.

In other States we've heard - and Victoria is one example - a hospital will advertise, "Come and work in, shall we say, Ballarat as an ophthalmologist, you'll be paid X dollars to work two days a week at the hospital and you'll have the opportunity to work in private practice as well."?-- Yes.

One gets the sense that there's been quite a deliberate strategy by Queensland Health not to encourage VMOs to or people who could act as VMOs to move to country locations preferring to have full time staff specialists and particularly the most malleable full time staff specialists who are the ones from overseas that simply aren't allowed to

work anywhere outside Queensland Health? Generally I would agree with that's been my experience, I'm not sure whether it was a deliberate policy but it was certainly, you know, an obvious effect of the policy that has been in place for the last 15 years.

Well, let's take your example, doctor. You chose, presumably for personal or family or lifestyle reasons, to move to Bundaberg?-- Mmm.

And I imagine that there was some, some risk involved in doing that, you didn't know whether you were going to have a successful practice, you didn't know whether you were going to get visiting rights at the local hospitals and so on?-- Mmm.

Had there been an advertisement in the Courier-Mail saying, "Come to Bundaberg as a surgeon, we'll give you two days work a week and pay you a retainer of say, $80,000 for those two days' work."?-- Mmm.

"And have the opportunity to work as a private specialist the other three days.", presumably that would have been an incentive for you to move to Bundaberg?-- It - in general, I think, and it certainly would have been an incentive for me personally, yes, if that's what you're asking.

I'm seriously concerned that there may be specialists who are not only in Queensland but in other parts of Australia, who would be very interested in coming to particularly the coastal provincial centres in Queensland, who are reluctant to make that move for the obvious reasons but who could be encouraged to do so by a pro-active employment program from Queensland Health rather than the sort of program we've seen in the past?-- The concept of incentivising these jobs isn't really counter to what Queensland Health has been pracitising for the last 15 years, which is to make it a uniform award across the board, which inevitably acts against people, against specialists deciding to go to the country for all of the social reasons, schooling, you know, restaurants, all of the reasons that it's difficult to get anybody to go to the country. These people who in general can choose, choose not to go.

And it needn't cost anymore. The example I gave of a sort of guaranteed income of 80 ,000 a year for sort of two days' work-----?-- Yes.

-----would be almost cost neutral as compared with employing - putting on a full-time staff specialist on 200,000 a year?-- I'm not really in a position to make those assessments.

Mr Atkinson.

MR ATKINSON: Doctor, you've worked in the city and the country. You've worked privately and in the public sector, Queensland and interstate?-- Yes.

Is there anything else you want to say about Queensland Health, the public health system, Dr Patel generally?-- I've done all those things, as you've mentioned, but I currently live in Bundaberg and Bundaberg isn't just an example of what's happening elsewhere in the State, even though it is that as well. Terrible things have happened there, not just to these people that I've mentioned today but to many others, many others, and in a community of less than 100,000 people, it really - it amounts to a - you know, to a tragedy. And that, I'd like to or I hope that whatever changes are mooted for Queensland Health, can start in Bundaberg because though it's obvious that there are problems elsewhere, Bundaberg is where the patients have died and where all of these complications that I've listed and many others have occurred. And the problems of attracting staff to the regions and rural Queensland is nothing compared to the problems that Bundaberg Base Hospital specifically is going to have to attract people after all this. So it's going - it is an acute, specific, urgent problem in Bundaberg right now and if it can be used as a case study, as a first step towards, you know, ameliorating the problems which are statewide, it would be, you know, a very good thing for the community and for the - for all of us who have been trying to help put these things right which I understand we are all working hard to do. So that's my parting word.

Thank you. That's the evidence-in-chief, Commissioner.

COMMISSIONER: Now, Doctor, do you have a plane to catch?-- No. Oh, I do, but not tonight.

I was going to ask, whether Ms Gallagher has any-----

MS GALLAGHER: Nothing, thank you, Commissioner.

COMMISSIONER: Does anyone at the Bar table wish to commence cross-examination?

MR ALLEN: I'm content to start and conclude in a short time rather than leave it for another day but I'm in the Commission's hands.

COMMISSIONER: Look, that's fine with me, although I'd like to offer Mr Diehm the first chance if he wishes.

MR DIEHM: I don't wish to, Commissioner. I'd prefer to do it in one go and after I've had access to some further documents.

COMMISSIONER: I think in fairness I'm bound to say that as the evidence stands there are some potential reflections on reply, so that if you wish to avail yourself of the opportunity to challenge Dr de Lacy's testimony relevant to those matters, you should have that opportunity to do so even if you're not in a position to deal with clinical questions which arise.

MR DIEHM: I appreciate that, Commissioner, but there is some overlap between the two and that's the reason why I'd rather leave it until the later occasion.

COMMISSIONER: As you please.

MR DIEHM: Thank you.

COMMISSIONER: Mr Allen.

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Dr de Lacey, my name is John Allen and I'm representing the Queensland Nurses Union. You spent two years as a director of the surgical department at the QEII Hospital?-- Yes.

And then following that, about two and a half years as a locum surgeon at Broken Hill and other New South Wales regional centres?-- Yes.

Was there any - I don't need the details but was the move from

Queensland to New South Wales because of personal or family circumstances?-- Personal.

And are you able, given that experience and also the time you spent as a locum surgeon at Maryborough and Hervey Bay, subsequently to draw any useful distinctions between Queensland and New South Wales public health systems in relation to perhaps, firstly, resourcing or staffing?-- Not in any but the most general way, that there were problems with both systems. I'm not sure exactly what you're getting at specifically but that there were - there were difficulties with the system as it existed in New South Wales as well. Certainly nothing of the magnitude that I've observed in Bundaberg but, I mean, I couldn't - I'm not really in any position to sort of, you know, make those sort of judgments. What I can say is that the medicine was exactly the same sick people and sort of trying to get them sort of access to, you know, curative surgery, working around whatever system was in place.

Okay. So there weren't any great demographic differences between, say, Bundaberg, and any of the New South Wales centres you worked at in relation to the type of patient who'd present, their acuity, et cetera?-- Oh, no, Broken Hill was an interesting experience. That was isolated medicine. So that was different. There were more Aboriginals. In fact, they were all unique. So there were some specific differences but in most of the circumstances where I was working, I was working as a staff surgeon, that is, on-call for acute patients, and running elective lists and outpatients and that tends to be the same not just in Queensland and New South Wales but it's around the world.

Did you find that you worked harder at, say, QEII than in, say, New South Wales or was it much of a muchness?-- I worked much harder at QEII than in Broken Hill. I had administrative responsibilities on top of a full-time surgical job.

Were you paid much better at QEII than you were in New South Wales?-- No, I was better in New South Wales.

So in Queensland, you work harder to get paid less?-- Judging by my own act, which is worked at a couple of regional centres in New South Wales and the similar in Queensland, so I can tell you roughly what my experience was but, really, it is going to be impossible for me to make sweeping statements comparing the two health systems that just have different-----

But what you're saying is you worked much harder at QEII?-- I was Director of Surgery. If I was - I was a Director of Surgery at QEII and I was working - I had a full-time clinical load, that's eight sessions a week, and in my spare time I was running the department. That was hard work. If I'd not been director and was working just as a staff surgeon, I would have worked less harder.

In relation to your observations of the type of workloads that nurses handled, equivalent nurses in Queensland and in New

South Wales, did there seem to be any great distinction?-- Not - if they were, they weren't obvious to me. I mean, I'm really not privy to the way that they're rostered, you know, how many hours they're expected to work a week. That's not - not really part of my responsibilities, and it wasn't grossly obvious although there may have been quite big differences that weren't obvious to me.

Okay. But nothing you could perceive which would explain why a nurse in Queensland might be paid 15 per cent less than the equivalent in New South Wales?-- No, I'm just - I'm honestly not in a position to make those sort of judgments.

Okay. You were a locum at Maryborough and Hervey Bay?-- Yes.

Up until April 2003?-- I think so, yeah, just past that.

And, of course, you moved to Bundaberg in, what, about June 2003?-- Yes.

And did you have any consideration at all at the time that you were thinking of making the move from being a locum at Maryborough/Hervey Bay-----?-- Mmm.

-----to whether or not you might be willing to take another position in the public health system if it was there?-- I actually assumed - I was recruited to start a private practice in Bundaberg. That was the prime - that was the motivation for the move and why I'm there anyway and I must admit, when I was making my arrangements, I assumed that I'd be working in the public system. I'd been doing that for 15 years or more in various capacities, consultant, registrar, resident, and that's the standard sort of way that specialists practise. You know, it is shared between public and private. I didn't - honestly, I didn't expect to not be working in the public system, you know, until I - until I'd had the interview with the hospital.

I was wondering whether in early 2003 you became aware at all that the Bundaberg Base Hospital was looking for a Director of Surgery as a full-time position?-- I was aware of it on the grapevine, yeah.

But it wasn't a position that you were interested in at that time?-- No.

Just one other matter. You were asked some questions this morning about a situation which, if you'd confronted as a surgeon, where a patient appeared to be experiencing significant pain during a procedure under local anaesthetic?-- Yep.

That you'd reached the situation where you'd basically put down your scalpel and not continue. Do you recall those questions?-- I do, yep.

Now, obviously there's certain risks associated with general anaesthetic?-- Mmm.

Which means that for certain procedures, local anaesthetic is preferred?-- Yes.

Obviously, if you were to go by way of general anaesthetic, there'd be no problem, if appropriately administered, in a patient writhing around or experiencing pain?-- Certainly no problem with them moving.

But there's some very good reasons why some procedures are carried out under local rather than general anaesthetic?-- Yes.

And it's true that different persons have different levels of resistance to pain?-- That's correct.

It's a very subjective thing in many people?-- It is.

And-----

COMMISSIONER: And different patients have different levels of - to which anaesthetics are effective, particularly local anaesthetics?-- Also true.

MR ALLEN: Some patients, because of their particular circumstances, such as being dependent on analgesics or other drugs, might not get the same effect from anaesthetic as others?-- That shouldn't affect local anaesthetic but it does - as a general statement, that's correct.

And I suppose if you're in the middle of a procedure as a surgeon under local anaesthetic, where you're either halfway through excising some type of growth from someone or halfway through stitching up a wound, it might be a difficult decision as to whether you simply stop halfway through and leave the procedure unfinished?-- Often difficult but the other side of that is that you're faced with that every day. Those sort of decisions are exactly what you're paid to do; to make them to the best of your ability. Local anaesthetic can have serious side-effects. General anaesthetic can have serious side-effects. Omitting the local anaesthetics can have side-effects. All of them, you balance the risks and benefits to the patient, assess the patient. It largely depends on the specific detail of the situation, and people who are well trained and approaching it from, you know, the right viewpoint tend to do that better than people who are poorly trained, slapdash or not approaching it, you know, with goodwill in general.

I suppose a very capable surgeon such as yourself might come across a situation where they make a decision to insert the five sutures even though the patient is complaining that they can - they're experiencing pain through the insertion of the first suture?-- Potentially I can envisage a situation where that would be true.

Because you want to get that incision closed and you know it's only going to take a few minutes?-- That decision may be the

right decision or the wrong decision depending on the details, but it certainly could be the right way to go.

Yes. Thank you.

COMMISSIONER: Thank you, Mr Allen. No-one else wishes to go ahead at this stage? Doctor, I'm afraid we are going to have to trouble you on another occasion. Can I make it clear that from day 1 of this inquiry we have been anxious wherever possible to minimise inconvenience to practising members of the medical profession and other health care professionals and we're very conscious of the fact that as a private clinical practitioner, the inconvenience to you is particularly acute. Can I say that I'd encourage you to liaise with counsel assisting to see how we can minimise the disruption. By way of example only, we're quite comfortable about sitting in the evening if you'd prefer to come up at lunchtime and have, in a cricketing sense, a day/night session. There is also the possibility that there is a potential witness in Bundaberg that we may have to go up and see at some stage and if that were to happen, we might have to schedule you on a day that suits you in Bundaberg. But please keep in touch with Mr Atkinson and try and work out what will inconvenience you the least?-- Thank you.

MR ATKINSON: Commissioner, there's just three administrative things that concern Dr de Lacy.

COMMISSIONER: Yes.

MR ATKINSON: The first is of these 151 patients he's identified, I'm not sure whether my friends require that every single patient file be made available in advance of his cross-examination. So that's the first issue. As I intimated, the same issue is with Dr Woodruff, who will be made available next week.

COMMISSIONER: What is the position?

MR DIEHM: Well, for my own part, Commissioner, I would have thought that - what would meet my convenience would be for me to be able to contact counsel assisting and nominate documents that I would like access to for the purposes of cross-examination. For instance, with Dr de Lacy, I neither want nor need every patient record relating to what he's discussed. I will have to give some consideration as to just exactly what it is that I do need.

COMMISSIONER: But obviously you can't leave that till the day before the witness is going to return and I think everyone has had Dr Woodruff's report for over a month now so you should be able to work out what, if any, of the files you need.

MR DIEHM: In the case of both witnesses, I will contact counsel assisting on Monday morning and let them know what it is I'm looking for.

COMMISSIONER: That would be splendid.

MR DIEHM: Thank you.

COMMISSIONER: Anyone else? Mr Devlin?

MR DEVLIN: Yes, I'm in a similar position. The judgment will have to be made what patient files are likely to be required to have questions asked. I'll try and get that request to counsel assisting as soon as I can.

COMMISSIONER: All right.

MR ATKINSON: Two other things then, Commissioner. One is that Dr de Lacy has explained to me that what he could do is an entire list of every single adverse outcome for every single patient but it would take him at least an entire day away from his practice and unless I'm pressed by the parties to do that, I'd rather not put him to that trouble. It seems to me that he's given illustrations and identified patterns and he doesn't need to be exhaustive.

COMMISSIONER: I'm inclined to agree with that. Whatever happens at the end of this inquiry, it was quite impossible for us to give a definitive account of every adverse result and there is nothing in our Terms of Reference that would make that either necessary or appropriate.

MR ATKINSON: No.

COMMISSIONER: The sort of evidence we have heard today is I think the sort of evidence that is relevant to our satisfying ourselves whether or not Dr Patel was a menace to society and I think that really satisfies the relevant purpose under our Terms of Reference.

MR ATKINSON: The last thing then, Commissioner, is then I had given some thought to the cross-examination happening via telephone. I suspect it can't happen that way because there may be many, many documents that my friends need to show Dr de Lacy.

COMMISSIONER: I think that's right, sadly.

MR DEVLIN: Yes, I'd say that's correct.

MR ATKINSON: Yes.

COMMISSIONER: I did raise the possibility that we may have to go to Bundaberg in any event for one witness. How does that matter stand at the moment?

MR ATKINSON: That seems more likely than not. I have spoken to - we have spoken to the party who would have the keenest interest in that witness and that party isn't prepared to have that particular witness give evidence by telephone. The witness is saying he's not prepared to come down, so that third-----

COMMISSIONER: And the witness has medical reports indicating that there are valid reasons for not coming down.

MR ATKINSON: There are - yes, he does is the short answer. He may have some problems with us coming to him. But he has consented to telephone evidence but, as I say, that's not acceptable to one of the parties.

COMMISSIONER: From what I know of that matter, I think that that's perfectly appropriate, that parties concerned shouldn't be forced to accept telephone evidence on that critical issue. Well, I think we should work, if at all possible, towards a Monday or a Friday in Bundaberg and do our best to-----

MR ATKINSON: Pick up Dr de Lacy.

COMMISSIONER: Well, to suit Dr de Lacy's convenience, again bearing in mind the possibility of sitting in the evening or, if you prefer, starting early in the morning and trying to finish by lunchtime?-- I spent my Fridays talking about nothing but Dr Patel and have done for the last four months, so I'll be - I'll make myself available if I have to and a Friday would be - would suit me fine. Whether at another time, you know, I would like to help.

Well, we might work, for example, towards Friday fortnight - today fortnight.

MR ATKINSON: There's some people scheduled for that date, in particular Dr FitzGerald, but we can work towards that.

COMMISSIONER: You work it around, Mr Atkinson, and let me know.

MR ATKINSON: I will, I will, Commissioner.

COMMISSIONER: Thank you. Anything else anyone wishes to raise before we adjourn - it is Monday, is it?

MR ATKINSON: Yes, and the witness order on Monday will be Jenkins, Tathem, Ray.

COMMISSIONER: Okay. Good. That's Dr Jenkins, isn't it?

MR ATKINSON: Sorry, yes, Dr Jason Jenkins.

COMMISSIONER: He's a vascular surgeon.

MR ATKINSON: Yes.

COMMISSIONER: And Dr Ray.

MR ATKINSON: He is a vascular surgeon as well. And Mr Tathem.

COMMISSIONER: Yes, thank you. All right. We will adjourn now until 9.30 a.m. on Monday morning.

THE COMMISSION ADJOURNED AT 4.52 P.M. TILL 9.30 A.M. ON MONDAY, THE 8 AUGUST 2005