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Transcript of Proceedings

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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 11/08/2005

..DAY 39

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THE COMMISSION RESUMED AT 9.32 A.M.

COMMISSIONER: Mr Morzone?

MR MORZONE: If it please, Commissioner, today's witness is Martin Louis Carter who is and was the Director of Anaesthetics at the Bundaberg Hospital. I call him to the witness box.

COMMISSIONER: Just before you do, is Dr Carter expected to take the whole day?

MR MORZONE: I think he probably will take most of the day at least anyway.

COMMISSIONER: I was just a bit concerned because we really do have to - we're under time pressures.

MR MORZONE: Yes.

COMMISSIONER: Mr Boddice, there was a suggestion Dr FitzGerald might be able to return this afternoon for at least some of his cross-examination. Would that be-----

MR BODDICE: I'll make some inquiries. I was told he was coming tomorrow, but I'll make some inquiries.

COMMISSIONER: I think Friday is the current schedule.

MR BODDICE: Yes. I'll certainly make some inquiries about this afternoon and we'll try to accommodate that.

COMMISSIONER: Thank you for that. Yes?

MR MORZONE: I think obviously if there is someone else available, Dr Carter's evidence is pretty extensively covered in his statements and matters that go beyond that can be confined. So we can cut our cloth to suit if Dr FitzGerald is available.

COMMISSIONER: We'll see how we go anyway. Dr Carter, would you be kind enough to come forward to the witness box?

MS GALLAGHER: If the Commission pleases, I seek leave to appear for Dr Carter.

COMMISSIONER: Thank you, Ms Gallagher. You have such leave.

MS GALLAGHER: Thank you.

MARTIN LOUIS CARTER, ON AFFIRMATION, EXAMINED:

COMMISSIONER: Mr Morzone, do we have statements of the doctor?

MR MORZONE: There are amendments to the statements that you would have had which are being copied now, Mr Commissioner, so you'll have them in a moment.

COMMISSIONER: Thank you. Dr Carter, please make yourself comfortable. Can I ask whether you have any objection to your evidence being filmed or photographed?-- None at all.

Thank you, doctor.

MR MORZONE: Doctor, your full name is Martin Louis Carter?-- Correct.

You are-----

COMMISSIONER: Is that L-E-W or L-O-U?-- -L-O-U-I-S.

MR MORZONE: You are currently the Director of Anaesthetics and Intensive Care at the Bundaberg Base Hospital?-- That is correct.

And you've been in that position since about the year 2000. Is that correct?-- No, I came to Bundaberg in 2001 and I became director about a year later.

Prior to that, in your statement you've set out your qualifications and experience, which I can briefly summarise as being that you graduated with a Bachelor of Medicine and Bachelor of Surgery from Newcastle upon Tyne in the United Kingdom-----?-- Correct.

-----in 1974. You worked in the United Kingdom for several years before obtaining your specialty as an anaesthetist in 1981 in the United Kingdom?-- That is correct.

You're now a Fellow of the Australian New Zealand College of Anaesthetists and also a Fellow of the Faculty of Pain Management of the Australian and New Zealand College of Anaesthetists. Is that right?-- That is correct.

Before you came to Bundaberg you worked in Darwin at the Darwin Base Hospital for about five years?-- It's actually called the Royal Darwin Hospital.

Right. And prior to that you'd spent several years as an anaesthetist in the UK army?-- Correct.

Now, a statement has been prepared in this matter by you and you've made a number of corrections to that statement and copies of that statement are now being photocopied for the parties. Is that statement with those corrections that we'll

see in a moment true and correct to the best of your knowledge and belief?-- That is so.

And are the opinions which you express in there opinions which you truly hold?-- Correct.

Okay. Now, can I ask you-----

COMMISSIONER: Mr Morzone, just so that the record's straight, we don't physically have copies of the statement, but we'll give it Exhibit 265.

ADMITTED AND MARKED "EXHIBIT 265"

MR MORZONE: Thank you, Mr Commissioner.

MR BODDICE: Commissioner, for our part, we don't have a copy of the corrections.

COMMISSIONER: Neither do we, Mr Boddice.

MR MORZONE: No-one does.

COMMISSIONER: I'm sure you'll have them as soon, if not sooner than we do.

MR BODDICE: Thank you.

MR MORZONE: Before Dr Patel arrived, you have said in your statement that when you first arrived Dr Nankivell was the Director of Surgery, and the Director of Medical Services was Dr John Wakefield, and he was then followed by a number of Directors of Medical Services including Dr Nydam and then later Dr Keating?-- That is correct.

Dr Keating arrived soon after Dr Patel?-- Yes.

After Dr Nankivell left as Director of Surgery, Dr Anderson was the director. Is that right?-- No, that is one of the corrections that I made. Dr Anderson preceded Dr Nankivell.

And who succeeded Dr Nankivell?-- Dr Sam Baker.

Now, during the time when those persons were there, that is the Directors of Surgery, are you able to comment on what the standard of surgery was like at the Bundaberg Base Hospital?-- It was very good for a regional centre.

And what was the moral like at that time?-- Moral - I must say I can only compare it to what I had experienced in Darwin. I think it was not as good as Darwin. I think trying to compare the English experience with the Australian experience would be inappropriate.

Did, first of all, the standard of surgery change after - or over the years through to when Dr Patel left, in your opinion?-- Overall the standard of surgery did not really change, no.

And what about the moral of the hospital?-- I think the moral went down because we were being more financially driven than at the time when Dr Nankivell was the director.

And is that a consequence, do you know, of changes in the Department of Health policies or was it particular to Bundaberg?-- I can't speak for anyone else apart from Bundaberg, so I can't really answer the question.

Now, after the arrival of Dr Patel-----

COMMISSIONER: Mr Morzone, just before we come to that, you describe the standard of surgery as good for a regional hospital in the earlier periods. Which surgeons were you working with at that stage?-- At that stage I was working mainly with Dr Nankivell, and especially Brian Thiele, who was quite an excellent surgeon.

Was Dr Baker performing any surgery at that time?-- Dr Baker came back after Dr Nankivell left. He took over as the director and he was doing a different sort of surgery to what Dr Nankivell did. He was more interested in laparoscopic work. He was more interested in some of the more technological advances in surgery.

There are a couple of other surgeons who have been mentioned in evidence - Dr Anderson, for example. Did you work with Dr Anderson over that period?-- I still work with Dr Anderson in his role as a VMO urologist.

Right. I think we've heard of Dr Kingston as a visiting surgeon?-- Dr Kingston has recently retired and he was doing very minor surgery mainly.

Thank you.

MR MORZONE: Now, you also expressed before that in your opinion the standard of surgery during Dr Patel's time didn't change much. Is that right?-- On the whole when he was doing the more routine work his standard of surgery was as good as anybody who had been there previously.

And the qualification that you've added there about routine work, do I take it from that that in complex surgery, including oesophagectomies, there was concern on your part?-- Basically his surgical technique for oesophagectomies I saw only on one occasion, and that was the first of the oesophagectomies that he did there. It was after the last of the oesophagectomies that I decided he'd crossed the threshold into an unacceptable standard and I could take this, with Dr Berens, who'd actually anaesthetised the case, to Dr Keating with my concerns.

Okay. I want to come to that case later, if I can. Can I ask you to go back to the arrival of Dr Patel. In paragraph 11, at least of your previous statement, you stated that when he arrived he was appointed to the position of Director of Surgery. Did you know Dr Patel as occupying any other position other than Director of Surgery?-- He came initially, I gather, as a staff surgeon and the position of director being vacant, he was given the position. I don't know what the thinking behind that was or the evidence for that was.

Do you recall when he first arrived and him being introduced to you for the first time? Do you recall that?-- Not specifically.

Do you recall how soon after he arrived he was introduced to you approximately?-- It would have been pretty soon after he arrived. It would be February/March of 2003.

Within a matter of days?-- It would be very soon, because he would have had to come up to theatres and look around the place and therefore be introduced to us.

And at that time when he was first introduced to you, was he introduced to you as the Director of Surgery or did that come after the first occasion?-- I can't recall.

You can't recall. Okay. Did you know at that time that the nature of his registration was as a senior medical officer and not as a specialist?-- No.

What was your understanding at that time as regards his qualifications and the nature of registration?-- It was never discussed with me.

COMMISSIONER: Doctor, I think we've heard a suggestion - I'm only going from memory on this - that Dr Patel and another doctor arrived at about the same time. It might have been Dr Gaffield?-- Dr Gaffield arrived at about the same time, yes.

And it had originally been intended that Dr Gaffield would become Director of Surgery, but a decision was made that because Dr Patel had - or claimed to have more experience, he was given the superior position. Are you aware of anything along those lines?-- No.

MR MORZONE: You state in paragraph 12 and 13 that there was practically no-one in a position to supervise Dr Patel's surgical skills. Other surgeons of a senior kind were visiting, and you say at paragraph 13 that as an anaesthetist yourself, and the other anaesthetists were not in a position to supervise surgery. Is that right?-- That is correct.

Why is that? There would naturally perhaps be a view that anaesthetists are in a good position to observe surgery, but is your training different, is it?-- Certainly. My training, as with all doctors, is to go through medical school, do what would over here be called an internship and then move on to

specialist training. If I was going to be a specialist surgeon, I would be sort of trained off in one direction, and as a specialist anaesthetist I've gone in another direction. The fact that we both share the operating theatre doesn't mean that we necessarily understand what either of us is doing.

Perhaps I can ask you this question first: did you at any time before Dr Patel left know he had been restricted in Oregon, USA, from performing surgeries involving the pancreas, liver resections and other operations?-- No.

At no time before he left in April 2005?-- The first I heard of it was in the press.

Right.

D COMMISSIONER VIDER: Doctor, in paragraph 12 of your statement you say, "There was no-one in the position to supervise Dr Patel's surgical skills." Is that in reference to your understanding of him as a senior medical officer?-- It's an understanding to his position as Director of Surgery within the hospital and there being no other full-time surgeon with what he alleged was his level of training. Dr Gaffield is an excellent plastic surgeon, but he will defer to Dr Patel's skills as a general surgeon.

Would you have an expectation that a Director of Surgery would require supervision?-- I would hope not. Within a larger hospital then you might have a Chairman of Surgical Division, which would include orthopaedics and all the other sort of surgical specialties, and they would be in a position to supervise. But a hospital with two full-time surgeons, no.

COMMISSIONER: To your knowledge was there any credentialling process undertaken before Dr Patel commenced surgery?-- Is that general to the hospital or is that specific to Patel?

Either?-- The answer is no to both.

Right.

D COMMISSIONER VIDER: Were you credentialled by a committee-----?-- No.

-----that you were aware of? No.

COMMISSIONER: Does that differ from your experience in Darwin or at other hospitals?-- In Darwin, before I was deemed as a specialist and given a provider number, I had to send paperwork to - I think it went to Adelaide, because South Australia seemed to have control over the Northern Territory's registration, and I actually got a piece of paper back saying that I was deemed a specialist from Adelaide.

But that would be different from the credentialling process that we understand exists in some hospitals where, for example, in surgery a surgeon's skills are reviewed and a determination is made as to which types of operations the

surgeon would be be capable of performing. Not only as a matter of the surgeon's own skill and experience, but also what the hospital's resources and facilities would support?-- That certainly wasn't taking place in Bundaberg. The experiences I had in Darwin were approximately 10 years ago, so the system there may well have changed as well.

Yes. Do you agree that at least in an ideal world, in a relatively small regional hospital, it is important to make a determination as to what standard of surgery can be performed both at the hospital generally and by individual surgeons working at the hospital?-- Certainly. But in a small area of regional Australia, who is in a position to actually do that credentialling?

Well, in this case you've told us about the fact that Dr Thiele, for example, was a very competent vascular surgeon. You had doctors like Dr Anderson, and no doubt it would be possible from Brisbane to make other specialists available to take part in a credentialling process if necessary, or do you see that as a difficulty?-- No, put that way, there's no difficulty at all to organise it for the surgical side.

Yes. Do you consider that that would be desirable?-- It sounds like an excellent idea.

D COMMISSIONER VIDER: Another way that credentialling can be organised, doctor, is also to utilise the medical practitioners of the various specialties from public and private where you have say a small provincial centre, and form the credentialling committee from both groups?-- I've had this discussion with our series of DMSs who have come through Bundaberg lately, and one of them actually suggested that it would be worthwhile getting the other directors to act as credentialling referees for each other. However, when I approached Dr Miach - who is our Director of Medicine - about that, he said he had absolutely no idea what I did as an anaesthetist and felt it would be unfair for him to comment upon me in my anaesthetic skills.

COMMISSIONER: And similarly, I suppose, you'd feel reservations about commenting on Dr Miach's specialty as a nephrologist or as a physician generally?-- Exactly.

So really what is required for a proper credentialling is a pool of people within the relevant specialty. If they're available locally, so much the better, but if they're not available locally, then one would expect people from Brisbane or other centres - possibly in the case of Bundaberg, maybe Maryborough or Hervey Bay or Gladstone or Rockhampton, but people from other centres to participate?-- That is - that sounds like a very good idea.

D COMMISSIONER VIDER: And the other way you can do it is have the group of doctors from various specialties in a smaller centre, but the particular specialist that's seeking to be credentialled, expert opinion is gathered from the college to which that particular specialist belongs and you have the

application assessed relative to the specialty that that person is acting in?-- Yes, which brings us back to what happened in Darwin and everything was referred to Adelaide.

Yes.

D COMMISSIONER EDWARDS: What form of official audit is done on outcomes of operations in a hospital at Bundaberg now?-- When Dr Anderson left, I gather they were using a system called Otago, which is a surgical audit system. I gather this was dismantled by Dr Patel, but they are in the process of rebuilding it. Professor O'Rourke, who is in the position of Director of Surgery at the moment, has reinstituted an audit system. Within the anaesthetic department we had Morbidity & Mortality Meetings once per month and discussed any problems that had come up and how we would handle those things in the future. So we had our own internal system. I assumed that the surgeon's had their own system, as did the physicians.

It wouldn't be an unfair recommendation to be considered by this Commission to consider that as a very essential part of any major hospital doing surgery of the type Bundaberg does?-- Certainly. One of the presentations I did to the Executive Council was to try and introduce the ILCOR system of audit into the hospital. This would be starting with trauma and cardiac arrests where it's very well useful for. It also can be extended into sort of surgical or medical so you have a uniform system of reporting across the hospital.

COMMISSIONER: Was it a matter of concern to you - you tell us that your understanding was that in Dr Anderson's time and prior to that the Otago system was in place and that was then dismantled when Dr Patel arrived, and I take it you weren't informed of any alternative audit system put in place?-- We were never part of the audit system on the surgical side. There was no standing invitation. There was no time made available for us to go and join with the audit. The surgical audit tended to take place on a Thursday lunchtime, and anaesthetists would still be involved in other cases on a Thursday - from the Thursday morning going into the Thursday afternoon. So there was no space made for us to actually attend these audits.

But so far as you knew, after the Otago system was dismantled, no formal audit system was put in place?-- I have no idea what formal or informal system was in place after that was ceased.

Yes.

MR MORZONE: Was it the case that morbidity and mortality rates within your department were discussed within a committee in the anaesthetics department, and that there may have been another committee within the surgical department, you don't know, that dealt with it from a surgical point of view?-- When you have a department that consists of about four people you don't have a committee.

I see that you mentioned in your transcript of interview to the CMC that you tried to raise mortality and morbidity rates at executive meetings that you attended. Do you recall that?-- I tried to get an open reporting of the morbidity and mortality rates.

And what happened to that suggestion? What was your suggestion first of all, and what happened to it?-- I can't remember exactly how it was phrased, but I was hoping to get the morbidity and mortality reports brought to the executive so that they could actually be talked about in open forum rather than keep everybody's bits of information separate. One of the problems I found with the administrative structure in Bundaberg was that we were so streamed that I was unaware of what was going on in surgery and I was unaware of what was going on in medicine, and equally they were unaware of what's going on in anaesthetics.

COMMISSIONER: Doctor, that sounds like a dangerous situation?-- It's proved to be.

Yes, thank you.

D COMMISSIONER VIDER: Would you attend - you're talking about the executive there. You're talking about the executive - the Director of Medical Services, the District Manager, the Director of Nursing, that meeting?-- I wouldn't know who was at that meeting because basically I wasn't part of it. The meetings that I got to were what's called the Executive Council. Now, there are separate meetings I'm aware of for the executive. There were separate meetings for leadership and management, and I wasn't involved with either of those and did not receive any minutes from either of those meetings, so I can't tell you what went on in them.

Thank you.

MR MORZONE: So the meetings where you tried to raise the general morbidity and mortality rates within the hospital was the Executive Council meeting?-- I took it to Executive Council and I took it to ASPIC as well.

Now, who comprised the Executive Council meeting?-- Executive Council tended - was District Manager, Director of Medical Services, Director of Nursing, the directors of the various hospitals specialties, including mental health. There was a distribution list that I wasn't quite aware of. Director of Corporate Services as well.

I don't know if you elaborated on the response that you got from the meeting as a whole when you suggested that there be this open reporting?-- I recall Dr Patel being against it, that they were doing their own audits and did not need other people involved.

COMMISSIONER: Did Dr Patel give any explanation as to why he opposed having, as it were, external scrutiny of their audit?-- Not that I can recall.

MR MORZONE: Whilst we're dealing with those meetings, do you remember any issue ever being raised at the Executive Council meetings about the competency of Dr Patel?-- No.

And - okay. He's referred to also being a member - and indeed you were the chairman, weren't you, of the ASPIC Committee?-- That is correct.

Were you Chairman through the whole relevant period of Dr Patel's employment?-- Yes

And that is a committee meeting of the anaesthetic and surgical wards, preadmission clinic, and intensive care ward, is that right?-- Correct.

And they occurred monthly?-- Normally, unless we were in quorate.

What was their purpose, generally speaking?-- That's a very difficult question to answer. I think various people had various views on what the purpose of the ASPIC committee was. It was functionally a clinic service forum, which is a suitably woolly term. We thought we had a remit to look at the goings on within those areas and discuss the various policies we wanted to introduce. The other things that were expressed to us as very important for ASPIC to deal with were patient satisfaction surveys, such as whether people thought they got a good reception in X-ray, or that the tea lady smiled at them when they did their meal. And we were told to go away with these pieces of paper and come back with recommendations on that rather than discuss the internal workings of the various wards and departments.

There were - there are two issues of relevance that we can deal with, perhaps, while we're dealing with the ASPIC meetings immediately. Evidence has been given of an issue having been raised by nurse Hoffman about the long-term ventilation in ICU at the ASPIC meeting of the 14th of April 2004, and I will just show you a copy of the minutes so that you have a copy in front of you. And it is exhibit TH11 to the statement of Ms Hoffman. I saw, I think, at some point you had some doubt about whether or not you were at that meeting. I am not sure that's still your position, but it notes you as having been present. Do you recall it at all?-- This is probably the standard sort of discussions we were having, yes. Item 02/031.1 is down under my name because we were introducing new forms that we wanted to disseminate amongst the ward staff to understand how we were going to manage peripheral regional anaesthesia with the various infusions that we were doing, patient care improvement we were introducing, and this is the sort of thing we should have been discussing. Again, we are here on the problems of consents not being performed, and that is sort of relevant to what we ought to be doing. Yes, I was certainly there at this particular one.

Okay. And do you recall the issue of ICU ventilation of patients, the extended ventilation of patients being an issue of concern to nurse Hoffman at that time?-- Yes, and I also raised it at the medical staff advisory committee and the report on the Department of Anaesthetics. I also raised it at the executive council.

And what was the concern, briefly, from your point of view?-- That we were basically doing more work, keeping patients longer and doing more complex patients, therefore increasing

the workload on the department.

COMMISSIONER: Were you also then, therefore, going outside the guidelines for how the Level 1 ICU should operate?-- Yes. I think Sister Hoffman deals with that quite well in her statement, annexure TH40, I think.

Yes. What reaction did you get when you raised it at the various committees that you have just mentioned?-- One comment that was made within the medical Services Advisory was is this affecting patient outcomes, can we check back on what has happened to these patients that have been kept longer, and I went away to start doing an audit on that, and I am afraid I got distracted by the clinical workload.

But, doctor, as I would understand it - and please tell me if I am wrong - the reason you have restrictions on the scope of work performed at a Level 1 ICU is to ensure that you have the capacity to deal with emergency situations as they arise. That's why you don't use all your ventilators at the same time. Whilst you only have patients there for 24 or 48 hours, you have spare beds for emergencies and so on. Is that generally right?-- That's the theory. The practice works out sort of very much differently. It is not always possible to get patients out in a timely manner. The retrieval service has a limit in its capacity in terms of the number of planes, the number of pilot hours, the number of doctors available, and they also have to prioritise what they do to assist us. If I'm trying to move a patient, shall we say, who has got a bad chest and will need long-term ventilation, that's not going to take priority over a seriously sick neonate, so we are stuck with these patients. Some of them it is appropriate for us to transfer, some of whom it's possible that with good phone consultation from Brisbane, that we can manage within the unit. So we don't always get the option of shifting the extra patients. We do have a third ventilator for just such emergencies, and unfortunately we have had to use a fourth at times as well, just simply because we are not in a position to move the patients that we have.

The point of my question was this, doctor: you were asked whether there had been an adverse impact on patient outcomes as a result of taxing the resources of the ICU, but it seems to me that's not entirely the relevant question. The relevant question is whether it mightn't have an adverse impact if you had all four ventilators going at the same time and suddenly there was an emergency situation, a road accident or a train crash, or just a casual emergency, you wouldn't have the resources to deal with that patient and that's why ICU should be run within its operating standards?-- I quite agree. Unfortunately, what you are saying is that we should be able to sort of shift these patients if we have to to make sure we do have this emergency capacity and if we cannot do that then we are already at the emergency capacity and other things have to sort of follow through from that.

I suppose that's part of what I am saying but I guess the other thing I am saying is that the surgical department

shouldn't be undertaking surgery of a very complex nature, particularly with very ill patients which is going to result in a need for ICU facilities which are just not available because ICU is operating at capacity anyway?-- If we were at capacity, then we would not be doing the cases. We work within the system for booking patients and it is often not the booked patients that are the problems, it is the unbooked ones that come in and we have to deal with them. We cannot move them on because we have to sort of deal with them on site at the time to stabilise them for transport.

Yes.

MR MORZONE: In your statement you have referred to - I will withdraw that. You have referred to guidelines there. This is guidelines relating to the level of the IC unit. Are you referring to a set of minimum standards for intensive care units put out by the Joint Faculty of Intensive Care Medicine which is Exhibit 6? I will just show you a copy?-- That is correct. One of the amendments I made on my statement was it wasn't exactly clear whose guidelines I was referring to. So the words have been-----

Have been inserted, very good. I will have that back then. There is no question, is there, that under those guidelines this was a level 1 ICU?-- Yes.

Can I ask you some more general things about ICU, and in particular the dealings with Dr Patel in ICU? First, we have heard evidence of there having been conflicts between orders for medical treatment between Dr Patel and various anaesthetists. Was that something you experienced?-- Yes.

How did you experience that?-- The easiest example I can give is that he liked to see his patients passing urine to show his kidneys are working nicely. Now, in my experience, you didn't really need to sort of push diuretics with a patient until about 72 hours, because with a major handling of the bowel that went on, fluid would often accumulate within the patient, and as the patient sort of started to return towards normality, that diuresis would start naturally. I felt it was worth waiting till about 72 hours before sort of administering diuretics. His idea was actually to sort of get the patient peeing earlier. Now, you can't actually pee properly if your kidneys aren't getting sufficient fluid, so it is important to fill the patient up first. Diuretics have completely the opposite effect and are just sort of producing urine to no good effect because you are just draining the fluid out of the patient so they can't actually perfuse the rest of the body.

Now, I think there is notes which exist of Dr Behrens having expressed a similar concern in a meeting with Mr Leck on the 29th of October, and the terms which he used was that "Dr Patel's critical care knowledge was not up to date, particularly in relation to his choice of drugs and fluids." Is that a reference to a similar sort of thing or-----?-- Same sort of problem.

D COMMISSIONER VIDER: Doctor, can I just come back to the statements that you have got here regarding the management of patients in intensive care, and you make reference to what might have been the system in America. You were the director - you are the director in the intensive care unit?-- Yes.

Dr Patel had an expectation that he retained control of the patient in intensive care?-- The system we had to run - because I, as an anaesthetist, do not have beds within the rest of the hospital - was that the bedhead on the patient remained that of the surgeon or physician who was responsible for the admission of the patient into the hospital.

I understand that?-- Because they are going to take that on. It proved too difficult for our admitting system to put dual bedheads on, so that I didn't have any notional control of the patient.

Except you could have had an intensive care policy that said the medical care of the patient in the intensive care unit is primarily the responsibility of the Director of Intensive Care?-- That is correct, and we did have such a policy.

But you didn't necessarily have adherence to it?-- We didn't have adherence to it - well, specially by Dr Patel. A lot of the other physicians and surgeons would take our advice into the management of patients but Dr Patel avoided the concept of joint care of any of his patients.

Do you know how Dr Patel was orientated into the Australian medical culture and the Australian hospital system and how it works?-- To be honest, I don't know that he ever was.

And so his reluctance to accept somebody else's authority came more from his personal style?-- Yes, basically.

COMMISSIONER: Perhaps what he was used to in the United States?-- That would be a fair comment.

D COMMISSIONER VIDER: But you are not sure if that is what the Americans did or not; it is just what he said he was used to?-- That is correct.

And therefore we have had evidence that one of the difficulties in managing patients in intensive care was knowing who was the primary medical officer. Now, whose orders do you follow?-- Basically there is a problem here because you say that I am director of intensive care but primarily I am employed in the hospital as an anaesthetist. I am not going into intensive care every day, and the only time I am there on a daily basis is when I am rostered there. Now, that works out about one week in three or four, depending on the number of anaesthetists we actually have in the hospital, because the person going in to do the weekend is the person I roster in to do the intensive care duties. This means you have got a continuity through the week but after, you know, the next week, it is going to be another anaesthetist. We have no intensivist. So I take an oversight view and if there

are any problems within the unit, people are very happy to come to me, and I expect that to happen. Dr Behrens, perhaps, excepted, of course. He had enough experience of his own not to need to ask for my advice, but with the SMOs, then they would often come to me about a specific problem, but other than that, my role was more titular to decide what sort of equipment we might be ordering and dealing with administrative rather than being in full-time clinical control of what was going on in the unit.

Were you aware that this situation of having two doctors giving orders for the patient care was a problem? Had that been brought to your attention?-- Yes, and I brought it regularly to the attention of Dr Patel. We tried to make him sort of comply with the joint ward rounds but if we were there at half past seven, he would have been there at 7. If we came in at seven, he would have been there at half past six. I think starting your ward rounds at midnight and laying in wait for the man would be a little bit stupid.

Yes.

COMMISSIONER: But-----

D COMMISSIONER VIDER: Was there any other avenue - could that have been the situation then where you either discussed that at the executive council or went to the Director of Medical Services to say, "We have a situation here that potentially can affect patient care."?-- The protocol we had for the admission and discharge was taken to the medical executive and read through and was approved by all there.

Including Dr Patel?-- Including Dr Patel, because he was a member of that executive. It was certainly before Dr Keating, it was certainly before Mr Leck who were on that committee. As Director of Anaesthetics and Intensive Care, I am not in a position to discipline Dr Patel as Director of Surgery.

COMMISSIONER: But I guess you are in a position in the appropriate case. Please understand I am not criticising you for not doing this, but one of the options would have been to go back to Dr Keating or even to Mr Leck and say, "Well, we have had this protocol, it has been agreed to, but Patel just isn't complying with it."?-- That would have been an option.

You, for whatever reason, chose not to pursue that option?-- Correct.

You see, we've also had a great deal of evidence, as you have been aware, from Toni Hoffman indicating that in her position as nurse unit manager for ICU she had great difficulty in dealing with Dr Patel. Did she convey to you her concerns?-- Yes. I mean, there was what was described as a personality clash between the two of them. I am not sure that Dr Patel had any respect for nursing staff in general.

You see, this expression "personality clash" has been bandied around a lot, but if one of your co-workers treats you with

contempt, that could be called a personality clash, but it could also be that things aren't working the way they should. I am just wondering whether it was within your scope as titular head of the ICU either to remonstrate with Dr Patel or, if that didn't work, to go to Dr Keating or Mr Leck and say, "We need intervention here."?-- Dr Patel and I certainly had discussions on the admission policies, we had discussions on the minimum standards that I waved under his nose on a couple of occasions. He was not keen to listen to anybody's advice.

You have made the point, though, Dr Carter, very properly, that you didn't have the authority to discipline Dr Patel. You would have had to get someone higher up the ladder involved to achieve that outcome. Why did you choose not to go down that course?-- I must say, I did not actually think of that course.

Mr Morzone?

MR MORZONE: You have mentioned nurse Hoffman and her position as nurse unit manager. What was the relationship between yourself and herself during the relevant time?-- I thought it was reasonably good, but the last time I socialised with her would be in September of last year when she invited me and my wife to be on the same trivial knowledge contest. We actually got the first prize and she was elated.

Okay. Obviously you had different line managers - yours was to Dr Keating and hers was to her Director of Nursing - but was there an interrelationship between the two of you where you gave directions to her and she discussed openly to you her concerns, or not so much?-- Difficult to define. Basically, yes, we had discussions about running of the unit. I knew she had concerns about Dr Patel's competence. Unfortunately for an understanding between us, the idea of what we're in a position to do about these sort of things is different between nurses and doctors. It takes a long time for one to work out whether you can actually prove almost effectively in a Court of law that the person you are talking about is incompetent to do what they are saying they can do and stop them doing it.

Okay. Now, I will return to her a little later when I ask you about the complaints that she had made and the content of them, but staying just, perhaps, while I remember, with Dr Patel's general habits for a moment, we have also heard evidence about a lack of appropriate aseptic techniques. Can you comment on that?-- No.

You didn't notice anything like that?-- Basically, when he is scrubbing I am in the operating theatre with a patient who I am putting to sleep. He comes through a door with wet hands. I don't know what he has done the other side of those doors.

Okay. We have also heard-----

COMMISSIONER: Dealing with some of these general matters, did it come to your attention that there was a standoff between

Dr Patel and Dr Miach?-- Yes, they certainly did not get on. I have since found out why, but at the time I had no knowledge of the actual cause of it. We offered through theatre a regular session for vascular access and dialysis access for the patients. Dr Miach never took it up. So I assumed there was something going on but I was never availed of the reasons for it. As I have said, the hospital ran in parallel rather than seriatim, so that I did not know what was going on in the medical unit or the surgical unit in those sort of terms.

As some people have said, it was like silos, that people in the medical department were in their silo, surgery were in theirs, anaesthetics were in theirs, and there was no bridging between the silos?-- Correct.

MR MORZONE: Were you not aware that Dr Miach had given instructions after 2003 and early 2004 that Dr Patel was not to operate on his patients for the purpose of inserting catheters?-- I was aware that he didn't make patients available, I was not aware that he had refused to have Patel's services.

Were you aware of Dr Miach having arranged for two nurses, nurses Druce and Pollock, to undertake a catheter audit of patients during the latter half of 2003?-- No.

Did you ever see such an audit that you can recall?-- No.

Were you aware that Dr Miach had discussed the audit with Dr Keating?-- Only well after the event.

When you say well after the event, do you mean-----?-- When the inquiry started going on at the beginning of 2005.

Okay. Whilst we're dealing with it, perhaps I will show you a copy of the audit, which is exhibit 18. At least that's the final version of it. And have you seen that since the inquiry started or not?-- No, I have never seen this before.

Okay. If I gave you a patient key-----?-- I have one, thank you.

Do you? Are you familiar with the cases on there? I know you are familiar with at least one, that's Mr Nagel, and I will come to that in a moment, but are you familiar with the other events as well?-- P8, no. P19, no. P24, no. P31, yes. P30 yes. P45, no.

Okay. Now, the P30 is Mr Nagel. His name has been released. I think the other one you mentioned was P31, was it?-- Correct.

His name has not been released. Do you recall - were you involved in that operation, do you know?-- When you say that operation, what do you mean?

Well, the insertion of the catheter or the later complications with it?-- I would have to look at the notes for that

particular gentleman. There were other areas of his care I was involved with but I cannot recall exactly whether I provided any service for the insertion of any of the lines.

Okay. Perhaps I can deal with Mr Nagel. He is a patient that you did have some concerns with, and, indeed, you made your concerns well known to at least the CMC in their interview. But can - he was a patient who needed vascular access for dialysis?-- Yes.

And he bled to death on the 17th of December 2003. Can you tell us the circumstances of that?-- I wouldn't say he bled to death. What I would say is that the bleeding occurred inside the sac that contains the heart and even a small amount of blood in the wrong place can effectively kill you. The heart's designed to sort of - to produce a volume of blood going out of about 70 ml, so it has to be able to contract and expand at least that amount. When you start putting 100 ml of blood or more into that sac, this restricts the ability of the heart to beat and it therefore cannot pump blood. So, yes, he died as a result of the blood inside his pericardial sac but he did not bleed to death.

Okay. Well, he was a man who required vascular access and he was a renal patient and Dr Patel was involved in that, wasn't he?-- Correct.

And what happened in terms of Dr Patel's procedure?-- This gentleman was quite a complicated case. Not only did he have renal failure requiring vascular access, he also had previous surgery and radiotherapy to his head and neck for a cancer in the floor of his mouth. This distorted the anatomy and left us with a situation where we couldn't sort of continually go into the same side because there wasn't another side to go to with the changes in anatomy and the changes induced by radiotherapy.

Dr Patel tried to introduce the vascath into the patient and using the guide wire I can only assume that he poked a hole through the main blood vessel going to the heart. Now, this would normally bleed outside the pericardial sac because the area out of this vessel outside the pericardial sac is longer than the bit inside. So a small amount of blood loss into the chest would not have killed this gentleman. The unfortunate thing is that the bleeding took place inside the pericardial sac, so even a small amount of bleeding would kill him.

COMMISSIONER: Doctor, just so I understand, you made the point that you wouldn't describe it as bleeding to death because that implies death through blood loss. This wasn't death through blood loss. But it's equally clear, isn't it, that Dr Patel's mistake in performing the procedure - I use the word "mistake" as a neutral word - I'm not saying he was negligent, maybe it was the sort of mistake that anyone could make, but leaving that to one side his mistake led to the death of this patient?-- Yes, I would have to agree with that.

D COMMISSIONER EDWARDS: This would have caused a cardiac Ambergard or something like that?-- That's right. That's what I'm trying to put into terms that are more easily understood, but that's the words that I would use to another doctor.

MR MORZONE: And as a result of Dr Patel's procedure the patient seriously - started to seriously lose blood pressure and, effectively, arrest and that's when you performed the perio - I beg your pardon, the cardio pericentesis; is that right?-- Yes.

That was an attempt by you to revive the situation?-- Correct.

And he improved for a short term, but eventually died?-- Correct.

COMMISSIONER: Mr Morzone, you say that name is still suppressed?

MR MORZONE: No, it's not, Commissioner, it's Mr Nagle.

COMMISSIONER: Mr Nagle, thank you.

MR MORZONE: At least it becomes more important - can I show you pages 6 and 7 of 11 of tape 4 of your interview where you deal with Mr Nagle and it was a matter which you, yourself, volunteered because you had some concerns about it right at the beginning; that's correct, isn't it?-- That is correct. This is one case that we actually reported to the coroner at the time.

Yes. I will just show you paragraphs - I beg your pardon, pages 6 and 7 of 11 and ask you to read shortly between lines 193 and 205 and then again between 218 through to 235, which is your description of the incident and if you agree with it,

then I will tender that to save dealing with that any longer?-- Sorry, would you repeat those numbers for me, please?

Yes, certainly. Between 193 and the bottom of the page on the first one?-- Thank you. "The only other person that I consider" - do I read the brackets?

No, no, don't read it out aloud, just to yourself.

COMMISSIONER: Mr Morzone's simply asking you to confirm that that accurately records your recollection, so that he can tender it rather than having to go through it bit by bit?-- Thank you.

MR FARR: Commissioner, while there is a lull, could I speak briefly to Mr Groth outside, please?

COMMISSIONER: Of course, yes.

WITNESS: I'm happy with that, yes.

MR MORZONE: Thank you. I will tender it may it please, Commissioner, extract of the record of interview of Dr Carter.

COMMISSIONER: Yes. Exhibit 266 will comprise extract from record of interview of Dr Carter.

ADMITTED AND MARKED "EXHIBIT 266"

COMMISSIONER: Thank you, Mr Morzone.

MR MORZONE: Whilst we're dealing with catheter matters, nurse Hoffman in paragraph 59 of her statement makes mention of another patient, P1. I will just show you an extract of paragraph 59?-- I had a look at the records for this particular patient.

Yes?-- This particular patient was not operated on by Dr Patel.

Okay. Leaving aside the identity of the person who operated on the patient, was - okay, we will leave that. Is there any reason to - is there any correction that should be made to that paragraph-----?-- Oh, I will read the paragraph.

-----seeing you are familiar with it, so that the evidence is corrected if it's not correct?-- Well, obviously the second line of that paragraph is incorrect because the patient was not operated on by Dr Patel.

I understand that?-- I would doubt the - line 4 of it, as well.

What is that line, and what is your doubt?-- "And possibly also the patient's trachea." It is almost impossible to do that.

Okay. Well, can you-----?-- I also note that in that paragraph she says, "I don't have any personal recollection of this case."

I understand that. From your familiarity with the case it's obviously a case that was raised and initially sparked some interest. Can you tell the Commissioners the correct sequelae of that particular patient, briefly?-- Again, I can only talk from what I have read in the notes of this patient and I would be very grateful for the opportunity of having them in my hand when I actually did it. My main-----

COMMISSIONER: Mr Morzone, can we shorten this? This is patient P1, is it?

MR MORZONE: It is.

COMMISSIONER: Is what you are telling us doctor that patient P1 wasn't a patient of Dr Patel's and, in any event, there are no real concerns about the surgery performed?-- I can't say there were no concerns about the surgery. All I can say is that the patient was not that of Dr Patel's and there is no evidence that the patient's trachea was pierced.

Well, I think that's enough to-----

MR MORZONE: Thank you, Commissioner, yes. I will get you to hand that back, please, Dr Carter. Can I ask you now about the Phillips matter? Now, you have dealt with this quite extensively in your statement at paragraphs 37 to 45. The Commission has heard evidence that the surgery ought not to have been an option in this case because of the comorbidities of this particular patient. Do you have a comment or view about that?-- Basically, the patient was presented to me in joint by the physician in charge of the patient who was Dr Miach, and the surgeon Dr Patel. They said that they felt it was beneficial for the patient to actually have the surgery. He had been knocked back by Brisbane and that the patient still wanted surgery, and given that he had a fair idea of the risks that were involved with this surgery I felt we could offer him the surgery.

COMMISSIONER: Are you confident in your recollection that Dr Miach advocated the surgery?-- That was my understanding at the time, and he certainly did not say anything different in our joint ward rounds on the patient after this operation.

Yes, but do you recall him actually saying that he was in favour of it?-- To be honest, no, I cannot recall that.

Thank you.

MR MORZONE: We've heard evidence also that between that oesophagectomy and the oesophagectomy of Mr Grave's which I

will ask you about, because I don't think you mention that nurse Hoffman had twice, once in the company of nurse Goodman and the other in company of Dr Joyner, anaesthetist, approached Dr Keating about whether or not oesophagectomies should be performed at the hospital. Did you have knowledge of that?-- No, and I was out of the country at the time.

That must explain it. Were you out of the country when Mr Grave's underwent his oesophagectomy-----?-- Yes.

-----on the 6th of June 2003?-- Yes, I was out of the country.

Okay. Again, after that incident there's evidence that nurse Hoffman complained again. Were you aware of that or were any discussions had with you about that when you returned?-- I was told about the case when I returned, yes.

And when was that, do you recall?-- It would be at the beginning of July.

And were you told about nurse Hoffman's concerns about those procedures occurring?-- Yes.

And did Dr Joyner also speak to you about it?-- Dr Joyner mentioned that he felt that we shouldn't be doing cases of this degree of difficulty without, I think he actually referred to me as the intensivist in the hospital. I'm not qualified as an intensivist, but - at that role, but senior anaesthetist. I think he felt I should have been present to help look after the patient.

COMMISSIONER: Doctor, dealing with Mr Phillips, patient P34, I wonder if you can clarify something for us. We've heard one version that was that Brisbane - a hospital or hospitals in Brisbane had refused to perform oesophagectomy. There seems to be an alternative suggestion that he hadn't been refused the procedure, but would have been put on a very long waiting list to get it. Do you have a clear recollection one way or the other?-- No, I have no clear recollection and when I have tried to go back through the notes I could find no indication of any correspondence on this matter at all, and that concerns me.

I do see in your statement, and quite seriously I'm not trying to trick you with this, doctor, but in paragraph 38 you say you remember "being told that there had been an attempt to transfer this patient to Brisbane for an oesophagectomy, however I recall from that conversation there was a waiting list of several months before he could receive the surgery in Brisbane". Is it the case that having thought further about this you are just not quite sure what you were told?-- I'm not sure what I was told because when I've gone back to look at this and try and work out from the notes what the course of events was, I cannot find any reference to any assessment in Brisbane.

Can you recall the source of the information that there had

been an attempt to transfer the patient to Brisbane?-- I can't remember whether it would be Dr Miach or Dr Patel.

But you think it's likely it would be one of the two?-- It would have to be one of those two.

MR MORZONE: There's mention made in nurse Hoffman's statement of another patient P39, and which I bring to your attention, also, and I will show you the relevant paragraphs. You are probably familiar with them. It's a matter I should ask you given what nurse Hoffman has said. She says that-----?-- Sorry, paragraph which?

If you go directly to 35?-- Right, thank you.

P39 is the patient and you might need to read the earlier paragraphs to remember the patient. He was a patient that was admitted following a motor vehicle accident and he was in ICU for a number of days, 12 days in all, and nurse Hoffman says she was told that you and Dr Patel had come to an agreement not to transfer the patient, and that she was concerned of that agreement having been reached. Do you recall that and whether or not there was such an agreement?-- There was no such agreement. The only agreement between myself and Dr Patel on that case is that I would provide the anaesthetic.

Okay. And the long stay of the particular patient in ICU, what caused that, from your point of view?-- He was there in - for 12 days, which isn't long for an intensive care patient. Through none of those days was he ventilated. He had had a severe injury in a road traffic accident. He was discussed with Brisbane by Dr Joyner and Brisbane didn't want to accept him, they felt we could perfectly adequately manage him in Bundaberg. There was no problem with this patient.

Nurse Hoffman's given evidence that she, on numerous - this is one of a number of occasions where she had discussed concerns with you about keeping patients in ICU for a long period of time; is that correct?-- Yes, she discussed the fact that we were keeping patients longer, and I think attached to her statement you have TH31 and TH40-----

Mmm?-- -----which outline some of the reasons that we are actually keeping patients longer in Bundaberg than, perhaps, we ought, according to the college guidelines.

And after that particular patient, do you recall speaking to Dr Keating about the matter?-- I don't honestly recall that meeting.

I will ask you to hand that back, unless there is something else you wanted to comment about it.

COMMISSIONER: Mr Morzone, that might be a convenient time to take the morning break, if that suits you?

MR MORZONE: Certainly, your Honour.

COMMISSIONER: We will adjourn for 15 minutes.

THE COMMISSION ADJOURNED AT 10.47 A.M.

THE COMMISSION RESUMED AT 11.15 A.M.

MARTIN LOUIS CARTER, CONTINUING EXAMINATION-IN-CHIEF:

MR MORZONE: Dr Carter, I notice in the statement that has been tendered by you, the relevant exhibits you never held at the relevant time, and it might be a convenient time now if I just show you a bundle of exhibits that might be able to be added to your statement, and if we go to your statement-----

COMMISSIONER: Mr Morzone, are these the ones we already have?

MR MORZONE: They were added to the penultimate draft, but what I think has happened is the final one that's been sworn never had the exhibits attached. So it's just a matter of ensuring-----

COMMISSIONER: Doctor, I wonder if you could take a few moments just to go through that bundle and confirm that they are the documents that you intended to refer to in your statement. Whilst that's happening, Mr Boddice, or possibly Mr Farr, I understand the waiting lists for the waiting lists have been found and are coming up.

MR BODDICE: I understand some material has been supplied, and also that searches are being carried out in respect of the other districts and will be supplied either later today or tomorrow.

COMMISSIONER: All I've seen so far is the Townsville list, and I have to say that if it's indicative of what goes on elsewhere, it's entirely consistent with the evidence that we've heard from a number of witnesses that the list for people awaiting appointments is in most cases four times the length of the list of people waiting on the official waiting list.

So in Townsville, for example, we have cardiology, 121 on the official waiting list, but 583 waiting for appointments; dermatology, 54 on the official list, 206 waiting for appointments; endocrine and diabetes, 147 on the official list, 489 waiting for appointments; gastroenterology, 86, I think it is, on the official list, 216 waiting for appointments; general medicine, 65 on the list, 347 waiting for appointments, and so on - cardiothoracic surgery, four on the official list, 179 waiting for appointments. It does seem very pertinent to the point that a number of witnesses have made if the pattern continues throughout the state.

MR BODDICE: As I said, Commissioner, I understand the other material will be supplied later today or tomorrow morning.

COMMISSIONER: Thank you. Perhaps for the time being I should have the secretary mark the Townsville list as Exhibit 267 and

we can add the other lists to that in due course. Exhibit 267 will be "Townsville Health Service District - Number of Patients Waiting for Outpatient Appointments as at 1 July 2004".

ADMITTED AND MARKED "EXHIBIT 267"

COMMISSIONER: I assume they're the latest figures that are available?

MR BODDICE: As I understand it, but again I'll have confirmation of that fact.

COMMISSIONER: Thank you.

MR BODDICE: Commissioner, what I'm told is that the other material that's being supplied - that was a snapshot taken at a certain stage, and I understand the other material is at the same stage. So there's - it's a comparison situation.

COMMISSIONER: Yes.

MR BODDICE: Commissioner, can I also indicate that I'm advised that if need be, Dr FitzGerald could be available this afternoon from 3 o'clock.

COMMISSIONER: Well, I'll leave that - Mr Morzone, perhaps that can be communicated to Mr Andrews. I don't think we'll take up the whole day with Dr Carter's evidence.

MR MORZONE: Certainly, Mr Commissioner.

MR BODDICE: Mr Atkinson has just indicated to me it may be that Dr Jayasekera might be this afternoon as well.

COMMISSIONER: Yes, that's one other possibility. Thank you.

MR MORZONE: Doctor, have you had a chance to look through at that bundle of documents?-- Yes, thank you.

I think the exhibit marking at the top has been cut off on some, but is the bundle of the documents otherwise documents which you have referred to in your statement?-- Correct.

I will tender those as a bundle, perhaps as part of the exhibit.

COMMISSIONER: The bundle of documents will be added to Exhibit 265 as part of Dr Carter's statement.

MR MORZONE: Thank you, Mr Commissioner. Dr Carter, I think I was asking you - or may not quite have asked you before the break, about whether or not you were aware of Nurse Hoffman having raised issues with Mr Leck at the end of February 2004,

and can I show you a copy of Exhibit TH10, and could I tell you that her evidence was that that part within the two arrows was the part that she raised with Mr Leck at that occasion. Were you aware of that meeting having taken place or of her concerns?-- I was unaware of the meeting taking place. I was aware that she had concerns about the fact that we were doing these procedures within the hospital.

And were those concerns which you shared? Or perhaps if that's too difficult to answer, would you have a comment about the concerns that she's outlined there that puts your perspective?-- My comment about her concerns would be that we'd already done oesophagectomies in the hospital during my time there and she'd raised no concerns then, and that we still regularly did aortic surgery, which is admittedly not quite as complex as oesophagectomy, but still of a high order of complexity, and I felt it was certainly within the capacity of the hospital to actually do it if we had a surgeon who was capable of doing these things.

COMMISSIONER: Doctor, you ultimately came around to Toni Hoffman's way of thinking, as I read your statement, because when you had two out of five patients die, you did some research and found that oesophagectomies should have a 90 per cent survival rate?-- That is correct. Certainly for the sort of oesophagectomies that Dr Patel was doing.

Yes. So do I deduce from that that perhaps you felt that Toni Hoffman was premature in raising these concerns, but as things have turned out her concerns were well placed?-- Oh, I'd agree with that.

D COMMISSIONER VIDER: And, doctor, my impression was that her concerns were certainly coming out of her observations that the technical competence of the surgeon was leading to a number of complications. So if you looked at clinical indicators like the number of times a patient returned to the operating theatre, unplanned admissions to ICU, they were indicators that were indicating that something was happening?-- The unplanned admission to ICU is often as a result of what the anaesthetist feels about the patient and the level of change within the patient. If I wished to take a patient to intensive care, I may do so because the temperature in theatre was incorrect and the patient has got a bit colder than I would like, or the warming blanket wasn't working, so you actually had a reason to bring the patient into intensive care for rewarming prior to them being discharged, because it's unsafe to try and wake a patient up when they're too cold to cope with the normal activities of life. So the fact that patients were being taken into intensive care was not purely on the competence of the surgeon. There are many other factors that would actually make you do such a thing.

COMMISSIONER: True, but statistically an unplanned admission to ICU is regarded as one of the indicia of problems in surgery?-- Yes, that's certainly so, but when you want to look at whether there's a pattern, it's very difficult to look just at one particular case.

Yes?-- You know, one of one is 100 per cent, but if that one is only going to be one of 100, then it's only 1 per cent, and until you've got a bigger picture, it's very difficult to know exactly what you're looking at.

D COMMISSIONER VIDER: Yes, but doctor, the example that you give, if you come back and that becomes a statistic, that the patient that needed to be warmed up went to the Intensive Care Unit at the request of the anaesthetist, you can take that through to some sort of clinical auditing committee and you can discuss that case and you come to the conclusion that the reason for the patient being admitted to intensive care was to do with the physical environment, if you like, in the operating theatre, not directly involved with complications that were influencing the outcome of the technical competence of the surgeon?-- Well, that's quite correct, but the reason I have particularly chosen this example is that if you have a patient on the operating table longer than you would expect, you would then have more likelihood of cooling, and even if you then, after your first patient, correct for the cooling problem, then you may still have a problem which is actually from the same cause. That way - I mean, you're not looking at a series of cases and you're saying that all of these are down to the same thing. You correct what you think is correctable and then you move on, and you may find once you've had about five cases with this particular problem, that it doesn't relate to the actual temperature in theatre or the efficiency of the patient warmers, but the speed at which the surgeon is working and the amount of blood that the surgeon is spilling. This is why you have to look at a big picture rather than sort of just jump on one particular problem, and I think that's a difference in approach between myself and Sister Hoffman.

Oh, I see.

MR MORZONE: After that meeting in February 2004, were you aware of Ms Hoffman wanting to try to sort - or to discuss these matters with Patel with your help?-- Yes.

And she states at transcript 1377 that you weren't interested in such a discussion taking place. Is that correct?-- Could I please have a look?

Yes, yes. Well, is that suggestion correct? That you weren't interested?-- No, I don't think it's a correct representation of whether I was interested in trying to mediate between Sister Hoffman and Dr Patel.

She also states at 1379 that one of the hardest things was that on a daily basis you would say privately to staff in ICU how terrible Dr Patel was, but that you wouldn't support her when the chips were down?-- There's a difference in context there. I did not like the man, and that was some of the comments that I was making. As I've implied sort of through the rest of my testimony here, Dr Patel on the whole was a reasonable surgeon, and there were times when we can look back and say very easily that he stepped outside his limitations,

and especially the limitations that were put on him in America, but at the time we did not know that, and I wasn't commenting on his general ability, but merely the nature of the man, because he was always brash and in your face.

I'll ask you to have a look at Exhibit 93 which is a record of certain statistics kept in ICU, and in particular we've heard reference from a couple of nurses about the increase in ventilation hours during the time Dr Patel was there. The suggestion has been made that that was the result of Dr Patel doing more complex operations and patients being kept longer in ICU at his request. Do you have a comment about those matters?-- The only comment that I would make about these is that these are the sort of figures that I was taking to medical executive and the medical staff advisory committees and sort of reporting the same to them. But again I can only direct you to other comments within Sister Hoffman's testimony where she says that we were having difficulties moving patients down the line and we were experiencing bed blockage as a result of what was going on in Brisbane. Now, I can't split up - because we didn't actually keep the statistics of when we start trying to send patients, when we then actually manage to transport patients, or whether we are sort of given sufficient guidance over the phone to manage the patients within the Bundaberg ICU as to say whether Dr Patel was contributory to this or not. There's a lot of factors there.

Okay.

COMMISSIONER: Well, you say there are a lot of factors, but I think you've already told us, haven't you, that Dr Patel was uncooperative to the point of not complying with the protocol that was in place regarding governance of the ICU. Is that correct?-- That is correct.

So it may be a matter of quantifying the extent to which that contributed to the problems that both Nurse Hoffman and yourself identified, but it was certainly a factor, wasn't it?-- Certainly.

And the reality is that despite having raised this at the executive meetings, nothing was done to address the problem?-- That is correct.

MR ALLEN: Could we have an exhibit number for that last document shown to the witness?

MR MORZONE: Exhibit 93. Perhaps one more matter about that. It's been suggested that whereas usually you were quite supportive about the transfer of patients, there was a reluctance when Dr Patel's patients were involved. Do I understand from what you say it's not so much a reluctance, but Dr Patel was insistent about these things?-- Neither. If those patients needed transferring for further care, then yes, they would be transferred.

Can I briefly mention wound dehiscence. That meeting that I showed you before, the 14th of April 2004, also raised the

issue of wound dehiscence, and we've heard evidence of Di Jenkins having raised at the meeting the increase in the number of dehiscences. Do you recall that?-- Yes.

And do you recall the reaction of Dr Patel to that suggestion?-- The first meeting where they were raised, Dr Patel was not present. He then stated during the second meeting, where they were re-raised, that it was all done in his absence, he hadn't had a chance to deal with the figures, and he wanted to go away and do an audit of his own and see what the figures were. The actual minutes of the meeting I think reflect that Dr Patel and I were going to do this jointly. He would not deal with me in this matter, and he came back with a series of figures that seemed to prove that none of his wounds dehisced.

COMMISSIONER: You, from your own observation, knew that that was untrue?-- Yes.

Doctor, please understand this comment isn't aimed as criticism at you personally, but we keep hearing these things about matters raised at meetings, something was going to be done about it, but then Patel goes off and does his own thing?-- The problem was with a lot of the meetings that we would put things forward and nothing would be progressed because the people involved weren't - either weren't interested in progressing it or we were getting no data back. We've had a lot of talk about the adverse incidents that are said to have occurred within the hospital. All these were submitted to DQDSU. We were getting no feedback on these so we were unable to assess exactly what was going on with the place, and I can recall sort of several complaints that I put in as adverse incidents and I have yet to receive any paperwork back on those, even though it's years down the track. We were told there was a problem with the system, we were told that they were changing the system, but we get no answers back from DQDSU. It is as though they go into a black hole.

The specific instance you've just mentioned though was a situation where the - I think it was the executive meeting, wasn't it, decided that you and Dr Patel would look into wound dehiscences. That wasn't a case where you were unwilling or unable or unprepared to do it, the fact was that Dr Patel spurned any cooperation with you and set out to do his own audit which produced results that you knew were falsified?-- Yes, except that it was the ASPIC Committee meeting.

I'm sorry, yes, ASPIC Committee meeting. What follow-up was there? It strikes me - and I'm outside the system. I've got no medical background, but it strikes me a hospital can't run when a high level committee says, "This is what's going to happen", one surgeon - one senior surgeon decides to ignore what that committee's resolved, comes up with figures that at least you knew to be incorrect, and there doesn't seem to be any follow-up. There doesn't seem to be any system of saying, "Well, this wasn't what was going to happen. Patel's come up now with these figures that are untrue." How do you progress

it beyond that point?-- Well, you can't, because where you say that ASPIC was a high level committee, it wasn't. It was a very low level committee, and I think a lot of the clinical service forums function merely as an opportunity to say we had these committees going rather than actually to get them to do anything. There was no power within the committee. I mean, you talk about me as the chairman of this committee. The role that I was given really as the chair of the committee was much the same as you would find with a speaker of the house in parliament as against the Premier who carries the power.

Yes. Doctor, I guess with the benefit of hindsight it would now seem to you that perhaps if you had raised these matters higher up the chain - again, I mean no criticism - but with the benefit of hindsight, if you had taken these concerns to Dr Keating or Mr Leck, or someone else at the time, some of the subsequent problems would not have occurred?-- I am not sure that's the case. For example, when I came back from an anaesthetic conference in Perth, one of the things we had been dealing with was the modern and outdated forms of cardiac defibrillators. I went around and had a look at what defibrillators were available in the hospital and produced a list of all the defibrillators that were past their shelf date and should have been replaced. In fact, it got so bad our senior cardiologist at the time, Dr Strahan, would not actually do cardioversions in the operating theatre recovery area because the machine was so old it was unsafe. Now, I was asked to submit a business plan to replace our cardiac defibrillators. I did so. I placed it upon the desk of Linda Mulligan, who had just started at that time, and I have no idea what happened to that because nothing seemed to happen with our defibrillators within the hospital. And it was brought up again by, I think, our current Acting DON over a year down the track and she was unaware that this business plan had been done. Now, if you have got to put in a business plan to replace obsolete cardiac defibrillators, I think, sort of bring it to the attention of the administration the fact that we haven't had any good result out of the dehiscence study that they had suggested we do.

Would I be right in inferring, doctor, that when you make those sort of points, you are not intending to be critical of individuals who held those roles; you are conscious of the fact that they didn't have the funding and resources and so on to assist you?-- I am conscious of that, and it is not specifically critical of anybody in a specific role, but when the clinicians put a package like that together, if they try and take it up the line and get approval for the spending of this money and they can't get it, then a return of information in terms of courtesy to say, "Well, we have tried to do this", or "This is what we're going to do and try and meet." It should come to you in some form that you can look at and peruse and be aware that they have actually done something for you.

I suppose the other side of the coin is you would appreciate - and if there is no money to buy knew defibrillators, being told in advance of doing a business plan that you are wasting your time, rather than using your valuable time to prepare that business plan and then having it ignored and getting no feedback?-- Exactly.

D COMMISSIONER VIDER: Doctor, in your years at the hospital then, when it is budget time or budget preparation time, you are not aware that any list could be generated that could be referred to as an asset register that would have indicated, for example, in the operating theatre or the equipment that you would have a direct relationship with, like anaesthetic machines, defibrillator monitors, and those sort of things, it

didn't print out which machines needed to be replaced because whatever year they had reached they were now obsolete or had used their use-by date? Most of the machines today comes out with a shelf life on it?-- Well, they certainly do, and these lists are available, and there are certain lists - and this is the list that I was working off and checking around the asset numbers because that's the only way I was going to find where all the defibrillators were. But in a lot of cases, the asset register is an absolute disaster area because you have got the part of the anaesthetic monitoring equipment in one bit of the asset register, another integral component to that is another part of the asset register. It is as though you are looking at your computer as the central processor, the printer, the keyboard, the VDU as separate entities all with a different sort of asset number, rather than viewing the whole machine.

Because that's an incredible waste of your valuable time. Somebody should have been able to put that on your desk?-- It is. It is such - one of our - I was going to say anaesthetic nurses, but he works more in radiology, has now been tasked with that and he is doing a wonderful job, but it is taking him a lot of time to work out what bits go where because all the individual modules for monitoring things like blood pressure, pulse oxymetry and anaesthetic gases, carbon dioxide, the ECG have all got separate asset numbers even though they are all part of the same machine.

So then at budget preparation time, taking it more generally, do you have some input into that so that you can say, "This is the equipment that needs to go on the capital expenditure budget for this year", next year, or whatever?-- We certainly do but it tends to come out two days before the actual money is due to be spent. I don't know where the problem for that lies. It may be well outside the control of the administration within the hospital.

COMMISSIONER: Doctor, I have to confess I am a big believer in putting recriminations to one side and looking to the future and how we're going to fix these problems, and I would genuinely be interested to hear your views on what needs to happen administratively in a place like Bundaberg to ensure that clinicians like yourself have the working environment, the facilities, the resources you need. Obviously, more money is a start but leaving that to one side, are there ways that administration blockages can be dealt with or improved?-- I think the major thing that could be done and should be done is keeping clinicians in the DMS position. Now, I don't sort of say that lightly against Dr Keating, he is a clinician, but I think the complexity of modern medicine basically means that I certainly don't understand the needs of Peter Miach as a nephrologist. I don't understand the requirements for surgical equipment and whether some of the newer devices are worth the extra expenditure. You know, like a harmonic scalpel, is this a good idea, bad idea, how much use would you make of it, is it sort of cost effective. But, you know, these things, you know, are well beyond the scope of the average clinician, but having the opportunity to have a senior clinician in what is now a DMS role might be an advantage to

that because you would at least know how the prioritisation was being done, and I agree with you wholeheartedly that pouring more money in isn't the whole answer.

If I can just play around with that idea with you for a moment, I think everyone accepts that actually running a hospital these days is a very big business operation as well as a serious medical operation and you need experienced administrators like Darren Keating who have a background or an expertise in administrative matters as well as the medical expertise, but is your point really that when it comes to those sort of clinical decisions, as to whether you buy this machine or that machine, it shouldn't be in the hands of someone who is primarily in an administrative role, it should be in the hands of someone who is primarily a clinician?-- I think so but I think it also needs to sort of be related to the nature of the hospital itself. It is very difficult to understand how the needs of a hospital like Bundaberg can be matched by the needs of any of the major hospitals in Brisbane. Now, what may be eminently suitable within a large complex is not going to be in the same league as with a smaller hospital. We're getting machinery that is really very nice but possibly ahead of what we need, and because we're getting sort of replacement machinery - I am talking specifically here about our latest round of anaesthetic machines, which we're getting sort of cycled in over a length of time so we can actually sort of have them falling off obsolescence at the same time we have got the new ones coming in. But because we don't have enough machines coming in at any given time, things like the network software, so we can actually print off our anaesthetic records, aren't matched, the 2003 machine won't, you know - sorry, the 2005 machine won't speak to the 2003 network, and we're going to be getting those machines in on a slower basis. You can't within the budgetary constraints - and I accept there have to be those - replace these sort of machines on a slow time basis because the software changes and it creates other problems.

Doctor, I suspect you are heading towards another of the themes that I find highly relevant here, and that is the question of autonomous control of regional hospitals. Again, I think everyone would accept that there are some things that are best done and have to be done at a Statewide basis but when it comes to deciding what personnel and equipment and resources are needed in a local hospital, it seems to me that it is counterproductive to have decisions made in Charlotte Street or anywhere else rather than on the ground with the input of the people who will actually be using those facilities and know what they need and know how that will work in conjunction with their existing resources?-- The problem, as I see it, with Charlotte Street - I am probably stepping well outside my area of expertise - is that they relate to what goes on in Brisbane and there is a political imperative to maintain smaller hospitals within the region, but if I look at the Wide Bay, and being perfectly honest and rational about it, it does not require three hospitals. Now, if you divide the resources that you have got in there between three hospitals, you are going to have three areas which, for lack

of a better phrase, lack the economies of size, and if you could sort of reduce that to two hospitals, then that would be sort of very, very good, but it is politically unpalatable, it is also unpalatable to the communities who rely on these hospitals. In the same way I have seen it reported that there are considerations of closing some of these sort of smaller hospitals within some of the towns like Gin Gin, Childers, or whatever, to reduce the capacity of those so you don't have to sort of send junior doctors out to staff them and you can maintain your staff within a slightly larger hospital and therefore produce better working conditions for the staff, and therefore safer conditions for the patients to come into. Then, you know, that is ultimately a problem for the politicians and what they are prepared to do, and they are sort of overriding what's going on in Charlotte Street because there has to be a sort of political control on the money that's spent, and I recognise that.

I suppose, doctor, one of the solutions that - and I personally don't enjoy the cliched expression labels that are put on these, but one of the solutions is referred to as the hub and spoke solution. The point is made to us, and I think made very well, that in various areas of medical specialty, having one specialist in a town is almost worthless because that specialist cannot provide 24-hour-a-day seven-day-a-week cover. It is much more sensible to have four specialists in a more major city with a rural medical specialist able to act as a sort of triage and to - a referral centre to send those patients who need the specialist care to the hub rather than trying to deal with them at the end of the spokes. Is that really the sort of point you are making, that-----?-- I think so, and as - outside my role as purely as an anaesthetist, actually as an intensivist within the hospital, I also run the chronic pain clinic. Now, ideally these should be multidisciplinary and dealt with by a large group of people. But by my being within the Bundaberg Hospital, I am at least in a position to filter out what patients go down to the centres in Brisbane to be dealt with at that level, and take away some of the waiting list time by sort of just acting as a filter at that point.

So just to take one example - this may not be a good example, I just take it at random - but amongst the three hospitals, you mentioned Bundaberg, Maryborough, Hervey Bay, rather than having a renal unit at each hospital, it may be more sensible to concentrate your resources in one of the three, and for present purposes it doesn't matter which one, and refer the patients as necessary to the hub to have that service provided, and it may well be the case that if you say, "Well, renal units will operate out of Maryborough", then dermatology might operate out of Bundaberg", or something else might operate out of Hervey Bay. But instead of trying to make each of the three hospitals a complete service hospital for every form of specialisation and every form of illness?-- That would certainly be a very good idea but part of the problem there is - shall we take the renal patients you have been talking about? They don't travel too well and would have to travel very regularly because dialysis isn't a sort of one off

appointment. With dermatology, with due respect to dermatologists, you can travel to see a dermatologist but if you want to maintain a service within the community - and shall we take ophthalmology for that as an example - then you can't necessarily transfer your patient 100 kilometres, you know, for day surgery to have them come back another 100 kilometres and still sort of want to have them in the community, which now has no resource to actually support them should anything sort of go astray, which admittedly ophthalmology it rarely does, but you still have got to have that sort of local back up. And something like ENT where a bleeding tonsil is an absolute dire medical emergency, to have your surgeon 350 kilometres down the road is a potential problem.

Yes. I probably picked the wrong example saying dermatology because that's - of all medical specialties the one that's notorious for not having emergency patients, except in very rare cases, and obviously for emergency situations you need to have someone with appropriate specialisation either at hand or at least readily available?-- Yes.

Do you have any other thoughts or suggestions that you would care to offer us at this stage?-- I think it is a very difficult problem to sort through and it keeps getting changed. I look at the example of what's going on in the UK and think that I am probably happier working in Australia than in England at the moment.

Yes?-- It is very difficult.

Just going back to the Patel crisis, you mentioned earlier that there are some hospitals that have a surgical Chairman. Different titles are used in different places. Do you see some merit in, even at a hospital the size of Bundaberg, having a Chief of Staff or a Chief Clinician or someone of that ilk who isn't necessarily involved in day-to-day administration but is the figurehead, the leader, the chief spokesman clinical-----?-- Certainly, but again you need to have a specific size to actually reach the ability to actually divide up - when you have got - well, we'll take Bundaberg-----

Yes?-- -----I am the only qualified anaesthetist in Australian terms.

Yes?-- Dr Miach is the only qualified Australian physician in full-time employ in the hospital. Prior to Dr Patel's departure, there were no full-time Australian qualified surgeons. The paediatrician - staff paediatrician, she is fully qualified in Australian terms and Dr Nydam, who heads the ATODS, is fully qualified in Australian terms. The D - the head of the emergency medicine is not. So where do you get - you haven't got this pool of people you can actually sort of draw up as a series of equals.

I guess, doctor, to be frank, my thought is not taking up the time of one of the existing staff and putting one of the

existing staff over the heads of the others, but in most towns there are experienced medical practitioners, both retired or currently practising in private practice, and I would have thought in a place like Bundaberg, just to take one name at random - and that's Brian Thiele - if you offered to him the position of being Chairman of the executive committee - we will call it that for the moment - as a part-time job simply to be the figurehead clinician, the leader, the chief consultant, something like that, so that there is someone outside the day-to-day operation of the hospital to whom people such as those you have mentioned can turn for advice, to comment, appeal to if there is a problem, who becomes their spokesman in disputes with administration?-- I would love to see Brian Thiele as a clinical, shall we say mentor, for the hospital. I think that would be a really excellent idea. I suspect, as you say, that within the sort of other areas of Queensland Health, in the smaller sort of rural areas and regional areas, there would be people like him who would be available, and I think that would be an excellent idea.

Thank you for that.

D COMMISSIONER VIDER: Doctor, can I just go back to something in that frame still, go back to something I understood you to say earlier, and that was when you were talking about attempts to have a more robust clinical review process, that your suggestion at the various clinical directors become part of the executive council, that would have opened up a forum that could have been appropriate for discussing some of these outcomes that you would have all been aware of?-- Certainly. In fact, I went as far as to convene a forum like that. It met a few times, but after Dr Patel's departure and after Dr Keating leaving the position as DMS sort of temporarily, we didn't meet again because the new DMSs were sort of calling us in for a regular sort of Tuesday morning meeting. Admittedly, Dr Keating did start doing that sort of meeting when he first arrived but it petered out very quickly, and I am not quite sure of the reasons why. I think a lot of it has to do with the fact that as clinicians, without a decent number of people to actually sort of do the work when you are actually at these meetings, then it takes a lot of time out from what you are doing.

To hold the meetings, say, at 8 o'clock in the morning going on until 9 o'clock - if I'm sitting in a meeting I'm not sitting in the operating theatre looking after patients and we don't have the sufficient numbers to deal with the - you know, to deal with all meeting at the same time. There are a couple of meetings within the hospital. All I have is a permanent, sort of, apology in because - not that I don't think it's a valid meeting to go to, but I think that it's a meeting that I don't have the time to go to because it's held at 11 o'clock on a Monday morning, and I have got to break into an operating list to go to it.

And then, of course, we're all sitting here because of the absence of all sorts of reviews. We've now had evidence presented from us by clinicians who are looking at and following up in the care of Dr Patel's patients. They're now able to categorise for us the complications that they're seeing and they're able to put together similar, sorts of, lists that are complications that are coming out of procedures that you wouldn't expect to have the range and rate of complications that Dr Patel obviously had. We're seeing anastomic leaks, incisional hernias, infection rates and wound dehiscence being commented on. They're coming out, sometimes, of procedures like lap cholies?-- I agree. When I, sort of, look down and look through some of these complication lists, and I have had a chance of looking through Professor Woodruff's report, that's the first time I have seen a lot of all these together.

Yes?-- As an anaesthetist I have to recognise what's going wrong in the operating theatre. If there's a lot of blood on the floor, if we're talking a lot of time in what's going on, I will recognise that where - you know, he's got a bile leak because he's having to do it. That's assuming that I'm dealing with every operation that Patel does, whereas it's being spread around four or five of us and we're not all seeing that particular problem with the particular frequency that would bring us to, sort of, worry.

If you don't have a robust gathering of some sort of clinical review and audit cases you don't get the whole picture either?-- That's correct, but there's - as I said, it comes down to what staff you have available.

Yes?-- Me sitting here today means that there is no Australian qualified anaesthetist in the hospital.

True.

COMMISSIONER: Doctor, is the heart of the Patel problem simply that he was put in charge of surgery with no-one - just blue sky above him, no-one to call in question his clinical competence or his procedures without the necessary checks to make sure that he was qualified to do that job?-- That's it in a nutshell.

D COMMISSIONER EDWARDS: Could I ask the doctor, if you really listened to people that we've met over this inquiry, listened

to doctors and nurses and so forth, we would have a specialist unit in every hospital, that's the requirements that some people expect of the health system and you mention Bundaberg, mayor bore railway and Hervey Bay and so forth (Maryborough) should there be some consideration to having, with the modern means of transportation that's available, aircraft and so forth, that there be an overall plan for the state relative to the provision of really specialised services or even less specialised services, so that they become really expert rather than being done in a lot of the regional centres and outcomes that we're hearing about continuously as a result of one particular surgeon, particularly, but it could have been repeated anywhere in the state?-- That's a very-----

I realise it's a political decision, but I think we have had some suggestions in some of the meetings that we've had, particularly, that people may well - to get the highest quality care people may well have to travel to specialised centres rather than what is happening at the present time?-- That's all very well. It's a very nice ideal, but I will just take you back to Sunday when I was theoretically off duty and I get a phone call, "Please could you come in, we have a patient with a ruptured aortic aneurysm." I'm not on call. Brian Thiele is fortunately in town and we spent several hours trying to save the life of this patient. Unfortunately, we were not successful, but within - something of that sort of situation you are not going to have the luxury of being able to transfer the patient to Brisbane because they will not survive the transfer. So you have to keep a degree of expertise in the periphery, so that you can deal with these sort of problems, at least, to stabilise them until you actually can move them. I gather there's some suggestions that the services in, sort of, some of the smaller hospitals should be, sort of, capped and the capping suggests that anybody with a bowel perforation should be transferred to a tertiary centre - maybe not tertiary but, at least, secondary centre rather than away from the primary ones, but how do you get them there? You can't necessarily fly them. I say this, sort of, with an army background that I do know a little bit about retrieval medicine. The plane service that we've got is excellent, but it's limited. The patients we've got have differing problems. With the increasing age and comorbidities of our patients they don't fly very well. The problems that we'd have if we tried to move a patient of anything more than 130 kilos, because the loading system in the plane won't necessarily cope with them and we can't get them through the - to, sort of, be safe on a trolley within the King Air. These are problems that have to be dealt with, as well, if you go that route.

Have you a view on that route?-- It's certainly, sort of, an interesting one, but I think you have to have the basic ability to deal with the problem, so that, maybe, you're not going to be able to transfer a patient, but if you can't transfer the patient, then for lack of a better expression a flying squad that could come out and help you in the hospital that you are in. Now, there's, sort of, flying surgeons that go around and do the little operations in the smaller outback

towns, and that's a great idea, and you keep your people there long enough and you keep them within the community. One patient I was involved with, sort of, early on in my time in Bundaberg was an unfortunate lady who got knocked over by a car, fractured skull, and they flew the neurosurgeon to us. So that would be an alternative way to actually do it, but then you denude your central areas of people who - expertise is valuable there. It's a difficult conundrum.

COMMISSIONER: I assume you deal from time to time with. Dr Rashford from whom we've heard evidence earlier. I know he's moved on from the public sector to the private sector, but the organisation which he really set up for the retrieval of patients, you - from what you are saying it sounds to me like you would prefer to see a concentration on not moving patients to the tertiary hospitals, but moving the tertiary hospital in the form of the necessary specialist to the patient?-- In certain circumstances that may be the only thing that you can do, because it's beyond the expertise of the hospital that you are in with their personnel to actually, sort of, satisfactorily stabilise the patient for transport.

Yes. You also have this dilemma, doctor, that you need people for emergency cases for acute cases, but obviously they're going to be quiet for most of the week because emergency cases of their very nature don't come in at regular times and, therefore, you get to them - the situation which we've seen with Dr Patel, that you have a person in a position of a senior surgeon at the hospital who is obviously needed there for acute cases, but is filling in the rest of the week doing elective surgery and, perhaps, doing elective surgery that was out of his league?-- I suppose you could put it that he got bored with doing the routine and wanted to, sort of - to keep his alleged expertise in - on the go. It's one of the reasons that I like doing, sort of, chronic pain because it's - it's something that is different from my regular work and keeps me, sort of, fresh in what I'm doing because I have another way to keep my interests going.

I'm not sure - I will probably get myself into trouble yet again for thinking out loud, but one of the mysteries about all of this is what drove Dr Patel to perform some of these operations that from what we've heard seem to be totally contraindicated as operations that should be performed by him in Bundaberg. You told us very candidly that you didn't like the man, you found him brash and abrasive and so on. Was it your sense that there was almost a degree of megalomania in it, that he thought he had come from America to show this little country town how surgery is done and he just saw no limits to what he could or should do?-- I think that probably would be a reasonable way of expressing it, certainly more polite than mine.

You are welcome to give us yours if you-----?-- I think I will sort of remember I am in a Court of law and being recorded.

Yes, thank you, doctor.

MR MORZONE: Can I ask you about a number of quite specific issues because a lot of things are dealt with in your statement. First of all, is there within - to your knowledge within Queensland Health policy a duty on doctors or, indeed, nurses to make complaints or to inform appropriate persons where circumstances warrant concern about a professional's clinical competence?-- I have been led to understand that since starting discussion with legal counsel, and as I mentioned earlier, we tend as doctors to take a broader overview of what's going on, you know, one person making one mistake, is that enough? I mean, without being frivolous, have you ever lost a case? You know, is that ground for being incompetent? You don't know the circumstances of the case and what's going on. You have to look at, sort of, a trend of things. I mean, if you as a barrister or solicitor were continually losing cases nobody would go to you, but at least you wouldn't be, sort of, losing anything other than your livelihood here. In terms of a surgeon or a physician or a psychiatrist or whatever, you know, how do you know when they're missing things - when they're missing things that they shouldn't miss or whether what's happening is, basically, beyond anybody's, sort of, care. Are we, sort of, saying there is no reason why a patient of 110 should die on the operating table? You know, that's, sort of, one end of the situation as against a 20 year old who one would expect to go through an operation, sort of, very, very smoothly.

I accept the force of what you say, but assume that reasonable circumstances exist for you to warrant concerns, leaving aside any personal convictions to do so, is there - to your knowledge is there an actual duty to complain in those circumstances that exists?-- I have been informed there is.

Okay?-- And that's to the Medical Board. I was unaware of it.

What about within the hospital, though, I mean not taking it necessarily to the Medical Board, but to-----?-- Again - sorry, I'm interrupting, my apologies.

-----but to administration; do you know of such a duty?-- I know of no such duty, but once the situation is passed a, sort of, certain point and which you have, sort of, more hard evidence to sort of - to lay in front of the administration, then that becomes something you can do. When I reached the point where I, sort of, was aware that Dr Patel's oesophagectomies had a 50 per cent mortality which is in excess of what I would expect, then I was prepared to take it to administration and when you are not just, sort of, sitting there as yourself taking a complaint to administration but there's more than one of you with the same view, then that carries more weight and it was subsequent to the death of Mr Kemps-----

Kemps?-- -----that both Dr Berens and I approached. Dr Keating about this and the outcome was that Dr Patel was not to do any more oesophagectomies.

COMMISSIONER: Doctor, this may sound outrageously cynical to you, but I also wonder whether part of the problem is everything has become too systematised and bureaucratised. I can imagine that 20 or 30 years ago the situation you describe is one where an anaesthetist would go and have an informal chat with the medical superintendent and things would be resolved fairly quickly, but without undue formality. Do you find working within Bundaberg, for example, that one of the difficulties is that whenever you make a complaint it's got to be in writing, it's got to be formalised, and you have to, therefore, have the resources to back up your complaint and statistics and details rather than being able to deal with things, in essence, doctor to doctor?-- I can go back to my experience in UK where you were aware within a hospital - they had what were called the three wise men, and these are the sort of people you would take your complaints and your worries to and get a decent, sort of, answer and it could be, sort of, dealt within a lot more informal manner, but that basically doesn't seem to exist any more. When I was in the army you knew, at least, that you were taking complaints up the line. One of the best things you could do was send a blind copy further up the chain to make sure that things got action because in this way you knew that you had passed the information to the relevant people and the people behind the relevant person were the ones that would also receive this information and it wasn't obvious to the person receiving the complaint who you had also spoken to.

MR MORZONE: You're critical of the complaints process in your statement at paragraphs 88 to 92, and I don't need to take you to it necessarily, but your criticism mainly is that there was no feedback coming back from complaints that were sent up; is that correct?-- That is correct.

And did that lead to barriers or a barrier about raising concern and the barrier being a feeling of incompetence grounded in the belief that even if a report was made nothing would be done about it?-- That's something I have been asking myself.

And was there - and I am speaking generally here rather than just yourself, personally, but did you perceive a culture within the hospital of not making complaints, of keeping your head down and minding your own business or is that taking it too far?-- I would almost think it went the opposite way. I mean, there was a lot of complaints within - just to make sure the paperwork had been done, even though you knew things may not well get action.

I see. So it became a paper chase?-- Yes.

A couple of other very specific matters. You have dealt with the Bramich matter extensively in your statement and in the attachments to your statement. A couple of critical issues about that, can I ask you quickly: first of all, do you recall when it was approximately time-wise that Dr Patel became involved in Mr Bramich's case? On the afternoon or

evening?-- I can't give you an exact timeline but, basically, the situation was that Dr Gaffield came out of theatre to review Mr Bramich, and he went back into theatre. He spoke to Dr Patel. Now, I can't actually say that I saw that meeting, but he came back in with Dr Patel and asked Dr Patel to take over the case as he had a doctor - as Patel was alleged to have a great deal of experience in trauma than Dr Gaffield.

Perhaps if I can put it this way: do you recall if it was before or after the CT scan that you accompanied Mr Bramich?-- It would be before the CT scan.

Before the CT scan. Now, we've also heard some evidence, and I think you have referred in your - at least the coroner's report MLC5. That was a report done by you-----?-- Mmm.

-----to there having been made a decision and you attribute it to the Director of Anaesthetics and, therefore, it's you to arrange for the transfer of a patient to a tertiary centre in Brisbane where there was capacity to carry out thoracic surgery; is that correct?-- That is correct, and as I was writing it as a coroner's report I used the person all the way through.

Yes, I understand that. My question is this: you also refer to the retrieval team being - the contact being made with the retrieval team at 1620, which is 4.20 in the afternoon, but there seems to have been a delay then in the retrieval team and you, in fact, refer to that as a concern. There's been a suggestion that Dr Patel changed the decision to transfer. Can you comment on that or not?-- The only way I can comment on that is that to get the information of the time that the call was logged to arrange the transfer I phoned the flight coordinator in Brisbane. They refer to their log book and told me the time the flight was called was 1620. The time the flight was dispatched was at, I think - I can't remember, somewhere about half past 7. You will have it in front of you.

1930?-- They made no mention of any intended cancellation of this flight.

And you weren't witness, yourself, to any discussion that Dr Patel had?-- I'm not a witness to it. As I said, that's how I got the information.

You refer in that statement to a concern being the paracentesis having been performed without any indication that it was necessary. I think we've seen a CT scan that suggested that it may have been unnecessary, but I note in your report that you say the CT scan wasn't available at the time; is that right, or the report of it?-- The report wasn't available until afterward and, unfortunately, I have noticed a typo in that because I have actually, sort of, put it wasn't available until the 30th of August.

Yes?-- It would have had to have been the 30th of July since that report was made available to sister Hoffman on the 4th of

August. So it can't be for the 30th because it had numbers on it.

Even though the report wasn't available, is it the case that there were contraindications that you had been aware of that there had been a need for such a-----?-- When I wrote that report I did not feel that there was an indication to perform a pericardiocentesis, but having had a chance to really think on it if you have a patient who suddenly collapsed then it would be worthwhile looking at it as a potential cause because we do know this gentleman had bleeding into his chest. If one of those vessels decided to start bleeding inside the pericardium, as we discussed with Mr Nagle, then pericardiocentesis would probably have been a reasonable idea, but if you have got the ultrasound guidance to do it you can have a look at the heart and see whether it's actually necessary because you can see the fluid within that sack.

COMMISSIONER: Doctor, am I right in understanding that pericardiocentesis is one of those crossover procedures that are sometimes done by surgeons and sometimes by anaesthetists?-- And sometimes by physicians.

Yes?-- It should be - I won't say a basic skill because it's not something that you do everyday, but I think it's something that most people would be aware of how to do because it is a lifesaving procedure as we've explained, sort of, through this.

My point is that although you've been, if I can say so with respect to your - very careful in saying the things that you can't comment on in relation to Patel's surgical skill, this is one area where you are just as qualified as a surgeon to comment on the procedure that was undertaken?-- Oh, yes, I would expect a surgeon to be able to do them.

Yes?-- And the same proficiency that I do them.

And one of the suggestions we've repeatedly heard in evidence from a number of sources is that there were very numerous attempts to insert the needle. One figure given was 50, which I suspect is a plain exaggeration, but certainly suggestions as high as 10 or 20 attempts. Would that be consistent with competent administration of a needle?-- No, it wouldn't. Basically under those circumstances, and certainly where I've - I've done them, you use an ultrasound probe to see if there is fluid within the area. If there is fluid within the area then you should be able to hit it pretty quickly within two, maybe three attempts. If you keep your guide there you are going to be, sort of, aware that you are actually in the fluid and can hit it and do it. Blindly stabbing away 10, 15 times is not the way a competent person would carry it out.

And having never had a needle inserted into my pericardium, would I be right in guessing that it's a fairly painful thing for the patient?-- Most patients who you do it to aren't feeling any pain at all.

I see. Yes.

MR MORZONE: A few other matters, if I can. Mrs Turton, and you refer to her in paragraphs 57 and 64. There's been some suggestion that before her life support was turned off you didn't do the correct brain tests. Can you explain, first of all, the requirements for tests, if there are any?-- Can I start by talking about Mrs Turton as a whole entity rather than just someone who is on the end of a ventilator at this point?

Yes?-- This lady was admitted on the 3rd of December with a heart attack. She was discharged from the hospital five days later and sent home on drugs that are designed to thin the blood. She is brought into the hospital on the 18th of December, some ten days later, having had a fall at home. The CT scan that was done at the time showed massive damage to her brain. She was left on life support and the CT scan was repeated the following day. This showed no change in the amount of swelling in her brain. From a review of the charts we can see that she's initially had high blood pressure and high pulse rate. The pulse rate is beginning to slow. One of the doctors who has treated her before has administered a drug that would, hopefully, reverse some of the anticoagulant that might have been on board because there was a question over which anticoagulant was being used. The second part of that was she was also administered a drug which was designed to reduce the amount of urine she was putting out because she was actually putting out a very high volume of urine. This is known as diabetes insipidus as against sugar diabetes, which is more common. The commonest reason for that is that the brain is so distorted that the small gland at the bottom of the brain, the pituitary, and the area above it, the hypothalamus are not producing what is known as antidiuretic hormone, ADH, so we give it artificially. So I have a woman who has fixed dilated pupils. I have a woman who is making no effort to breathe after some 24 hours of sedation. I have a woman who has a CT that's, sort of - I think somebody described look as though a blender had been through it, and a woman who is showing other signs of severe brain damage. There is enough clinical evidence there without the necessity of doing brain stem death tests to know that nothing is going to happen when you turn off the ventilator.

Okay.

COMMISSIONER: Doctor, thank you for that explanation, which is very useful. I think it's important for you to understand I don't understand there to be any criticism of your decision to turn off the ventilator with this patient. The suggestion that has been made is that Dr Patel put you under pressure to do that. No-one's suggesting that you gave into that pressure or that you made anything other than the appropriate clinical decision at the time. The concern, though, is that Dr Patel put that pressure on you not for the reasons you mention as the reasons why you decided to turn off the ventilation, but because he wanted the bed for another patient?-- I'm aware of those suggestions, and I can only say that they would have no

bearing on the way I would have dealt with the patient. What I-----

Doctor, we accept that entirely. We accept that it had no bearing on you, but the concern is still that Dr Patel tried?-- Oh, I appreciate the concern. I, sort of, see no reason for people not to raise that. Dr Patel desperately wanted to do this case as it was - if he didn't do it then he was going to be on holiday, and the patient wouldn't get the operation that Patel thought was appropriate. His concerns about the well-being of this patient who could wait were matched by my concerns for the patient on the ventilator who might or might not have a future until I had actually, sort of, gone through the notes, found out what was being done, because the other thing that was in the notes is that on the 19th of December there was an NFR order signed by one of the relatives of this woman, I believe her brother, which indicated that they felt that she would not want to be, sort of, going on under these circumstances, and this was reiterated when I went and had a word with the relatives afterward. The time lapse between me being called in to see the patient by Dr Patel, sort of, coming and trying to storm my office to put some pressure on me, me talking to the relatives is - it was about half an hour and while the family was collected there was about another half hour prior to myself turning off the ventilator.

Can you tell us, though, about the pressure that you were put under by Dr Patel, accepting as we do without any hesitation that the pressure ultimately had no effect on your clinical judgment?-- Nothing that I could ignore - sorry, I'll rephrase. Nothing I couldn't ignore.

And I accept that as well, but tell us what did happen?-- Well, in polite parlance, he came to see me in my office. I'd just got back from leave, and I was just sort of trying to get through some of my sort of early paperwork, and he came and had a tantrum in my office that his orders had not been followed by Dr Joyner. Dr Joyner spoke to me afterwards and said that he felt that he wasn't qualified to make such a decision, and I sort of agreed with Jon that it is not something that he, as a - I don't - I won't say part-time anaesthetist, but sort of a non-specialist anaesthetist should be expected to do, and I think this was the basis of Dr Patel wanting someone to look at the patient and presumably carry out his orders. Now, if it had been inappropriate, as you say, I would not have done it, but with this patient I felt it was appropriate, and we were merely extending her death.

Well, doctor, just then so that the position is perfectly clear, your view is that firstly the patient Patel wanted to operate on wasn't urgent. It was a matter of his convenience rather than a matter of any urgency concerning the patient?-- Yes.

Secondly, that Patel was desperate to get a bed in ICU so he could proceed with the operation?-- Yes.

And thirdly, that he tried to get that bed by having the patient taken off ventilation in the first instance by asking Dr Joyner who, as you say, wasn't in the right position to make that judgment?-- Yes.

And then he tried to put pressure on you to do the same thing?-- Yes.

D COMMISSIONER VIDER: Doctor, can I just ask you that - we have had evidence given to us that this particular incident caused a degree of distress to the staff, and I thank you very much for the clinical profile that you've given to us regarding this patient. After the event, was there any opportunity for some sort of debriefing session for you to be able to sit down with the staff and go through with them that profile that helped you make the decision that you made, and were comfortable in making it?-- Unfortunately not, because that was immediately followed by, of course, the operation on Mr Kemps and his untimely demise. So Ms Turton - I apologise for this to the family and to my staff - we didn't get a chance to sort of talk through what had happened because I think she was lost in the fold of Mr Kemps' death.

COMMISSIONER: Mr Morzone?

MR MORZONE: Mr Kemps - I think in paragraphs 46 to 56 you deal with it and you state that you had no actual clinical

involvement in that operation. Is that right?-- That is correct.

You subsequently had concerns and wanted a post-mortem, and you went and saw Dr Keating, and you explained that in your statement. One of the matters that I think the Inquiry has found a little alarming, and sometimes frustrating, was that we know before the Kemps operation Nurse Hoffman had again been to see Mr Leck in October 2004. Did you know about that?-- No, I was unaware of her having discussions with anybody except Linda Mulligan, her line manager.

Did you know that there'd been a decision to take some steps to have Dr Patel investigated before the Kemps operation?-- I had no knowledge of that.

Is there any reason that you know of why you, as head of anaesthetics, might not be told that by the executive?-- I can think of no reason why I shouldn't have been told about that.

We also know that on 24 December - I beg your pardon, the 31st of January 2005, documentation was forwarded to the Medical Board, including an assessment of Dr Patel. Were you at any time asked about the assessment of Dr Patel's performance for the purposes of his re-registration?-- No.

Were you asked about the assessment - about Dr Patel at any time before his re-registration in earlier years, or re-registration - I should perhaps be more specific - in 2003? There was only one other one?-- No.

COMMISSIONER: Doctor, in relation to Mr Kemps, you describe in your statement - I don't want to go over it again - the approach that you and Dr Berens made to Dr Keating with regard to the possibility of referring the matter for a coronial inquest. My understanding - I don't pretend to have any expertise in this field of the law - is that a death certificate should not be issued, the matter should be reported to the coroner, if a death occurs in the course of a medical procedure where death wasn't an expected outcome. Is that consistent with your understanding?-- The Coroner's Act of 2003 has become very, very woolly.

Yes?-- People with cancer die.

Yes?-- Therefore, is their death unexpected? That's a moot point. What concerned me about Mr Kemps was the mode of death was not what one would expect-----

Yes?-- -----for that particular form of operation. It also concerned Dr Berens, and that is the reason we went to Dr Keating. He, as the anaesthetist who had performed the anaesthetic, and myself as his line manager, for lack of a better phrase. We presented this to Dr Keating, that we felt this was inappropriate, and the fact that a coronial inquest would probably be a very good idea. Unfortunately, during the course of this conversation we found out that the funeral was

under way, and certainly it was my view at the time that I'm not sure how much we would have gained by stopping the funeral, in terms of what we would have done to the family. As I say in my statement, that is something I would have to think over very, very many times. The problem being - and I don't know whether the funeral was rushed or not - we have a gentleman who dies on the cusp of the 20th and 21st of December, we have a funeral that is arranged on the 23rd of December. We do not have the option of putting things back a couple of days. We are into Christmas. And that sort of really complicated the matter as to what, with propriety, we should possibly do.

I was really approaching it in a slightly different way, though. Often emergency procedures are undertaken to attempt to save a life, they're unsuccessful, and in that situation I can imagine a surgeon conscientiously taking the decision death was an expected outcome. "We tried to save the life but it was unsaveable and therefore there's no need to report the matter to a coroner." But in a case where a death arises from what is elective surgery in the genuine sense of the word - not just emergency surgery that's been put off for a day or two, but what is genuinely elective, it seems to me self-evident that Mr Kemps would not have agreed to undergo this operation if he'd been told, "You're likely to die."?-- I'm aware of that, and in fact when we actually went to Dr Keating we weren't aware that the process for the funeral was so far gone that that meant that a death certificate had to have been issued. Now, in that sort of space of time which we thought we had to sort of approach Dr Keating and potentially get a coronial inquest rather than what happened, we didn't realise there was no time to have this done.

Yes?-- I quite agree with you, this gentleman should have gone as a coroner's inquest, but at no time did we realise, until after - well, during the visit to Dr Keating that the funeral arrangements were already in the process.

Doctor, again in case you think any of this is intended as criticism of you, I can assure you it isn't. Indeed I don't know what I would have done in your situation, but it seems to me that you took the responsible course in raising the matter and you took the appropriate course in not pressing it when you realised that you'd interfere with a funeral that was already under way?-- I think that credit should go to Dr Keating as well, who was in agreement with that.

Indeed, and for that matter Dr Berens also. But my question is simply whether there are other cases like this where patients died as a result of surgery that was genuinely elective, where the patient chose to undergo the surgery without any sense that death was a likely outcome, but Dr Patel chose not to issue death certificates - chose - I'm sorry, chose to issue death certificates and not to refer the matter to the coroner?-- I can see where you're going, and there are sort of reasons that patients would die that would be as a result of the surgery, but you can't predict the unpredictable. I know that sounds trite, but if somebody is

going to have an adverse reaction to an anaesthetic drug - you can tell them of the risks of that, and you can tell them the risks are one in a million, but if you're that one, it's pretty-----

It's one in one, yes. I understand. Thank you, doctor. Mr Morzone, would that be a convenient time to break for lunch, or were you almost finished?

MR MORZONE: I'm probably only two or three questions away from finishing.

COMMISSIONER: Go for it.

MR MORZONE: How does that sound?

COMMISSIONER: Yes.

MR MORZONE: Can I ask you to look at the TH37 Hoffman letter? I assume you're familiar with its contents now?-- I've been made familiar, yes.

Do I understand you not to have known about that letter having gone to the executive?-- That's correct.

Again it would seem extraordinary that the Nurse Unit Manager of ICU would have had those concerns and for her not to have communicated them to you. Is there any reason why that would happen?-- Well, there were several letters that she talked about. I'm not aware of this specifically because there are also the letters that I knew she was writing about the sexual harassment aspects of this particular problem, and those are letters I really didn't want to see, and she may have tried to raise these with me, but I was unsure exactly what she was saying in terms of what letters they were. So no, I haven't seen this letter, and it is possible that I did shut her out a bit because I wasn't exactly sure what she was talking about. But no, I have not seen these letters before.

Now, we've heard evidence that it was you that first coined the term "Dr Death". Is that true?-- No.

I have nothing further. Thank you.

COMMISSIONER: You don't wish to point the finger at anyone else?-- If I could do this privately I would be delighted to, but I'm not going to do it on camera, for various reasons.

Can I put it this way: I had inferred from the first suggestion that was a name used around the hospital and someone might have heard you use it perhaps socially or perhaps in jest, and therefore assumed that you were the original source. Is it something like that anyway?-- No, it's not actually. If I'm going to have to go on record, then I'll ask a favour of you at the end, but the term "Dr Death", I'm informed, was actually current in the hospital before Dr Patel arrived.

I see?-- It was referred - it was used to refer to a member of the ancillary staff.

Right?-- I'll quite happily give you the name of who that was.

There's no need for that at all?-- It was not my coining, and it was - and this is one of the reasons that Toni was able to hear it so early on in the piece of Dr Patel's arrival, because it was already current.

But current with reference to someone else?-- Somebody else.

We might resume then at 2 o'clock, if that suits everyone.

THE COMMISSION ADJOURNED AT 12.44 P.M. TILL 2 P.M.

THE COMMISSION RESUMED AT 2.06 P.M.

MARTIN LOUIS CARTER, CONTINUING:

COMMISSIONER: Ms Gallagher - sorry, Mr Tait?

MR TAIT: I have no questions, thank you.

COMMISSIONER: Thank you. Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Dr Carter, can I just ask you about your knowledge of a task apparently entrusted to Toni Hoffman and yourself to review the ICU policies for admission and discharge of patients? Do you have any knowledge of being asked to undertake such a task by anyone in hospital management?-- Yes, we were both approached by Dr Keating and Linda Mulligan.

Okay. Do you have any recollection as to when you were approached in relation to that?-- It would be early in 2005, yeah, pretty well.

We've seen in evidence some documentary evidence in relation to that being discussed in early 2005, and then some e-mail correspondence to which you were a party in relation to the updating of that policy?-- Yes.

Okay. It certainly isn't your understanding that that process had been requested of Toni Hoffman back in July 2004?-- We'd only just updated the policy at that stage, because with the ACHS accreditation, we'd just recently done a new version of that.

Okay. So you would agree with Ms Hoffman's recollection that that process of updating the policy was first raised by management in either very late 2004 or early 2005?-- Yes, they seemed-----

MR FARRELL: Commissioner, I would object to that. That's simply not accurate. The evidence during the cross-examination-----

COMMISSIONER: No, I'm sorry. You can't object because something is inaccurate. Learned counsel is putting something to the witness and we'll hear the evidence.

MR FARRELL: Well, Commissioner, with respect, if he is to put evidence that's been heard by the Commission, he should put it accurately. Ms Hoffman accepted in cross-examination that there was a discussion held in July 2004 and that it was agreed in that discussion that she would review the issue of the transfer policy. I simply submit that if evidence is to be put to the witness on the basis that it is the evidence, it should be represented accurately.

COMMISSIONER: I don't see any inconsistency between what you've just referred to in the transcript and the question put by Mr Allen, so I'll overrule the objection. Yes, Mr Allen?

MR ALLEN: Okay. Your first knowledge of any type of process in which you were to be involved in updating the ICU policy came to you in early 2005?-- No, it's basically being updated since I arrived in 2001. There's two versions that - prior to the one that we did in 2005 of mine - were already in existence, and we merely updated them. The policies as they were updated were put through to the Medical Executive Council - Executive Council - let's get this exact - for submission and discussion in the previous year. I'm afraid I cannot remember the exact dates, but again it would relate to the ACHS accreditation meeting when everything was revamped.

Yes, but I thought you'd agreed with the fact that there was a process in 2005 whereby both yourself and Ms Hoffman would look at the formalisation of a new policy?-- Yes, there was a process at that time, but it was not a new policy. It was updating the existing policy, which didn't have much in need of change.

I understand that?-- Because the transfer components were already in it.

Yes.

COMMISSIONER: Doctor, was there a point in time that you recall - I don't mean the exact date, but a point in time when a request came from the hospital executive - Dr Keating or Mrs Mulligan or someone - to do a new revision of the policy which they might have referred to as a new policy?-- Yes, that is correct.

And when did that occur?-- Early 2005.

Before that there had been discussions from time to time about updating the policy?-- We tended to update every now and again. When I arrived, the policy that was in place was under the signature of Martin Wakefield, my predecessor.

Yes?-- I sort of had a quick look through and basically changed the signatures and nothing else. About two years later we went back and had another look at the policy and slightly revamped it. The policy that we've just talked about was again an updating of that policy, and at this time we sort of put in some elements about things we should audit as effectiveness of our policy.

All right. From whom did you receive that request?-- I received it from Dr Keating and Linda Mulligan.

And you say that was in early 2005?-- Yes.

You can't be more specific than that?-- No, I can't be more specific than that.

Thank you.

MR ALLEN: And there was nothing - anything said to you by either Dr Keating or Ms Mulligan to indicate that they were concerned about the length of time that process was taking?-- They seemed to want to put an early timetable on it, but given the clinical workload that I had at the time, Toni and I weren't able to get together to actually sit down and put a formalised version on. So there were versions going between the two of us, and a version was sent to Dr Keating which at the time he did not realise was the final version because he'd also received a version from Toni Hoffman which was approximately the same, but we then had to go to another meeting to clarify the fact these were our final thoughts and this was the final version.

That whole process-----

COMMISSIONER: Sorry, Mr Allen. When you were asked to do this in early 2005, it wasn't put to you on the footing that this was something that Mrs Mulligan or Dr Keating or someone had understood that you had been working on for six months or some period of time at that stage?-- No.

It came as an entirely new request?-- Yes.

Thank you.

MR ALLEN: Thank you. You gave some evidence in relation to a patient, P30?-- Yes.

Okay. Is it the case the real concern about that patient is that the surgery you've referred to was necessitated by the failure of Dr Patel to initially properly place the Tenckhoff catheter?-- No, that wasn't made clear to me.

You weren't aware of the reasons why the surgery was being undertaken?-- The problem was that the Tenckhoff, I know, was not working correctly and, as Patel said at the time, it had flipped up under the liver and he sort of re-opened the abdomen to flip the end back. But once - when you've only just sort of redone that, you can't actually use the Tenckhoff catheter because with a hole in the abdomen, the peritoneal dialysis fluid would leak out. So it necessitated removing his old Permcath and putting a new Permcath in, and as I said in my evidence, he'd had surgery on that side in the past and that sort of complicated the insertion.

The problem arose from the Tenckhoff catheter flipping up under the liver?-- You could put it that way.

Well, would the surgery have been required if that hadn't occurred?-- It may well have been required even if that hadn't worked, because in the situation where the Tenckhoff catheter has become misplaced, you may still have the potential for a leak, as I sort of explained. It is unlikely that it would have needed to be done if the Tenckhoff had worked properly.

Right.

COMMISSIONER: I'm sorry, doctor, I think this was the point though: the surgery was necessitated because the Tenckhoff catheter wasn't working?-- I can accept that.

And for similar surgery to be necessary there would have had to be some misadventure with the catheter, whether it was the case of it flipping up under the liver or some other blockage or dislocation or something that caused further surgery to be needed?-- Yes.

If the catheter had been correctly installed in the first instance and hadn't undergone some such misadventure, the surgery would have been unnecessary?-- That is correct.

MR ALLEN: You gave some evidence-in-chief that you were aware of a meeting between Toni Hoffman and Mr Leck in February 2004, and also aware of her concerns as demonstrated in a document you were shown which is Exhibit TH10?-- I think I said I hadn't seen that and was unaware of the meeting.

I see. Well, I may have misunderstood your evidence, but I'll ask you to have a look at TH10, the document you were shown earlier today.

COMMISSIONER: For what purpose, Mr Allen, since the doctor has told us he was unaware of it?

WITNESS: I was unaware of this document.

MR ALLEN: You were unaware of that document?-- Unaware of that document.

Okay. Thank you. You were asked at the same time whether you shared any of the concerns which are raised in that document in relation to complexity of surgery being undertaken, and you said that you were a bit bemused because Bundaberg Hospital had already done oesophagectomies, and that Ms Hoffman hadn't raised concerns about them with you. Do you remember giving that evidence?-- Yes.

I suggest to you that after Ms Hoffman commenced at the Bundaberg Base Hospital, and prior to Dr Patel's arrival, there had only been one oesophagectomy performed?-- You're probably about right.

So you are saying that Ms Hoffman hadn't raised any particular concern with you about that oesophagectomy being undertaken?-- No.

Is that so? So do you somehow say that that means that you therefore discounted or would discount her concerns about oesophagectomies being undertaken by Dr Patel?-- No, that isn't what I meant. I meant just saying her concerns were raised after the case of this particular gentleman, Mr Phillips, that they weren't raised at the time that - when we planned and did an oesophagectomy with another surgeon.

Right, one oesophagectomy prior?-- Yes.

Now, was your evidence that you were actually on leave at the time that oesophagectomies were carried out by Dr Patel initially at the hospital?-- No, I anaesthetised Mr Phillips. So I was definitely there during that period. It is the next patient who had the oesophagectomy who I was not in the hospital for.

I see. All right. But was your evidence that you were aware that Toni Hoffman went to Dr Keating on two occasions, once with Glenda Goodman and once with Dr Joyner to discuss her concerns about oesophagectomies being carried out?-- I was aware of that meeting. I was made aware of it on my return from leave. The concerns that I gathered, when talking to Dr Joyner, was that these sort of major surgeries should not be taking place without the senior anaesthetist available.

You didn't understand that the concerns being voiced were that operations of that complexity were outside the scope of practice of the Bundaberg Base Hospital?-- My understanding was that they were outside the capabilities of Bundaberg Hospital when they had no senior anaesthetist.

So you - Dr Joyner never indicated to you that his concern was merely the fact that they would be carried out at Bundaberg?-- No, he - I understand from Dr Joyner, of what I have read, that Dr Joyner was not concerned about the fact that the operation was happening, but the fact the operation was happening without the senior anaesthetist in the hospital.

So then you were present for - excuse me, you weren't present for the second oesophagectomy?-- Correct.

When did you next hear any concerns being voiced by any members of staff about oesophagectomies being carried out at Bundaberg?-- I don't exactly recall.

Well, was it in 2003, the same year?-- I suppose what could be interpreted from what you are saying is that yes, I did hear, because the concerns were raised with me that the oesophagectomy had been carried out while I wasn't there.

I mean subsequent to that?-- No.

Never heard any other concerns raised after that time?-- We - not till much later on in the piece. I suspect this would be around about the time of Mr Kemps.

So very late in 2004?-- Yes.

Nothing till then?-- I heard nothing till then.

And was it after the episode involving Mr Kemps that you first raise any concerns with management regarding the carrying out of oesophagectomies?-- With the evidence that we now had, that two out of the four oesophagectomies that had been performed had died in the immediate post-operative period, one of whom had died because we don't quite know why, with torrential bleeding which had no place in the problems that this patient would potentially die from-----

Is that Mr Kemps?-- This is Mr Kemps. That with that evidence, and now enough to go to Dr Keating with a complaint from myself backed up by the anaesthetist who actually anaesthetised the patient, we were in a position to sort of say Dr Patel had obviously passed the threshold where we could say that he was not competent to do this particular procedure.

So your answer is yes, the first time you raised concerns yourself with management on that subject was after the matter involving Mr Kemps?-- Correct.

COMMISSIONER: I don't think we need to ask the witness to repeat the answer. That's precisely what he said.

MR ALLEN: In relation to the matters you are aware of concerning the statistics from ICU, the increase in ventilated hours, et cetera, you indicated that you would take those details yourself to two forums?-- They were mentioned, yes, at two forums, the Medical Staff Advisory and the Executive Council.

Okay. And the Medical Staff Advisory Council, what did that comprise?-- Theoretically, all the specialists within the hospital, plus invited members of the community. It would include local GP representatives as well, as well as members of the hospital executive.

Which persons of the hospital executive?-- Dr Keating, Dr Leck - Mr Leck, rather.

And the other body was the medical executive, is that right?-- The executive committee, the Executive Council.

Okay. So that would include, what, Dr Keating, Mr Leck, the Director of Nursing?-- Yes.

And some other members?-- Plus the directors of the various departments, plus corporate services, plus mental health.

Do you remember over what period of time you would have taken those matters to those two bodies? Do you remember when it

would have started?-- It was part of my normal report but I can't remember exactly when it started. I would always be sort of commenting on the hours that were being done and the amount of overtime that was being done, both in anaesthetics and with the intensive care staff.

Did you notice a trend in increased ventilated hours during the time that Dr Patel was Director of Surgery?-- Yes.

And do you recall when that trend was first being noticed; how soon after he started?-- As I said, when I was examined earlier, the problem with looking at those figures just by themselves is there are a lot of other things going on. Obviously, as he was doing more complex surgery, then we were sort of having more patients on ventilators. Also, as we were moving less patients to Brisbane because Brisbane had less opportunity to take our patients, then those hours are going to increase. And as the ambulance men got more efficient at resuscitating people after cardiac arrests, then there is going to be an additional number of patients who are going to come in from that who are going to require ventilation for a short length of time.

Do you remember when you first noticed the trend towards the increase in ventilated hours? Was it soon after Dr Patel commenced as Director of Surgery?-- The only figures I actually sort of produced for the committees usually related to a particular year, particular quarter. Whether Dr Patel was there or not, I am afraid I didn't take any notice of that.

So the figures were examined quarterly and you recall which month that they would be collated in relation to a particular quarter?-- Quarterly. No, I don't know exactly which month was picked to do the divisions.

COMMISSIONER: Doctor, do I take it from your evidence that you accept that the volume of complex surgery performed by Jayant Patel contributed to the overtaxing of the resources in ICU but it wasn't the sole cause?-- Yes, thank you for putting it like that.

Yes.

MR ALLEN: At either of these forums did you have discussions with members of the executive as to this trend of increased ventilated hours? Did you simply present the figures or did you speak to them?-- I don't understand the difference you are trying to make.

Did you raise as a topic for discussion the fact that there was this significant increase in ventilated hours?-- It is reported and it was discussed on a line of the costs of actually the overtime, the costs in terms of fatigue for the anaesthetists, and more in general sense, not just specifically to say, "Well, you know, what can we do about it?", because if you can't send your patients out because you are bed-blocked, then there is no answer that you have within

the unit.

COMMISSIONER: And did you identify as one of the factors - not the sole and perhaps not even the major but as one of the factors the level of complex surgery being performed by Dr Patel?-- There were possibly only about half a dozen cases that were complex surgery. If we're talking about major surgery, then we're talking about things like oesophagectomies, we're talking about biliopancreatic surgery, the Whipples procedure, if you like, the half a dozen patients that he did in that nature could not have caused the rise in the number of ventilated hours unless we'd have had the patient there for sort of several weeks on a ventilator.

MR ALLEN: So are you saying that you did not regard Dr Patel's undertaking complex surgery as a significant factor in the rise of ventilated hours?-- Correct.

So therefore you wouldn't have voiced any concern to executive as to the complexity of any surgery he was undertaking?-- That is correct.

Were concerns voiced to you by any other persons other than Toni Hoffman as to Dr Patel's clinical practices?-- There was an argument he had with Dr Berens where he came and complained to me afterwards - and that is Dr Patel came and complained to me afterwards - saying he had never been spoken to like that since he was a medical student. Dr Berens was very keen on evidential medicine and inquired of Dr Patel, you know, where he got the evidence for doing the techniques that he did. So, yes, I suspect that Dr Berens was criticising some of his clinical skills in patient management. I don't know that he was criticising skills in other areas.

So did any other staff voice to you concern about his clinical competence?-- I suppose - there were comments from Sister Hoffman, yes.

And other nurses?-- No.

Do you recall ever having a conversation with Gail Aylmer where she asked you for your opinion as to Dr Patel's ability as a surgeon?-- No.

Did you ever indicate to Ms Aylmer that you wouldn't certainly let him operate on you?-- That's correct.

Isn't it-----

COMMISSIONER: Sorry, sorry, is it correct that you wouldn't let him operate on you, or is it correct that you told Ms Aylmer that, or are both correct?-- Both are correct. There is certain - certain problems about having surgery within your local area, that basically should anything go wrong within your own hospital, then you don't want to be at the wrong end of that because it creates even more havoc. Doctors and nurses make very bad patients and they make even the worst sort of patients within their own hospitals.

I think that remark has been taken in a slightly different way, though. It has been interpreted as if you are saying that confidence in Dr Patel's clinical skills were so low that you wouldn't have allowed him to perform surgery on yourself?-- I think the rest of the remark actually made at the time was that I wouldn't allow anybody in town to operate on me for those reasons, and I think Dr Thiele is an excellent surgeon, I think our orthopaedic support is excellent, but to actually have things done in your own town in the small environment is sometimes not the world's greatest idea.

So if that comment's been interpreted as a reflection on Dr Patel's clinical skills, that wasn't how you intended it?-- No.

You have your views about Dr Patel's clinical skills but you didn't convey them and you didn't intend to convey them at that time?-- No, that was not my intent.

Yes?-- It was - I think it was - I think it was taken that way.

Right.

MR ALLEN: Did you have your own views as to his clinical competence?-- If I had minor basic surgery done, yes, I suspect I would have let him loose on me, but anything more than sort of basic surgery, no. I think he could, as somebody put it, drive a good scope. His endoscopy work was, on the whole, reasonable. It took him a while to get used to the equipment we had, but sort of got better very quickly. Most hernia operations went reasonably, most gall bladders went reasonably, and that's the bulk of our surgery. So for doing the routines, he was a perfectly competent surgeon, which is probably one of the reasons that I was sort of a lot slower to try and make up my mind about whether he was capable of doing the complex stuff.

So you considered him capable of the lesser more standard procedures?-- Yes.

COMMISSIONER: Mr Allen, we really don't need to get the witness to repeat every answer. He has said that.

MR ALLEN: Did you form any opinion as to his ability to undertake more complex procedures?-- As I said before, not till after Mr Kemps. That's where he sort of crossed the threshold that I would sort of no longer have a sort of - sufficiently low index of suspicion that he probably shouldn't be doing this sort of work.

Now, can I suggest to you that you frequently, in the presence of Toni Hoffman, referred to Dr Patel as Dr Death?-- No, I didn't. The first time I came across that remark was in the press.

And that you also referred to Dr Patel as Dr Death in the

presence of other nursing staff at the hospital, including Jenny White, Gail Aylmer, Martin Brennan and Vivian Tapiols?-- No, did not.

You gave some evidence that you weren't aware of Toni Hoffman seeing Mr Leck in October 2004 and not aware of any investigation into Dr Patel commencing at that time?-- That is correct.

Do you know that you were working at the hospital during October 2004?-- Yes, I was working in the hospital in 2004 in the October that month. I was away in November/December when I had to go back to the United Kingdom.

I see. So you would have left some time in November?-- Yes.

And did you return, what, late December, I expect?-- I was away for three weeks for a family crisis, came back for a week, and then went on leave for a week and then returned to work on the 20th of - it would be the 20th of December.

Okay. You gave some evidence this morning that those patients at the Bundaberg Base Hospital who required transfer for further care would be transferred?-- That is correct.

All right. Did you have any involvement in relation to the care of a 15 year old boy, P26, in late December?-- I had very fleeting contact with him. He was being transferred out of the unit when I was around. What I have to make clear is that although I am notionally head of the department - the intensive care unit on the medical side, it doesn't mean I am around there all the time. I will be there sort of rostered on about one week in three or four, depending on how many staff we had. So although he spent time in the unit, I may not have been the intensivist on, and if he was not requiring involvement from the anaesthetic side, we would not have been anywhere near him.

You can't comment as to whether he was transferred at a time when transfer was required?-- I can make no comment on that.

And you are not purporting to speak as to all of the patients Dr Patel may have operated upon, whether they were transferred at an appropriate time or not?-- I can't comment on that, because a lot of the patients I was not the anaesthetist. Or, again, unfortunately, I take holidays.

I am just trying to understand the basis of the comment you made that those patients who did require transfer for further care would be transferred?-- Certainly when I was around.

When you were around? Okay. Were we-----

COMMISSIONER: Sorry, Mr Allen. I guess it wasn't always your decision, though; that if the patient was under Dr Patel's care or, for that matter, Dr Miach's care, or someone else's care, you didn't get to choose whether the patient was

transferred to Brisbane?-- Well, I could certainly recommend it.

Yes?-- But when you are transferring care of a patient, you have got to make sure there is a person in a position to receive that patient, and surgeon to surgeon or physician to physician contact is a primary sort of need for that sort of situation.

Yes?-- If I am transferring somebody for intensive care reasons, then I will talk to the intensivist, and certainly if we need to sort of send to intensive care, I would do that. But if the ongoing care needs to be surgical or medical, then it is up to the physician or surgeon who has their name on the bedhead to make contact with the receiving hospital.

So, really, all you are saying to us is that when it was your decision, or when you were making the recommendation, you made what you considered to be the appropriate decision or recommendation?-- Yes.

You are certainly not giving evidence as to the appropriateness or otherwise of decisions which Dr Patel made regarding his patients?-- That is correct.

And specifically we have been told from other sources that Dr Patel was apparently reluctant to have his patients transferred to Brisbane, and at times kept patients in Bundaberg who a more competent surgeon might have realised was beyond his skill and had transferred to Brisbane. You are not commenting on that aspect-----?-- I am not commenting on that at all, and the problem with the specific example that's been chosen, this young gentleman is in fact not on the intensive care unit when the decision should have been - could have been made, and any input from the anaesthetic side just wouldn't have come because the patient was not in the intensive care unit.

He was actually in the surgical ward?-- Yes.

MR ALLEN: Can I suggest - I will ask this: do you recall the third oesophagectomy which was carried out by Dr Patel? You weren't there for the second, from what you have told us?-- I would need to look at my notes for a name. There is three names that stick well with me but I am not sure of the fourth.

COMMISSIONER: What's your question, Mr Allen?

MR ALLEN: Yes. Can I suggest to you that at around that time, Gail Doherty spoke to you voicing concerns about oesophagectomies being carried out by Dr Patel?-- Could I have a name or a number for this patient, please?

No, I can't, sorry, but it was either after the second or third oesophagectomy carried out by Dr Patel?-- If it was-----

MR MORZONE: I can hand the witness Exhibit 89, which is the

list of oesophagectomy and Whipples procedure. That may assist.

COMMISSIONER: Thank you.

MR MORZONE: I think they are listed from the latest back to the earliest, rather than the other way around.

WITNESS: In that case there is only three oesophagectomies in here.

MR DIEHM: I think there is four. It is November 2003, I think, from memory, if that assists the witness.

WITNESS: The patient I have on this list is for December 2003.

MR DIEHM: Sorry.

WITNESS: And he survived. He is still alive as far as I understand.

MR ALLEN: Yes. Can I suggest that either after the second or third oesophagectomy carried out by Dr Patel, that Gail Doherty spoke to you about Dr Patel undertaking oesophagectomies?-- I have no memory of that.

I suggest that you said words to this effect: "The patients are fit for anaesthetic, and Dr Patel said he could do them, so we can't say no."?-- I can't recall that conversation.

There has been some evidence given suggesting that you were unnecessarily disruptive and uncooperative and rude at ASPIC meetings and that that therefore adversely affected their function. Do you have any comment as to that?-- I think that would be incorrect because I, as the Chair of the meeting, would try to keep order.

Did they seem to be a useful process?-- No.

Why not?-- Too many people involved, too many people trying to put disparate views into too short length of time. I spent a lot of time trying to get the ASPIC group broken up so we could have two smaller groups which might be able to accomplish something.

Okay. What about the quality of the information that was coming into the meetings for discussion?-- The best bits of information were brought together by people who wanted to introduce policies and that was sort of well handled. The other information was very limited. The discussion that was being made on wound dehiscences didn't seem to come in with any particular coordination. Dr Keating, Mr Leck, and Dr Patel decided they wanted to rereview it and they took it away. They came back with totally different answers and the thing just died. So there is no real coordination of how information came to the unit, and that produced one of the big arguments that was there because the DQDSU staff, who were

meant to be supplying us with this sort of information so that we could look at in terms of the complaints process, the adverse incidents, were not coming back to us with any information. At one point they decided that we will not - we were not worth dealing with and they walked out because they weren't allowed to run the show in the way that they wanted.

But one of the problems was they weren't bringing the information they were supposed to?-- Well, that's right. We wanted them as a source of information. They wanted just to run the show.

I see. It's been suggested that one of the difficulties with the ASPIC meetings which you were chair is that Dr Patel would try and talk over people and, in particular, was aggressive towards yourself, Ms Hoffman, and Di Jenkin?-- Correct.

So that was another difficulty which led to you suggesting breaking them up into two groups?-- Correct.

Did that happen?-- No.

Was there any reason why it didn't happen?-- Basically Dr Patel left.

Okay. So it was a discussion towards the end of 2004?-- Yes.

Right. In relation to Mr Bramich, the evidence is that the request for his transfer was made at 2.30 p.m. or thereabouts, I think?-- The only-----

Oh, excuse me, 4.20, 4.20 p.m. Now, are you aware whether there had been any contact with the Prince Charles Hospital prior to that time to actually attempt to arrange a bed for him?-- There would have had to be because you can't arrange transport unless you know where the patient is going to.

And there's been some evidence from Ms Hoffman that at an earlier stage she had rung the Prince Charles, they didn't have a bed, but then they got back to her saying there had been a bed found at the PA Hospital, but the difficulty was that Dr Patel wouldn't speak to the surgeon, and that that was a necessary step for any transfer to be arranged?-- Well, that can't be the sequence of events because nurse Hoffman would not have been the one initiating phone calls. The phone call, as I mentioned earlier, has to go from surgeon to surgeon. We have to have a receiving surgeon in these sort of situations. So the initial phone calls would have been made, and I believe I'm correct in saying Dr Boyd, and once the - the phone call may have come back that sister Hoffman took, but she would not have been the one initiating any of this form of transport.

COMMISSIONER: It is conceivable, though, that as Mr Allen says, someone rings the Prince Charles and says, "Do you have a bed", that could have been Dr Boyd or almost anyone?-- I would expect it to have been Dr Boyd. Sorry, I'm interrupting, I apologise.

They don't have a bed at that time, but a call comes back saying there's no bed at the Prince Charles there's one at the PA, it's quite conceivable Toni Hoffman would have received that call for the purpose of putting it through to the surgeon which at this stage would have been Dr Patel?-- At that stage the surgeon involved was probably still Dr Gaffield.

Right?-- But I would suspect that would be the sequence of events, as I understood it.

And it would then have been an obstacle to a transfer if Dr Patel had said, "No, I'm not going to speak to the surgeon at the PA, we're going to keep the patient here"?-- That would have been an obstacle, except the transport was booked at 1620, according to the log at the flight coordinator which was, I think, basically before Dr Patel got involved with the case.

Thank you.

MR ALLEN: Your recollection is that he didn't become involved with the case until after that?-- That is my recollection.

There was some evidence given, including by Dr Strahan, about an occasion in early 2005 where there was concerns that Dr Patel might undertake a procedure on a patient which might lead to him, perhaps, undertaking a Whipple's procedure and that as a result an arrangement was reached whereby the patient would be booked into a medical ward for a medical transfer and then - so as to facilitate surgery in Brisbane rather than Bundaberg?-- That's perfectly feasible.

Do you have any recollection of that?-- I have no specific recollection of that.

Is it possible that you were, in fact, consulted about that and agreed to that course?-- I can't honestly remember.

COMMISSIONER: Had you been aware of the fact that Dr Patel was contemplating a Whipple's procedure on a patient in Bundaberg would you have supported the notion that it would be preferable for the patient to go to Brisbane rather than having that operation in Bundaberg?-- Yes. Basically, with the past history at this stage with the - knowing that he wasn't really up to doing the oesophagectomies, I don't think I would have contemplated providing an anaesthetic service for him for a Whipple's.

MR ALLEN: Finally, I don't actually have a copy of your final statement in front of me, but around about paragraph 57 or 58, I expect, the numbering has been changed, you deal with Mrs Turton?-- Yes.

And does it commence with paragraph 57 or has that changed?-- It commences with paragraph 56.

56, thank you?-- None of the paragraph numbering was changed.

Okay. Thank you. Look, the amendment you made in the first line of paragraph 57, was that after actually being able to review further material so as to clarify that?-- No, that was my looking at the CT scan.

So your initial look back in December 2004?-- Yes.

So - and just so I understand the clarification, whereas the draft originally referred to an intracerebral bleed which is a bleed, what, in the brain?-- Yes.

You have clarified that it was actually intracranial, which is inside the skull, both inside the brain and outside the brain?-- Yes.

And, what, extracerebral, would that be the same as a subdural haematoma?-- Yes.

So it wasn't - and I suppose now it would be paragraph 60, whereas your draft originally indicated that it was the intracerebral haemorrhage that was so severe as to mean that brain death testing wasn't required.

COMMISSIONER: Paragraph 60 has been amended to refer to both extensive intracerebral and extradural haemorrhage.

MR ALLEN: Yes, I'm just clarifying that whereas the draft originally indicated the intracerebral that was so severe you now clarified it was the intracerebral and the extradural?-- Yes.

Okay. Did you, at the time, have the benefit of any radiologist report?-- No, the radiology on that lady was not reported on until a week ago.

Is there usually a five or an eight month delay in reporting?-- That's a bit excessive, but normally we would get the results back after the patient had left the hospital. It would be quite common for that to happen.

How common is it that it would go for five months or so?-- I think that would be highly uncommon and I think, basically, because this patient was deceased that nobody bothered to, sort of, check up whether the radiology report had been done or not.

I see. But there would have been provision for you, would there not, to chase up radiology reports at the time?

COMMISSIONER: Mr Allen, what does it matter?

MR ALLEN: Well, I'm just trying to clarify the circumstances.

COMMISSIONER: I don't think anything's even remotely unclear at the moment.

MR ALLEN: Well, it wouldn't seem like a difficult question to answer, whether it was possible to obtain radiology opinion at the time.

COMMISSIONER: I'm sure you can think of a lot of questions to fill up two weeks that aren't difficult, but can we move onto things that are relevant?

MR ALLEN: Well, this is relevant, in my submission.

COMMISSIONER: Okay. Keep going. Keep going.

WITNESS: The comment I had from the radiologist that I got to review this was, "I don't do acute work."

MR ALLEN: So you tried to get a radiologist report?-- This is when I got this radiology done a couple of weeks ago. We have a delay system, which I don't know why. At various times we've complained that X-rays are not reported. There was no reporting system because the radiologist who was working in town left town and the X-rays were sent to Melbourne, to Tasmania, by electronic means and they were reported at leisure by the radiologists, as far as I could understand. The reporting system was, to use a word, pathetic at times and this also came up at various medical executive meetings. We were complaining about the level of reporting. There are some X-rays that you can read, yourself. I mean, I'm perfectly happy looking at a chest X-ray, a chest CT, a blatantly obvious brain CT, but some of the nuances that you might see or might not see in certain X-rays, I think they're beyond me. As an anaesthetist I'm certainly happy reading some of them, and I will read MRI's of the lower spine because that's part of my training as an - in pain medicine, but a lot of the routine radiology was not reported until well after the event.

COMMISSIONER: Doctor, with specific reference to the patient we're talking about here, was there any ambiguity, uncertainty, lack of clarity in the - that required you to have the assistance of a radiologist?-- None at all.

Has this situation improved in relation to the provision of radiological reports to the Bundaberg Base Hospital?-- Yes, it has now that there's the - a new radiology practice has opened up in town. I think the people we refer to now will up their game.

So it has improved?-- Yes.

You obtained radiology reports a couple of weeks ago?-- Yes.

And was that prior to you making the amendments to your draft in relation to the nature of Mrs Turton's condition?-- Well, I didn't make the amendments until this morning because the - I wasn't quite sure how to go about it in the appropriate manner, so I took advice on to how to do this and produce the amendments that you see. The statement wasn't actually sent to me till after I got the radiology review because it came up for - from a conversation with Martin Brennan saying that when he was here he was asked to review the reports of the X-ray and these could not be found. So we went back into the hospital system and found that the X-ray had been performed but not reported.

Yes. And Martin Brennan in his evidence, without being in any way critical of you and specifically making that clear, was concerned about the sort of haste involved, as he perceived

it?-- Certainly that was his comment.

Yes. And he made it quite clear, doctor, that he wasn't in any way questioning your ultimate clinical judgment; do you understand that?-- I appreciate that, and he told me so, himself.

Yes, thank you. Dr Patel reported in the patient notes that he had reviewed the CT scan and there was brain stem herniation. That would have indicated brain death, itself, would it not?-- No, not necessarily. It's highly likely. The clinical response that I went on to that was the fact that the patient was producing a large volume of a dilute urine with no diabetes insipidus. As I said earlier, this indicates that the little gland at the bottom of the brain, the pituitary, had been damaged and if that has happened then brain stem herniation has occurred

COMMISSIONER: Did you, yourself, observe anything on the scan to suggest brain stem herniation?-- I was actually looking at something else on the scan which is basically the size of the scan. There's - sorry, the size of the bleed on the scan.

But, doctor, did you, yourself - are you able to confirm Dr Patel's claim that the scan showed brain stem herniation?-- I didn't look for it.

Has - the radiology report recently obtained, does that comment on that issue?-- I don't have the report in front of me, but I cannot recall seeing it.

Yes.

MR ALLEN: If you could just have a look at this.

COMMISSIONER: Really, doctor, I'm wondering whether Dr Patel either as a matter of wishful thinking or with a more sinister motive claimed to see something that wasn't there.

MR ALLEN: You have two radiology reports there?-- Yes.

One from a CT scan of the 18th and one from the 19th of December '04?-- Yes.

And these are the reports that you obtained on the 27th of July this year?-- That is correct.

Yes.

COMMISSIONER: And do they refer to brain stem-----?-- They do refer to brain stem herniation. What I was looking at and what the radiologist has commented on was the size of the bleed within the - I will have to remind me of the side - on the right side; the size of the extradural bleed on the right and the fact that the midline of the brain had shifted over so much that it had obliterated the normal spaces, the ventricles that are referred to here. So that size of that bleed and the condition of the patient is almost universally fatal.

Doctor, accepting all of that, I think the concern is how Jayant Patel convinced himself that there was evidence in the CT scan of brain stem herniation or whether that may have been merely an excuse that he raised because he wanted to turn off the ventilation and get the bed for another patient?-- That's quite possible.

MR ALLEN: Because the report, itself, says there's an extensive right-sided extracerebral collection passing around the brain and causing marked compression?-- Yes.

The - you've clarified your statement so as to indicate that, in fact, there was an extracerebral bleed as well as intracerebral?-- Yes.

COMMISSIONER: Mr Allen, we've heard that now three times. Do you have to ask it any more times?

MR ALLEN: The - there's reference there to not being able to entirely exclude a slight degree of instance substance, high density material; would that be a reference not being able to exclude slight degree of bleed in the brain?-- Correct.

But the major abnormality is a very large extracerebral collection?-- That's one of them. The main thing in that - in that X-ray report is what is talked about with the midline shift obliterating the ventricle on that side. That says there's a huge pressure effect and that's what I was going on when I interpreted the CT.

That pressure effect is, in some cases where it's appropriate, addressed by evacuating the subdural haematoma?-- Correct.

Is that correct?-- Yes.

And-----

COMMISSIONER: Was that possible in this case?-- The patient had been referred two days earlier to the neurosurgeons at the Royal Brisbane Hospital. They had declined to accept this patient and said the transfer was a waste of time given the patient's poor prognosis.

MR ALLEN: Did they have the benefit of CT scans?-- I believe they did.

The same ones taken on the 18th and 19th?-- Yes. I can't promise that, because the normal route of transfer down to Royal Brisbane would be by e-mail and the person who takes the photographs of the scans and sends them down by e-mail wasn't available. They could have been couriered down, but I don't think that anybody would need to make any comment about those particular scans as other than the Brisbane people referred to them.

So the scan, itself, would have been couriered down?-- That is my understanding.

And reviewed by someone who then communicated to the Bundaberg Base Hospital?-- That is correct.

And to yourself or to someone else?-- Since I was in Norfolk Island at the time this lady came in, then it wouldn't have been to me. I think - the memory says that the writing was Dr Sangee's.

And so Dr Sangee has made a note in the record?-- Yes.

I will tender those, if the Commission wishes, otherwise I will ask for them back.

COMMISSIONER: The radiology reports relating to Robyn Turton will be marked collectively as Exhibit 268.

ADMITTED AND MARKED "EXHIBIT 268"

MR ALLEN: Thank you, doctor.

COMMISSIONER: Thank you. Mr Mullins?

CROSS-EXAMINATION:

MR MULLINS: Thank you, your Honour. Two matters. Briefly, doctor, my name is Mullins. I appear on behalf of the patients. You mentioned that you believed Dr Patel was a reasonable surgeon in basic or routine surgical procedures?-- Yes.

But as far as complex surgery was concerned you believed he wasn't capable?-- By the time Mr Kemps died I had good for that.

You said in your evidence it was not realistic for an anaesthetist to supervise a surgeon during the course of surgery?-- That is correct.

And there were, at least, two reasons for that; firstly, you are not trained in the same field?-- Correct.

Secondly, you're busy monitoring the patient's staying alive during the course of the surgery?-- Correct.

Your ability to observe and assess the surgeon's surgical skills are also limited by those two matters?-- Certainly, plus a large green sheet in between us.

And you would agree that another specialist surgeon who has

subsequently assessed Dr Patel's patients is in a much better position to assess the quality of his surgical skills than you?-- Certainly.

Doctor, in respect of patient 34, Mr Nagle, some evidence has been given previously that the cause of the complications - the complication to Mr Nagle may have been the inappropriate insertion of the J tip of the catheter?-- I have read that, yes.

Well now - and that the doctor who gave that evidence suggested that the - if the J tip was inserted in the reversed position it may have caused the perforation?-- The catheters that we actually - the guide wires you pass through the catheters have two ends. One is a soft end, so the - you are not forcing a sharp object through the blood vessel. The other end is stiffer, so that you can actually thread, first, the dilator and, second, the catheter over that wire because you don't want to try and, sort of, feed a, sort of, small floppy thing through the hole. It's not - it doesn't work quite as well - quite as easily. So it may be possible that Dr Patel reversed those - the wire. I didn't notice that at the time.

All right.

COMMISSIONER: And if Dr Patel did reverse the wire that would be consistent with potential injury to the artery?-- Certainly, certainly.

MR MULLINS: Thank you, your Honour.

COMMISSIONER: Thank you. Mr Devlin?

CROSS-EXAMINATION:

MR DEVLIN: Ralph Devlin for the Medical Board, doctor. If I can just show you up on the screen a document taken from James Phillips file, P34, and here I have a hard copy of it, as well. The first document-----

COMMISSIONER: Can you focus it out a bit, so we have full width?

MR DEVLIN: The first thing I want to show you is the address on the top of the document, if you can drop it down a bit. It's addressed, "Bundaberg District Health Service, Bundaberg Base Hospital". If we go to the bottom of the document the purported signature is Mark Appleyard. He was a visiting gastroenterologist from Brisbane?-- Correct.

If we go back up the top of the document it's dated 23 April 2003?-- Yes.

It's in respect of James Phillips and addressed to Dr Miach, correct?-- Yes.

I just want to go to the recommendations now. Does this appear, that this follows an endoscopy?-- Correct.

And the recommendations from Dr Appleyard are, "I am concerned about the appearances of the oesophageal nodule. If the biopsies are negative he should be put on a double strength proton pump inhibitor and rebooked for an endoscopy in six weeks time. If the biopsies are positive he will need surgical assessment and consideration for oesophagectomy with Dr Miach in approximately ten days time." Do you see that?-- Yes.

Go to the next document, please, in the bundle. Under a box up there we see collected 23 April, same date as the Dr Appleyard report?-- Yes.

Drop down to the summary for the histopathology report, "Oesophageal biopsies: Poorly differentiated invasive adenocarcinoma associated with Barrett's oesophagus." Does that suggest then that consistent with the wording in Dr Appleyard's report that the biopsies were positive?-- That is correct.

Thank you. If we go to the next document then, this is a consent form. If we scroll down to the bottom we see the signature purporting to be James Phillips, 10th May. I will come back to the date 10th May in a moment, and the signature of Jayant Patel 10th May. Just go over the page, please madam operator. Do we see there risks of the procedure listed on the document? First of all the procedure, itself, oesophagectomy, above that to deal with the condition of oesophageal cancer; correct?-- Yes.

And then over on the list of possible risks and complications down the bottom "possible death"?-- Yes.

Now, 10th of May, if we can go back to that part of the document. Firstly, does the document purport to be an explanation by the surgeon of the possible risks of the procedure? Does it have that appearance to you?-- Certainly, for generic consent, yes.

Yes. Go down again to that date. Dr Appleyard's report would have suggested that he was to have a follow-up appointment with Dr Miach by early May. From your knowledge of how the documents in the hospital operate, would the follow-up - would you expect the follow-up with Dr Miach to be recorded in the same patient chart that later recorded Dr Patel's oesophagectomy procedure or would it be somewhere else?-- I would have to ask you how many volumes this gentleman had in terms of his notes.

Well, yes, unfortunately what I have here in hard copy is quite thin. So I'm wondering - there are two volumes, are there? There's, apparently, two volumes on the disc, I'm

told. Does that assist?-- Yes. Basically what I would expect to find in this circumstance is that Dr Miach's visit - sorry, Mr Phillips' visit to Dr Miach would have been recorded in the specialist outpatient notes and then a follow-up specialist visit by - to Dr Patel.

All right. Could I ask this of you, because I don't want to delay the commission today: would you be prepared to do a follow-up up examination of the records because there are a couple of aspects of your evidence which I would like you to check against - check your recollection against what the records tell us. Are you happy to do some follow-up checking-----?-- Certainly.

-----if you have the whole record, because I'm afraid I can't give you the whole record?-- I appreciate that.

My question is this: in your earlier evidence you said that your belief was that he had been knocked back in Brisbane for an oesophagectomy; that was what your recollection told you?-- That's my recollection.

Do those documents I have shown you change that recollection at all?-- Well, the last time I looked through these notes and I did, sort of, look through this gentleman's notes in connection with a coronial inquiry. What I couldn't find was any evidence that this gentleman had actually been to Brisbane. Now, seeing Mark Appleyard's name on the gastroscopy reports, at least, gives me some idea that he may not have been to Brisbane, but that he was seen by the Brisbane endoscopist in Bundaberg, which is slightly different to what I - my memory of what was presented to me.

Then to take it a bit further, if we go back to that first document, at least - as of the 23rd of April a possible oesophagectomy was, at least, in contemplation if the biopsies were positive?-- Yeah. Well, it says "surgical assessment and consideration oesophagectomy" because the other thing that I have a problem with now is that there is only a nine day gap between the report of the biopsy and the - and Patel taking a consent. So I cannot imagine that the gentleman would have been down to Brisbane, reassessed, assessed by the anaesthetic side or the surgical side and returned to Bundaberg in that length of time with a letter coming through from - from Brisbane to complete the feedback.

Could we leave it on this basis: on the basis that some of these matters have now been drawn to your attention, are you content to assist the commission further, if you can, by a closer examination of Mr Phillips' record?-- I would be delighted.

Thank you. Now, we'll move on. In relation to patient 39, Mervyn Smith, the Commission - so long ago, it seems - received some evidence along the lines that Mr Smith had to be ventilated for a consistent period of 12 days and this created problems in the ICU. Did I hear you say earlier that he was not in fact ventilated?-- Correct.

Was he not ventilated at all at any time in the ICU as far as you're concerned?-- In the ICU - I'd have to check my notes, but I'm pretty sure that he had - was not ventilated at all. I'd be very grateful for a look at the notes to confirm this.

Again, perhaps, if you've got to come back to assist the Commission, perhaps you could again double check that. I should go back to Mr Phillips. Is it your memory that Dr Miach and Dr Patel spoke to you together about Mr Phillips, or would you rather go back to the files to-----?-- I'd rather go back to the files with regard to the pre-operative system.

Yes?-- I do recall that we had joint ward rounds after the operation-----

That's certainly there. I can inform you of that?-- That is definitely there.

All right. Let's give you that opportunity to go back. I don't want to press it any further. Going to Mr Bramich, Mr Bramich - how much contact - sorry, I'll start that again. We know from Dr Boyd and others that he appeared to go downhill quickly at about 1 p.m. on the day of his ultimate death. He passed away at about midnight that night. How much - of the 27th of July. How much of that time then were you in and about the ICU that day?-- I was informed that he'd been brought back to the unit at about 1 o'clock. Some time very shortly after that, Dr Younis came through to the theatres where I was and asked me to come and have a look at this gentleman, saying that he'd had to go in and ventilate the patient. So we're talking about half past one at the earliest. I was with him probably until about just before 6 o'clock when I had to leave the hospital to give a lecture to some local general practitioners. So about four and a half hours is your answer.

Thank you. I'm just going to put up on the screen a little report you did. You might recognise it. It doesn't have a lot of detail in it, but you might be able to tell us how soon after the events it was. Do you see that's your little heading there?-- Yes.

It seems to be a report to the coroner, I'd suggest to you. Drop down, please, madam operator. "The initial suggestion was mine when this gentleman was returned to Intensive Care Unit at 1430" - that's 2.30 p.m. - "on the 27th." Drop down and see if there's a date on this document. Over the page? The 27th of March '05. Just move it over so we can see. The 27th of March 2005. So go back to the main page, please. Back to the shaded areas, thank you. So the suggestion in

relation to what? Transfer?-- As I said, there was a series of questions that actually went with this, and it's in direct answer to those questions.

Yes, it's in the bundle. Sorry, Mr Commissioner-----

COMMISSIONER: We might take a 10 minute break and let you get that in order, Mr Devlin.

THE COMMISSION ADJOURNED AT 3.18 P.M.

THE COMMISSION RESUMED AT 3.40 P.M.

MARTIN LOUIS CARTER, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Yes, Mr Devlin?

MR DEVLIN: Thank you. If we take it, witness, that the first question was, "Whose decision was it to move the patient to Brisbane", then your answer might make sense?-- Yes, it would.

"The initial suggestion was mine when this gentleman was returned to the Intensive Care Unit at 2.30 p.m. on the 27th." Now, we know that the aircraft, from you checking the log - was that at RFDS or the clearing house in Brisbane?-- Clearing house in Brisbane, the flight coordinator.

Thank you. You checked up and it was 4.20 p.m.?-- Correct.

The delay then from your suggestion - 2.30 - to 4.20 p.m., can you ascribe any particular reason to that?-- I would expect a lot of that would be sort of ringing around and trying to organise a bed for the patient to go to.

Righto. Now, you've already said then the delay - no, we'll come to that in your responses. The next question, number 2, was, "Who actually made the decision to transfer the patient to Brisbane and at what time?" You've said, "Dr Younis discussed it with Dr Gaffield"-----?-- Are you sure you have these in order?

I might be asking the wrong questions. I might be putting - anyway, look, let's just stick to what you say. Is the first one, though, right? That you made the initial suggestion?-- Yes.

Is the second one correct, that "Dr Younis discussed it with Dr Gaffield, the surgeon in charge of the patient, but he was delayed in the operating theatre"?-- That is correct.

"And presumably it was Gaffield who suggested that we perform a computerised axial tomography."?-- Yes. The situation here was that with the rapid drop in blood pressure and Mr Bramich becoming unstable, we might have missed something going on inside the abdomen. The spleen might be damaged, the liver might be damaged, and this is something we would need to deal with before Mr Bramich could be sent safely in a plane to Brisbane. So as we were having to wait, then to do the CT during that time was sensible.

Very well. In answer to similar questions, Dr Patel provided this answer to whether the decision to transfer the patient to Brisbane ever changed. He says this. Just listen carefully. "I do not recall that the decision to transfer ever changed. However, when I went to the Intensive Care Unit after completing the surgical procedure" - and I'll come back to the hours he claims he did that - "the patient's condition was so critical and unstable, requiring minute to minute management by the surgical and Intensive Care Unit teams, that he was considered unsuitable to put in the plane." Do you agree or disagree with that account?-- I was not there for that discussion, but from what I've heard afterwards that would be reasonable. The patient destabilised, and if you have anything that you need to sort out before you get on the plane, you do it. To try to deal with a patient in a plane is very, very difficult.

If Dr Patel advised in this circular that he was in theatre approximately from 1600 hours, or 4 p.m., to 1800 hours, or 6 p.m., do you have any information to suggest that's not right?-- I have no information whether it was right or wrong. I know that he hadn't got back to the intensive care before I left, and I left just before 6 o'clock. I can't recall what time he started the surgery that he had to do on the colonoscope patient.

Paragraph 3 of your answers, "I was informed by Dr Younis that Dr Patel had said it was not necessary to transfer the patient to Brisbane. This followed a long discussion with the family." Did you see that as a delaying factor of significance?-- I was informed about this, but since there was no indication when I phoned the flight coordinator that any changes had been made in the flight booking, it will not have affected the timing.

Thank you.

COMMISSIONER: Doctor, would this be a fair statement: that Dr Patel's decision that the patient did not have to be transferred to Brisbane was the wrong decision, but in the result it had no adverse impact because the patient could not have been transferred to Brisbane in any event before he died?-- That is certainly the case, because when the retrieval team arrived, they had to start with resuscitative measures to try and make Mr Bramich fit for transfer. They were unable to do so, even with the help that we gave them, and unfortunately Mr Bramich died.

Thank you.

MR DEVLIN: I'm just having put up on the screen now the concluding summary of your report attached to your statement. "Areas of concern: the delay in the arrival of the retrieval team...mixed messages being conveyed to the family...poor triaging with a patient with a perforation of a prepped large bowel being prioritised ahead of a patient with catastrophic intra-thoracic bleeding." Perhaps if we just stop there, I think we've been through one enough. Number 2, can you add anything to what you've said there by way of summary?-- Not really. I don't think it was made clear to some of the nursing staff that when Dr Patel came in, he came in at the request of Dr Gaffield. Dr Gaffield believed that Dr Patel had a lot more experience in trauma than he did, and handed over the care of the patient. I'm not sure that was made clear to the nursing staff.

Is the mixed messages also to the family being told, "He's going/he's not going", that sort of mixed message?-- Yes, as well, because at the time that I left, if he was fit enough to take out of the unit to go and do a CT scan, then he was probably fit enough to fly. The fact things changed afterwards would have led to this sort of very much yes/no idea that was going on.

Very well. Poor-----

COMMISSIONER: Similarly mixed messages about the patient's prognosis? It seems the family were told by Dr Patel earlier in the afternoon that he didn't need to go to Brisbane, the facilities in Bundaberg were good enough to look after him, and within four or five hours after that Mr Bramich was dead?-- I wasn't present in those conversations and can't - wouldn't care to offer comment.

But is that what you had in mind when you were talking about mixed messages?-- I think it's certainly covered in that area, because I had heard - or been informed of what was said.

Yes?-- It can't have been easy to know what was going on when you've got one team saying one thing, one person saying another, and the whole thing leading to horrible confusion.

Thank you.

MR DEVLIN: Is paragraph 3 about poor triaging another way of saying that at critical moments Dr Gaffield was off line?-- No, basically I think Dr Patel had more time to spend doing an assessment of Mr Bramich than sort of going straight on to theatre. A perforation needs to be dealt with, but a perforation in someone who has had a bowel prep and doesn't have so much material inside the colon that can contaminate the peritoneum is probably a little bit safer than a person who perforates without the benefit of being cleared out on the inside. So there was possibly a little bit more time for him to spend assessing what was going on with Mr Bramich.

Righto. Then number 4, the pericardial paracentesis. We've heard from Dr Rosemary Ashby that, to summarise, it didn't do any good, but it didn't do any harm. Do you accept that description from Dr Ashby or would you put a different view on it?-- No, I would agree with that assessment. I outlined in my evidence that I thought that it probably wasn't sort of indicated, but that you might want to do this as an inextremist thing to see if this really was the problem, because it could be a lifesaving manoeuvre. But if it's done under ultrasound control you can certainly see whether there's fluid there or not, and if there had been sufficient fluid to be worth trying this, then yes, it was a good idea. But if you were looking with the ultrasound, which we don't have any sort of report on, then no, you can't have any benefit from the procedure if there's nothing there to take out. But if you're doing it blind, then hit or miss you might save a life, but you're not going to make things that much worse.

Thank you. Lastly, the lack of radiology support is what you talked about in your answers to Mr Allen?-- Yes.

Thank you. We won't delay on that. That's all I wanted to do there. Ms Turton, P44, the lady what was taken off ventilation. If you had formed the judgment that the ventilator should not have been turned off, would you have acceded to whatever pressure Dr Patel applied?-- No.

Have you been subjected to pressure of that kind or other pressure from other practitioners in your career?-- No.

So that stood out as an event where you were put under a lot of pressure, but you were big enough and ugly enough to look after yourself?-- Yes.

And the patient?-- Most importantly the patient.

Indeed. Next you were asked by counsel assisting about the report to the Medical Board in late 2004, which was preparatory to a renewal of the Area of Need Certification for Dr Patel. As head of the ICU, would you have expected to be consulted about the next report to go to the Medical Board about Dr Patel's performance?-- I'm not surprised that I wasn't consulted.

Why?-- Basically because as an anaesthetist we aren't particularly highly regarded in terms of what we think of surgeons. I mean, as far as anaesthetists are concerned, all surgeons are too slow and always late. Surgeons tend to think that anaesthetists are too slow and always late.

Some people say that applies to criminal lawyers too?-- No, it did not surprise me. I would not necessarily have expected to be consulted on this matter.

COMMISSIONER: But, Dr Carter, am I right in thinking that of the medical staff - I don't mean the medical department, but of all the medical practitioners at the hospital - and I think

you've already identified that there was only a handful who were Australian qualified specialists, of which you were one - you were certainly in the best position to provide advice regarding Dr Patel's performance in surgery?-- In as much as there are limitations on how anaesthetists can view a surgeon's skills. But we've just sort of had a series of locum surgeons through who have been appointed into the position. Now, I've had no communication about who is going to do it and what I think of that in the same way that when I've asked for locum anaesthetists, the surgeons aren't asked as to what they think about that and the qualifications of the people coming in. We do tend to stick very much within our own specialties to determine the people coming in. I would be very, very offended if an anaesthetist was appointed without someone speaking to me about it, but less offended if it's going to be a physician or a surgeon, because I may not have the same knowledge about this person's expertise or non-expertise.

I understand all of that, doctor, but if the Medical Board wants a considered opinion from Bundaberg Base Hospital, the fact of the matter is that Dr Miach wasn't in surgery with Dr Patel. I think he told us he happened to visit once while surgery was taking place. But the Director of Gynaecology wasn't in surgery, the Director of Psychiatry wasn't in surgery, Dr Keating as Director of Medical Services wasn't in surgery with Dr Patel. Really the only person in the hospital, apart from possibly Dr Gaffield or one of the more junior PHOs or JHOs - the only Australian qualified specialist who had spent any time in surgery with Dr Patel was yourself?-- That is correct, and I think it would probably be a good recommendation, if you're looking at renewal of contracts-----

Yes?-- Because you are going to be the person who is going to continue to work with that surgeon on the anaesthetic side. So it would be a good recommendation. But at the time we were at, I don't think it is anything that had been considered.

I have a little difficulty in understanding how, for example, Dr Keating could give any clinical view to the Medical Board without a review regarding Dr Patel's performance?-- I think Dr Keating would be the best one to answer that.

MR DEVLIN: I will just briefly touch on a couple of patients on which this Commission has heard some evidence. P26 is a patient called Maureen Williams and the Commission received evidence at page 177 of the transcript that a lady came in after a motor vehicle accident with a ruptured spleen, acute abdomen, went to theatre, had a splenectomy, and then there is a notation "complications, transferred to Brisbane". Do you have knowledge of that case?-- I have knowledge of that case.

Is that an accurate summary?-- No.

Can you tell us in short order what happened as far-----?-- In short order, there were two people in the car. I gather the other patient - I don't know whether his name has been released or not.

You can call him P168, if you like?-- P168 was more severely injured than Mrs Williams and required transfer first. The obvious injuries to Mrs Williams were orthopaedic. We knew - had discovered that she had a spleen because her abdomen blew up and we had to do a splenectomy while we were waiting for further transfer, but P168, I think you said, had to be transferred out first and you can only get one plane at a time.

Right. Somebody called Marsh, who is P25, it is said of that person that there was a colectomy performed by Dr Patel, the spleen was nicked during surgery and ended up undergoing a splenectomy. Is that a correct summary of what happened to P25, Mr Marsh?-- Could I please have a look at the notes-----

Yes?-- -----for this patient to definitely remind myself?

If they are there. While they are being found I will move to another one. P50, Priscilla Broome at page 78 of the transcript?-- This lady had a several volumes of notes. I have not seen all of them and I would really prefer to have a look at the notes before making any comment.

That's all right. I won't delay if you are going - if you can assist the Commission, you might want to address those two patients when you have had a chance. Couple more questions. Not just out of curiosity, but I think it is relevant: if this person, who we don't want to know who it is, was the ancillary staff member who attracted this colourful sobriquet, what was it about an ancillary staff member that attracted that, so far as you are aware?-- I am informed it was his smell.

I see. And, again, this seems indelicate, but I feel I should ask it: did Dr Patel have any aura about him of the olfactory kind?-- He smoked like a chimney and used rather cheap aftershave to cover it up.

Now, Dr de Lacy, among many things he said, said that he found evidence of Dr Patel removing the wrong organs. If a wrong organ was removed, despite the presence of the green shroud between you and the surgeon, would you, in the ordinary course of business, have reason to notice?-- I think I'd notice whether a spleen or a kidney came out, depending on which was the one that was meant to be leaving.

Now, I can only ask you about your own, then, observation when you were working with Dr Patel as his anaesthetist, but did you ever note the wrong organ being removed?-- No.

That's all I have - sorry, I have one other. P31, Phillip Noppe, Dr Miach gave evidence at page 1664 that there was, in his view, inadequate sedation. Do you know of that one at all?-- I know that - if I can get my notes - a gentleman who had a pericardial window performed on the 17th of August 2003.

Yes?-- There was an operation lasting about one hour, during which time this gentleman received five milligrams of Midazolam, two milligrams of Alfentanil, and 170 milligrams of Propofol, plus Gentamicin. During that period his pulse remained stable at about 120. He was not hypotensive, his oxygen saturations remained between 95 and 100 - and this is about as good as you need to be - and he also received, in addition to what I gave him, some lignocaine from the surgeon. I gather from Dr Miach that he feels that all these patients should be receiving general anaesthetics for this sort of procedure, because that's his experience. I am afraid his experience and my experience are different. This gentleman had heart failure on the 14th and what was described as a large left pleural affusion. The other one decided to fill up by the 16th, so we have bilateral pleural affusion. So he has fluid on both lungs. In addition to this, he has a potassium level of 6. The normal valleys for potassium run between 3.2 and 4.7. I have seen aboriginal patients with lower potassiums do quite well, but on the whole, if you get your potassium level too high, it is not good for you. The heart doesn't work very well. And in addition to that there is evidence of problems with his liver because his liver function tests were not normal. So this is not a fit patient. This is not somebody who you want to give a full anaesthetic to.

Liver functions test, were they just below normal or worse than that?-- I have only made a note of deranged.

What does that mean?-- Abnormal.

Off the scale?-- Some of them were a bit high, yes.

COMMISSIONER: Not off the scale in the sense of grossly abnormal, but out of the usual?-- If they had been off scale,

I would have been suggesting that Dr Patel had done it purely under local. I don't have an exact record of this. That's my notation about this patient.

Yes.

MR DEVLIN: Thank you. Just generally, are you able to estimate the number of operating theatre procedures you did with Dr Patel as his anaesthetist? Is that possible? If it is not, I don't want you to speculate?-- I have no idea, to be honest.

Given your experience, are you a practitioner who would speak up if you observed abnormalities which were, in your view, unprofessional and likely to harm the patient, or are there situations where you would defer to the surgeon, whoever he or she was?-- The answer is that we have actually refused to provide anaesthetic services for a surgical locum who was sent to us in Bundaberg.

And?-- So, yes, we are prepared to stand up and say no.

So that is the ultimate sanction, is to say, "Well, you may want to do the operation. I am not going to anaesthetise that patient, nor am I going to authorise my staff to do so". Is that what you are saying?-- That is correct. We would always sort of make an assessment of both the patient and the surgeon. We - most surgeons are quite comfortable in being told that you can't operate on this patient because they aren't fit. They don't want adverse outcomes. The problem is when you get to the sort of nature of surgery that Dr Patel was proposing and we went to, the mode of death of these patients is highly unpleasant. Both with oesophageal and pancreatic cancers, they are not very nice cancers to have, and I know that might sound as a truism, is any cancer a nice one to have, but these are particularly unpleasant in terms of the nature of the pain. Pancreatic cancer pain is very difficult to deal with. I say that as a practitioner in pain medicine. Oesophageal cancer leads to sort of malnutrition, you can't eat, you can't drink unless you are being fed through your veins or through a hole in your stomach wall. You can't, in addition, swallow your own saliva. You are sitting there and dying by inches and very unpleasantly, and, in the nature of this surgery, to my mind, be prepared to take a slightly higher risk because if you can help the patient, then you have done a very good job, and unfortunately for the patients who do not survive these procedures, then you are in a situation - well, I hate to use the word, but euthanasia has been provided. Because if we take Mr Phillips, he did not wake up after his operation. It was not the intent for him to die during the procedure, but, effectively, he had a less uncomfortable, much quicker death, and that's not the way one should look at how one does surgery. But certainly when you are weighing up the options and when you are presenting the options to the patient, that this can be sort of a view to take.

So a patient in dire straits might mean an adjustment of the

risks that you as an anaesthetist are prepared to undergo?-- Yes.

Thank you.

COMMISSIONER: Comments you made about Mr Phillips a moment ago, they wouldn't apply to the same extent to Mr Kemps, would they?-- Mr Kemps was a lot fitter gentleman. I mean, he had had vascular surgery, an aortic aneurism prepared, but was basically fitter and well after that. The situation he would have been in was his basic disease would have been manifest very simply in the state of his heart and that was monitored and checked as being sort of adequate and safe for surgery. Mr Phillips, with his renal problems and muscle problems and nerve problems, definitely had an increased risk of surgery, which, from my reading, I could sort of say is about eight types what one would expect in a patient who didn't have renal failure.

The things which stand out with Mr Kemps, at least in my way of thinking, are his underlying health was significantly better, firstly. Would you agree with that?-- Yes.

Secondly, he wasn't in extremis, in the sense he wasn't on death's door, if I can put it that way?-- Correct.

And, thirdly, he didn't have the peaceful passing that Mr Phillips did of not waking up after the surgery. He had quite a traumatic experience over the last few hours of his life?-- That would be a correct assessment.

Yes. Mr Diehm?

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Dr Carter, I am Geoffrey Diehm and I am counsel for Dr Keating. Just still on Mr Phillips, briefly, is it your understanding of those medical practitioners who were involved in the management of his surgery, the plan for his surgery, that generally speaking the view shared by them was that this man certainly faced significant risks going into surgery but that it was an option that provided him with some hope compared to what he might face if he did not have the surgery?-- That is correct.

We have heard some evidence concerning the lead up to Mr Phillips' operation that it was a team effort because of his comorbidities that there needed to be some careful planning with respect to his post-operative management. Are you aware of that?-- That is correct.

And the anaesthetist, perhaps more specifically yourself, were

involved in that, were you?-- Well, as I was the anaesthetist, yes.

Yes. And you had an extra role beyond just being the anaesthetist, in the sense you were also Director of the ICU that he was going to have to go into after the operation?-- Yes.

And so your involvement would have been additionally for consideration of management of those issues as well?-- Yes.

Now, you mentioned that he was a renal patient. Do you have a recollection of there being staff involved in renal management at the hospital being involved in the preparations of Mr Phillips for the surgery?-- The specifics, no, but certainly Dr Miach was involved post-operatively.

Yes. Now, is it the case that until you go back and do this file review that Mr Devlin has asked for, you are not sure enough about whether Dr Miach or others under his charge were involved prior to the surgery?-- That is correct.

All right. We will leave that till you have been able to do that exercise. On oesophagectomies more generally, you have told us that there was one that was performed some time shortly before Dr Patel's arrival. I think in your statement you thought it was some time approximately 12 months before Dr Patel's arrival?-- Somewhere in that, yeah.

I won't trouble you with looking more specifically at it, but the document that you were shown before that had the oesophagectomies on it, shows an oesophagectomy being performed in the month before Dr Patel's arrival. That would be the one you are thinking of then?-- Probably.

Yes. It was performed by a surgeon Dr Feint?-- Yes.

Do you recall him?-- Oh, I recall Dr Feint, yes.

Do you recall him being the one?-- I recall him being the one. I just couldn't give you a name for the patient.

Yes, thank you. We had some evidence a couple of days ago now from Dr Younis suggesting that at around the same time Dr Feint also attempted another oesophagectomy, but on opening the patient up and seeing what was inside, decided not to proceed further. Do you have any knowledge about that?-- That is correct.

Okay. Now, you mentioned quite specifically in your statement that there are different types of oesophagectomies or different ways in which oesophagectomies can be performed?-- Yes.

And you have given us a description in paragraph 38 of your statement about the pull-through scale of oesophagectomy?-- Yes.

As I understand it, that's the one that you say that Dr Patel was doing, is that right?-- That's my understanding. I am not exactly sure what the difference between a transhiatal or a pull-through or an Ivor Lewis is because I am not a surgeon.

Yes?-- I mean, I basically understand the ones that involve a minimal displacement of the oesophagus and the stomach being pulled up into the chest and anastomosis being made up there. Now, exactly what the differential between those three is, I am afraid you would have to ask a surgeon.

Respecting your answer and without wishing to press you beyond what you have just said, would it be a fair but simple statement to say that the kind of procedure that you understood Dr Patel was performing with respect to these oesophagectomies was one that did not involve opening the chest?-- And you have pretty much got to go inside the chest to do most of these.

Yes, all right.

COMMISSIONER: Would there, to your knowledge, be a difference in the degree of opening of the chest required for the different procedures?-- From an aesthetic point of view, what you are trying to achieve for a surgeon who is doing that is the deflation of the lung to give him a lot more access to the oesophagus. So, really, all you are interested in is being able to give access, and we have the equipment to do that. At the end of the procedure when the surgery is done, you can reinflate the chest, clear the air out of the pleural cavity, leave a chest drain in place and hopefully things will run smoothly, and that all really depends on the skill of the surgeon.

Yes.

MR DIEHM: Thank you, Commissioner. Dr Carter, your view prior to the procedure, with respect to Mr Kemps at least, was that the Bundaberg Base Hospital ICU was capable of managing oesophagectomy patients post-operatively?-- Yes.

Can I suggest to you that after you returned from your leave in mid-2003 - and you have told us about how you were approached by Dr Joyner and Ms Hoffman regarding their views about the performance of oesophagectomies. After you returned from that leave, you were also approached by Dr Keating who asked you questions about your views on the ability of the ICU to care for patients after they had had operations such as and including oesophagectomies. Do you recall a discussion along those lines?-- I can't recall the exact discussion.

You say you can't recall the exact discussion. Have you got some vague idea of it having happened?-- I seem to sort of think that this would have happened, yes.

Yes. Certainly if Dr Keating did approach you over that issue, your answer would have been that in your view the ICU was capable of handling those post-operative - or the

post-operative care of those patients?-- That is correct.

And you would not have said anything to discourage - specifically discourage the performance of oesophagectomies at the Bundaberg Base Hospital?-- Correct.

Thank you.

COMMISSIONER: That's until you became concerned about the performance of those operations, as you have told us, following Mr Kemps?-- Yes, but at the time of the conversation with Dr Keating, which I am pretty sure would have taken place, then, no, I had no reservations at that point in time.

Yes.

MR DIEHM: Thank you, doctor. Doctor, with respect to Mr Bramich, you say in paragraph 68 of your statement, referring to the reports or statements, if you like, that were prepared by yourself and by Dr Younis - you say that a copy of those reports were given to Dr Keating. If I suggest to you that the report of Dr Younis was not given to Dr Keating, are you able to-----?-- The report of Younis was not given to Dr Keating.

All right. Thank you?-- It went to the Coroner but I don't think it went to Dr Keating.

Yes, but you did give a copy of your report to Dr Keating?-- Yes.

In fact, Dr Keating had, some time prior to that, asked you for a report or, as it were, an audit of the management of Mr Bramich?-- Correct.

Indeed, in fact, in fairness to you, I suggest perhaps it was your suggestion to Dr Keating in the first place that there should be consideration or investigation of this particular matter?-- That's correct, and Dr Keating agreed to that.

All right. If I can just put this document on the reader, please? I hope I am right, Mr Commissioner, that this document isn't in evidence yet. I apologise if I am wrong. Now, you don't need to get into the minutia of what it says. Perhaps we can pull back so we can see the whole of the document on the reader. Is that the memorandum that Dr Keating sent to yourself as well as to Dr Patel asking for a report from you about Mr Bramich's death?-- That is the request that I saw and, as you note, the bottom line says, "Should you require any further information, please don't hesitate to contact my office." At that stage I asked for a copy - a formal copy of the PM report as I only had an informal copy, and that was sent to me on the 2nd of September, and my report was in within a week-----

All right?-- -----of that. You should have a copy of that, I think.

A copy of what, sorry? Your report?-- Yes.

I think it has been annexed to your statement, as I apprehend it?-- And I think there is a copy on there of the postmortem report on Mr Bramich.

Yes?-- The typed copy and the front sheet of that is from Dr Keating with the date of 2nd of September on which gives me access to the formal report.

All right. Dr Carter, I am not about to take you to this next document to make any criticism of you, please understand that as I show it to you, but in the context of what you have just said and understanding your explanation for the delay, I just ask you to look at this document on the screen. Now, that purports to be an email from Dr Keating to yourself on the 10th of September 2004 asking about your report and when Dr Keating might be likely to receive it. Do you recall receiving that email?-- Yes.

All right. Commissioner, I will tender that email. I am not sure if Mr Morzone was trying to got a message to me that that memorandum was already part-----

MR MORZONE: It is. It is KN13 to the statement of Mr Nydam Exhibit 51, from memory.

COMMISSIONER: And the one that was just on the screen?

MR MORZONE: No, that's not in yet.

COMMISSIONER: Thank you. Just so that I understand the context, the second line says, "Please remember you wanted to review this case and I presume you were informing Tony H of your delay." What's the significance or context of that?-- I am not sure about the last line, but as soon as I got hold of the formal report, I sent it on to - back to Dr Keating. I think I handed him a copy of the report. The only way I actually know it was the 9th of September, that I actually sort of finished this report because it was on that date that the properties on the word document that I produced has the date of the 9th of September. I have been in and out of it a few times since printing but that was the date it was done.

One way that it could be interpreted - and I don't say this is the correct interpretation, I am really only asking - you know, "You are dragging the chain on this. You are a naughty boy. Bear in mind you don't only have to answer to the author of this, Dr Keating, but you also have to answer to Toni Hoffman and you will have to give her an explanation for the delay."?-- That cannot be the explanation because basically Toni Hoffman already had a copy of that report when she was writing one of her reports, and that was dated in - some time in August, early August. So she had a preliminary copy of the - of that.

It just seems strange that the Director of Anaesthetics should

report to Toni Hoffman about his delay in complying with a request from the Director of Medical Services?-- I was aware of the fact that Toni was doing a report on this patient, and I think in one of her annexes she actually says that, you know, "I received the document" because I have written - I think it was something like, "Toni, I hope this is what you wanted." And that was her receiving an initial copy of my report, which I sort of finished off when I actually had a formal copy of the PM report.

MR DIEHM: So you had an understanding at around these times that Toni Hoffman was a person who had an interest in knowing how the progress of the investigation into Mr Bramich's case was going?-- Yes.

Thank you.

COMMISSIONER: Exhibit 269 will be the email dated the 10th of September 2004 from Dr Keating to Dr Carter.

ADMITTED AND MARKED "EXHIBIT 269"

COMMISSIONER: I assume, by the way, there is sometimes problems with these dates as to whether they are American or anglo Australian style but this is 10/09/2004. That would be the 10th of September rather than-----?-- I would assume so because, as I said, the date I have got on the properties for the actual completion of that is the 9th because that's when I moved it into a different file for printing.

Right, okay, thank you.

MR DIEHM: Thank you. Dr Carter, another topic, you did - I am sorry, before I leave Mr Bramich, the date of your report, it seems, that was provided to Dr Keating - I have heard what you say - what you discovered on your computer - but the date that your report was received by Dr Keating, I suggest, was the 13th of September 2004. Do you feel it was earlier than that?-- I know I completed it on the 9th because that's when I moved the pathway for printing it. I can't explain the odd sort of few days between.

All right.

Doctor, with respect to the questions you were asked earlier today about a supposed deal that had been struck between you and Dr Patel about not transferring a patient of Dr Patel's after surgery, a proposition which you have rejected, you said that there was no such deal; do you recall what I'm talking about?-- Yes.

You said in answer to a question that Dr Keating did not speak to you or you did not recall Dr Keating speaking to you about that?-- No.

I'm getting what I deserve for asking a negative question and getting a negative answer to it. I will start that question again, Dr Carter. My proposition to you is that Dr Keating did actually speak to you at around the time of those events, the management of this patient, because it had been relayed to him that you had entered into such an arrangement with Dr Patel and that you in response to Dr Keating's inquiries said that you had not entered into any such arrangement?-- That is correct.

Thank you. Now, again, another topic: you've referred in your statement in paragraph 56 to an issue - speaking to Dr Keating concerning Dr Patel's surgery. You tell us there - and I'm looking at the unamended version. I'm not certain whether or not there are any changes.

COMMISSIONER: 56 is not amended.

MR DIEHM: Thank you. You talk there about Dr Patel wanting to perform a lobectomy, which as you describe is a partial removal of a patient's lung, and it's necessary to perform a thoracotomy in order to do a lobectomy.

COMMISSIONER: I'm sorry, this is paragraph 56?

MR DIEHM: Yes. I'm told it's 55 of the amended statement, Commissioner.

COMMISSIONER: I see.

MR DIEHM: But does still appear to be unamended, and with respect to that you say that you remember speaking to Dr Keating about it and that you believe that Dr Keating said, "I don't think" - sorry, you believe that you said to Dr Keating that you shouldn't be cracking chests in the hospital. Dr Keating informed you that Dr Patel had assured him that the procedure was a lobectomy and not a thoracotomy. Now, can I ask you to have a look at this document, please? Doctor, are you satisfied that that's the same case that we're talking about?-- Yes.

And I suggest to you that the chronology was that you had come to Dr Keating expressing concern about a thoracotomy being performed by doctor - being proposed to be performed by Dr Patel at the hospital, that Dr Keating came back to you, as we see here in the e-mail, having discussed the matter with Dr Patel, and that what he understood was that it was a wedge

biopsy as opposed to a lobectomy. Now, they're different procedures, aren't they?-- Marginally.

They both involve a thoracotomy?-- Both involve a thoracotomy, both involve cutting lung tissue and, therefore, having to sew up lung correctly.

Yes?-- As I understood Dr Patel to be more a general surgeon, where I was happy for him to go inside the chest in terms of making an anastomosis bowel to bowel he was not, basically, disrupting lung architecture. Now, making a hole in the lung which is going to potentially stay there is a problem that he possibly couldn't deal with and we certainly aren't equipped for dealing with it in Bundaberg. Where the - the idea is that you don't make holes in the lung, then that's probably, sort of, relatively safe to do in Bundaberg, but if you are deliberately making a hole in the lung that wasn't safe to do in Bundaberg.

COMMISSIONER: And, doctor, would a wedge biopsy ordinarily require the patient to be - to receive intensive care after the operation?-- Possibly not, but our surgical ward didn't have an HDU facility, so as the intensive care was both high - intensive care unit and the high dependancy unit, then the safest place after that form of surgery would be in the intensive care unit.

What does that memo or this e-mail say to you regarding the author's understanding of the procedures involved?-- I'd explained to him that I didn't think that this was an appropriate procedure to be done. He said - and he had, sort of, overridden my advice.

Yes.

MR DIEHM: A couple of things, Dr Carter. Firstly, what Dr Keating communicated to you wasn't such that he didn't understand what a thoracotomy was, in the sense that it's an opening of the chest, but rather that he saw this as being a different procedure than the lobectomy which had been spoken about?-- A wedge biopsy basically is just a small - taking a little less than a lobe. So wedge resection, lobectomy, they're just a, sort of, matter of degree. I mean pneumonectomy is slightly one up, but there's not that much between lobectomy and wedge resection, especially if you don't know which lobe the nodule is in.

Doctor, my next proposition is that after Dr Keating's e-mail you came back to Dr Keating and you told him that you, too, had discussed the matter with Dr Patel and that you were satisfied that the procedure was different than you had understood and you were satisfied that the patient would not need ICU care; do you recall that?-- I recall we had a further discussion when Patel had assured me that he knew where the nodule was and wasn't to go into two bits of the lung instead of just one bit of the lung, and I thought it might be feasible for us to do it and, certainly, we would be able to get the patient out if we had a problem post

operatively.

So in the end you were satisfied - having spoken to Dr Patel as Dr Keating had you were satisfied that it was in order for the procedure to go ahead?-- With having informed Dr Keating that I had objections initially, then yes.

Yes.

COMMISSIONER: It wasn't that you backed down, you didn't withdraw your objections, as it were?-- I would still have been in the same position to transfer the patient out afterwards if things had gone wrong and I think that - I suppose there was a bit of a backdown there.

Thank you.

MR DIEHM: And in fairness to you, Dr Carter, a backdown because you discussed it with Dr Patel and he had persuaded you, as well, that it was in order to proceed?-- Yeah.

If I can have that tendered too, please, Commissioner.

COMMISSIONER: Exhibit 270 will be the e-mail from Dr Keating to Dr Carter of the 20th of August 2004.

ADMITTED AND MARKED "EXHIBIT 270"

MR DIEHM: Thank you. Now, just bear with me, please. Just dealing with some of the matters that you've described in your evidence concerning Mr Kemps-----?-- Could I just interrupt you and ask would it be out of order if I asked for a comfort break?

COMMISSIONER: Certainly. Just break for five minutes?-- Thank you.

THE COMMISSION ADJOURNED AT 4.33 P.M.

THE COMMISSION RESUMED AT 4.42 P.M.

MARTIN LOUIS CARTER, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Just before we continue, Mr Boddice, thank you for arranging this. We now have all the waiting lists or the waiting lists. I think when I was looking at these earlier I

may have misinterpreted them too benevolently for Queensland Health. Do I understand correctly that when these lists show what is called in these lists a waiting list that's the waiting list for people wanting to get an appointment with a specialist, and then there's a separate list for those who already have an appointment with a specialist.

MR BODDICE: In all honesty I can't answer that question because they have come so quickly to the Commission that I haven't seen them yet, Commissioner. I can answer that question tomorrow morning.

COMMISSIONER: On the face of it it seems, for example, to take the PA Hospital, there's a list here totalling almost 19,000 people, 18,942. Under the column headed "Number With Appointment" there's 9,000. Under the column headed "Number on Waiting Lists" there's 9,800, but as I now understand it, none of those people are on an official waiting list. The number with the appointment are those who have got to the stage of actually been given a time to see a specialist. The other column are those who are still waiting to be given a time to see a specialist, but none of them are on a waiting list.

MR BODDICE: As I said, Commissioner, I can find out overnight and I can let you know.

COMMISSIONER: Thank you for that. Those documents will be added to and form part of Exhibit 267. Mr Devlin?

MR DEVLIN: For the record, to preserve the record I took the witness to some extracts of Mr Phillips' patient file. I seek to tender the four pages to which I referred the witness.

COMMISSIONER: Yes, certainly.

COMMISSIONER: Exhibit 271 will comprise an extract from the patient file of James Phillips.

ADMITTED AND MARKED "EXHIBIT 271"

COMMISSIONER: Mr Andrews?

MR ANDREWS: Commissioner, Dr Jayasekera has been waiting to be called as a witness this afternoon by telephone. I have, 10 minutes ago, informed the doctor that it's unlikely that he would be called this afternoon.

COMMISSIONER: I'm afraid that's right, yes.

MR ANDREWS: Thank you.

COMMISSIONER: Thank you. Mr Diehm?

MR DIEHM: Thank you, Commissioner.

COMMISSIONER: Can I ask, Mr Diehm, how long you expect to be?

MR DIEHM: About ten minutes or thereabouts.

COMMISSIONER: Is there anyone else who expects to have cross-examination?

MR BODDICE: We do, Commissioner, but probably only 15 minutes.

COMMISSIONER: Doctor, are you booked on a plane tonight?-- Tomorrow.

We might as well finish tonight then.

MR DIEHM: Yes, thank you. Doctor, I had just introduced you to my next topic of Mr Kemps. I just wanted to ask you some questions about the discussion that you had with Dr Keating on the day of Mr Kemps' funeral. Is it right in terms of the chronology of things that before you went to see Dr Keating you phoned him first?-- Yes.

And did you go up and see him on your own initially?-- No, I went up with Dr Berens.

Now, you list in paragraph 52 of - what will now be paragraph 51 of your statement what was the - what were the matters or the issues that you felt needed to be investigated?-- My main concern about this gentleman is that patients who do have a - that sort of surgery can die, but a catastrophic haemorrhage of that nature is - would be highly unusual.

Can I just start by suggesting to you that the last of those matters that you have listed there in the paragraph that Dr Patel had told you afterwards that he couldn't find where the bleeding was coming from, that that wasn't a matter that you specifically raised with Dr Keating?-- I think I did actually raise that comment to Dr Keating because I think that was the comment that provoked me to think that Dr Patel was not competent to carry out this sort of surgery. If he couldn't find out where the bleeding was coming from, then he really shouldn't be there.

Doctor, did Dr Keating tell you that Dr Patel had told him that the cause of the bleeding was a thoracic aortic aneurysm?-- I think that's what Dr Keating said to me.

And that the - the context of that - of what Dr Patel had told Dr Keating was that the patient had previously had a triple A, which had been repaired?-- Yes.

So that was said to be relevant in terms of the development of the thoracic aortic aneurysm in this procedure?-- Well, that doesn't really change the outcomes and the problems because if he knew that the patient had a thoracic aneurysm what was he doing in the chest in a place that could not cope with a

patient with a thoracic aneurysm?

Dr Carter, again please understand I'm not asking these questions-----?-- I'm aware of the way you're - what you are asking. It's, sort of - it's just that that sort of answer from Dr Patel provoked a different question as to his competence. His competence in not being able to find the bleeder is one thing, but if he knew there was going to be a problem of this nature, then he should not have been, sort of, suggesting the operation.

And I'm certainly not asking questions with a view to defending Dr Patel's conducting of that procedure or how he conducted it or anything along those lines or, indeed, quarrelling with your view that you had formed at that stage, subject to what was then discussed with Dr Keating and Dr Berens about referring the matter to the coroner. So that's the context of where these questions are coming from. I'm simply trying to put to you some propositions about what was discussed or not discussed during the course of that meeting. Now, in terms of the knowledge of when the funeral was to occur was it the case that during the course of your discussion you got up and left Dr Keating's immediate office, leaving Dr Keating and Dr Berens in there, and checked the local newspaper to find out when the service was occurring?-- Yes.

And you returned with the information that you had gleaned from the newspaper?-- Yes.

And that was the context then of the discussion about the ultimate decision being taken to not interrupt that funeral by making a reference to the coroner at that point in time?-- That is correct.

You accept, do you, that that was a decision that albeit after discussion about the merits and the pros and cons that you were free to make for yourself, Dr Keating didn't apply any pressure to you or try and coerce you into a particular view?-- No, he did not.

Thank you. Indeed, would not have been able to even if he tried, no doubt, in that regard?-- Correct.

With respect to to the issues that have already been well canvassed in your evidence concerning the transfer of patients and the work load of the ICU, just a couple of things perhaps as much out of concern of making sure that we all understand the parameters of what's being spoken about, as you say in paragraph - what was 30, it may now be 29 of your statement, the first paragraph under the heading of "Transfer of Patients" - yes, 29. The 24 to 48 hour time frame that's spoken of when it comes to keeping patients in the ICU was a time frame that referred to patients who were on ventilation at the period, isn't it?-- Yes.

There's never been any notion that a patient should not be kept in ICU for longer than 24 to 48 hours?-- Well, that's

correct.

You've mentioned the fact that there were multiple reasons for the increased work load of the ICU, and including a couple of ventilated hours. Now, one of the contributing factors to the increased work load was an increased number of medical patients; is that right?-- Yes.

And not just an increased number of medical patients, but an increased length of time on ventilation for medical patients?-- Yes.

Is it something in your view that is a problem for ICU management in a hospital like Bundaberg, perhaps others, as well, that medical patients, patients who have suffered massive heart attacks or stroke or other such complaints who are dependant on ventilation tend to be kept on ventilators longer than what is, in your view, reasonably appropriate in the sense that their life is preserved or their death delayed because of our cultural beliefs or our sentimentalities in that sense?-- This is a very interesting ethical area. I had cause a while back to write to one of our journals and have the letter published on the care of patients in intensive care with specifics to the Jewish religion as a Jew myself. There is a concept which is still well argued over what is known as a Goses, G-O-S-E-S, which is a person who is said to be in the last three days of their lives, and that the death is an inevitability, and one should not do anything to maintain them on - in this world before letting them go to the next. This includes making loud noises, and the particular one that is always quoted, you should not let somebody chop wood nearby. You should not, sort of, put salt on their tongue to try and maintain them. A lot of these are very, sort of, ancient ideas but the argument still exists as to whether you should, sort of, delay somebody's passing when their passing is inevitable. Yet the bible also tells us that we should have patients and not, sort of, refuse them either food or water to keep them alive. So what happened in Victoria recently would definitely be against Jewish law, but in terms of patients who are what one would describe as brain dead or, sort of, in that sort of category, then the withdrawal of life support would be highly appropriate. But in other patients whom life is definitely still there and is not definitely going to be extinguished within the next three days we should be continuing to look after. So the fact that we continue to ventilate patients is appropriate from my ethical standpoint, but some of these patients who have had long standing problems are not in a position to be transferred either away from their community support and the family or into a tertiary centre which is unlikely to accept them because in the long term they do not have a curable condition.

So yes, we have been ventilating patients longer because we do get patients in who sort of slip into a requirement for ventilation, and it's very easy to start ventilation, but very hard to stop it, and when there is no particular reason from an ethical point of view to consider them going to die a respiratory death - because when we look at death we define either a cardiac death, when the heart stops, or a brain death, where we have such gross signs that we know what's going on, or subtle signs where we might want to check what's going on with the use of brain stem death tests. But the respiratory side is very poorly covered, and often the mind of the person who is there on the ventilator is there as well, and these people still need our support and are there to sort of be taken slowly through their illness. If overwhelming senesces takes them away then so be it. A purely respiratory death is very, very hard to die in the modern world.

Doctor, have you expressed a view in the past - I'm thinking in particular of your interview with the CMC - that there was a culture at the Bundaberg Hospital that meant that non-resuscitation orders on patients - medical patients in the ICU were too infrequently written up or too belatedly written up?-- My problem with the NFR orders was basically that the patient was transferred to intensive care and then an NFR order is put on them. So you're left in that half-way house. You've already done virtually everything there is to be done, and yet you're being told, "No more." I mean, you can't withdraw from having a ventilator without being effectively asked to perform euthanasia, and that's certainly against the law.

Yes. So that is where you identified, if there is a problem in this area - and I appreciate what you're saying about it being a very difficult ethical problem, but that there was a culture of tending to take these patients, often medical patients, and create a burden for the ICU perhaps unnecessarily by writing the - not writing a not for resuscitation order before they'd already been effectively resuscitated?-- Correct.

COMMISSIONER: I guess - and I'm not sure that it's useful to go into those ethical and moral questions in too much detail in these proceedings, but leaving aside medical - both medical and ethical considerations, there are also questions of compassion, of allowing the family to have time to travel to see the dying relative and that sort of thing?-- That's what I was alluding to when I talk about community and family support. To take the people away from their families at a time like this is often more distressing, because if you fly somebody down, the family cannot go with. You commit them to a drive 360 kilometres down the motorway to wherever, and it may be further south. If you can't get a bed in Brisbane you may be sending them on to the Gold Coast. So you're looking at a 400 plus kilometre drive just to stay in touch with their family. I'm not sure that a lot of people driving in that sort of frame of mind are going to arrive intact mentally, physically or whatever.

It brings to mind a report some years ago that King George V was allowed to slip away during the night because it was considered more desirable that his death be reported in the morning papers rather than the afternoon papers. I guess as soon as we start exploring those areas we're getting into things that are far outside the realm of this inquiry.

MR DIEHM: And I won't take it further, Commissioner.

COMMISSIONER: Thank you.

MR DIEHM: Doctor, with respect to P26, the 15 year old boy, do you recall Dr Keating speaking to you a few days after that patient had left the Bundaberg Hospital about that patient?-- Not specifically, no.

Well, I'll suggest this to you to give you an opportunity to comment on it: Dr Keating spoke to you - and the date - don't hold me precisely to this, but it's about the 4th of January or thereabouts of this year - about that patient, and sought your views - appreciating again that you're an anaesthetist, not a surgeon, but your views about the management of that patient, and that you were of the view that whatever other fault may have lay with respect to the management of P26 at the Bundaberg Hospital, you didn't identify anything wrong with Dr Patel's management of the patient itself - himself?-- Thank you for giving me the chance to think back about this particular case. I do recall a conversation that we had in which I actually relayed Dr Patel's versions of what happened to Dr Keating. I still feel that the first operation on this boy saved his life. The story about what then happened becomes very murky as to what the exact series of events were, but at the time I knew of nothing in the immediate care of that patient that had Dr Patel as the villain of the piece in the subsequent care. That's when we had the conversation. From subsequent readings, I'm not sure that Dr Patel was actually presenting me with the facts as they were, rather than the facts that he wanted them to be.

Thank you, doctor, and again all I'm trying to get to is what was discussed between you and Dr Keating on that day. You've given some evidence in answer in particular to questions from Mr Devlin to the effect that if you formed the view that a surgeon was an immediate danger to their patient, either because the surgeon was incompetent or perhaps because the surgeon was intoxicated even, or had come in temporarily blinded on that day, or the lights weren't working in the operating theatre - whatever - you, as the anaesthetist, are a protector for the patient in the sense that you can decline, and your staff can decline to anaesthetise the patient to protect the patient from the surgeon, and you would do it?-- We have done it in the past, but that was before Dr Keating's time, and I have done it before then when I sent a theatre nurse home because he was drunk. But that was in UK.

And you would do it again-----?-- Yes.

-----of course, if a surgeon walked into the Bundaberg Hospital tomorrow and you formed the view that he was either temporarily or definitely incompetent to perform the procedure, you wouldn't anaesthetise the patient?-- That is correct.

COMMISSIONER: You are referring there to a case where it is obvious to you, where it's not a matter of fine clinical judgment as to the competence, where there is a clear reason for supposing the person is incompetent?-- That is correct.

MR DIEHM: And there, of course, was no occasion where either you or any staff member under your direction refused to anaesthetise a patient for Dr Patel?-- I am unaware of any while I was in the country.

That's why I specifically said that it was either you or a staff member under your direction, and I meant in the sense that you directed the staff member not to anaesthetise the patient?-- I would have to qualify that. We have occasional problems with patients who aren't withdrawn from forms of medication that they should be to ensure optimum safety during their surgery. Now, this may be diabetic medication, this may be heart medication or a few others, but under those circumstances we would defer the surgery if the patient wasn't appropriately fit. We would await for blood results-----

COMMISSIONER: I'm sorry to interrupt you, but counsel's question was specifically relating to concerns over the competence of the surgeon rather than whether or not the patient was ready for the operation.

MR DIEHM: Yes. Thank you, Commissioner.

WITNESS: Sorry. Thank you for that. Then in answer to your question, it sort of goes back to - sorry, I'm lost. Can we start again?

MR DIEHM: Neither you nor any anaesthetist under your direction had declined to anaesthetise a patient for Dr Patel out of a concern that he was incompetent to perform the procedure?-- That is correct.

Thank you.

COMMISSIONER: Doctor, had Dr Patel attempted to perform a further oesophagectomy following Mr Kemps' death, is that a situation where you would have considered, as it were, withdrawing your services?-- That is definitely correct.

MR DIEHM: Thank you. That helps illustrate the next point I wanted to get to with you. You've described your view that Dr Patel was a surgeon who seemed, from the observation - we understand all the qualifications you make about that - but the observations you were able to make, that he was competent to perform the routine general surgery that the Bundaberg Hospital had to deal with. That was your view about him?-- Yes.

And prior to Mr Kemps you apparently thought, did you not, that he was competent it perform even more complicated surgery such as oesophagectomies?-- Yes.

And it was after Mr Kemps' procedure that your view presumably retracted to being one that he was only competent to perform the more routine surgery?-- Yes.

And that's why you continued to anaesthetise patients, presumably, for him for the more routine surgery even after Mr Kemps?-- Yes.

You gave some evidence in answer to a question from - I can't recall specifically who now, but it was a question about whether or not Dr Keating - I think it may have been Mr Morzone - Dr Keating had spoken to you about Dr Patel's competencies or performances before submitting any documents to the Medical Board, either in 2003 or in 2004. Do you recall that? Your answer was that he hadn't?-- Yes.

COMMISSIONER: My recollection is the question related to January 2005.

MR DIEHM: I'm sorry, Commissioner. Thank you.

COMMISSIONER: I assume it's the same answer.

WITNESS: Yes.

MR DIEHM: The situation was such that you had reasonably regular contact with Dr Keating, would that be right?-- Certainly I was up there quite regularly, because we were having staffing problems in terms of numbers and trying to arrange locums and if people went on holiday. Yes, I was up in his office on a reasonably regular basis.

And during the course of discussions that you would have with him, there'd be discussion about how things were going in terms of the general functioning of your area of the hospital?-- Yes.

And there would be undoubtedly detailed discussion at times, the details of which may well be expressly forgotten by both of you by now, but discussion about throughputs in surgery and outcomes in terms of surgery, not only from the anaesthetists' point of view, but generally from the hospital's point of view?-- The main discussions that we were having on surgery were in the Theatre Users' Committee, which basically was planning how we were going to sort of manage the surgical throughput in terms of the requirements on us from Queensland Health, and those were very regular monthly meetings. So yes, we were having long discussions on how to manage cases and sort of pre-planning and what we needed to be doing in advance of these sort of things. But I don't think surgical outcomes were ever a part of those discussions.

Certainly there wasn't any discussion generally speaking of adverse outcomes or disasters or poor performance by Dr Patel during the course of those conversations?-- No.

If Dr Keating was to - whatever may be the minutiae of the discussions that you had with him over time about your areas of interest, if he was to glean a view from you about what you thought about Dr Patel over the varying timeframes, it would have been consistent with what you've already outlined for us was your view about his surgical competence?-- Yes.

Thank you. Doctor, as the Director of Anaesthetics you would have been in a reasonably good position, would you not, to get a sense of adverse trends - anecdotally speaking - that were emerging from surgery?-- No, I don't think we would. A lot of what we see in theatres doesn't necessarily translate to post-operative complications. If a patient develops an incisional hernia in a wound, that's not something we're going to see in theatres. It's going to develop down the track. And again if you are looking at who anaesthetises for these particular lists and what's on them, then if I see a patient coming back on the list and it says "incisional hernia", I don't know who the surgeon was with the initial event because it may have been something that was done by Pitre Anderson way, way back in his career as a general surgeon, because there is no necessary timeframe to put on those.

COMMISSIONER: And it may be that the patient was anaesthetised for the earlier operation by a different anaesthetist?-- Well, exactly, and unless you see patients coming back on a regular basis, then you're not going to be able to put that down to a particular surgeon, and I tended to rotate people through the various lists so that you didn't get an indefinite dose of gynaecological surgery, or an indefinite dose of orthopaedic surgery, or you only ever got to do the endoscopies. So you were moving people through and they're not getting a consistent view. So any one of four or five people may actually anaesthetise the patient for the initial surgery, and a different one of the rest is going to be doing it for any subsequent reparative surgery. So it's difficult to-----

I was going to say, you're speaking specifically there of adverse consequences which result in further surgery, but there are also adverse consequences which don't such as wound dehiscences which will not necessarily go back into surgery, wound infections, and even deaths from surgery which simply wouldn't come to your attention?-- Unless they're coming through the Intensive Care Unit - like there's a couple of patients that I have had a look through their notes and I would say yes, these are definitely surgical foul-ups, but more than that, until you actually start to look at the big picture with all these names and numbers in front of you, you can't put in a good opinion as to what's really going on.

MR DIEHM: Doctor, I should have qualified my question further. It was some of the things you pointed out, with respect, are obvious answers to what I have just said, but at least in certain respects, in the sense of unplanned returns to theatre within the same admission, that would be something which to the anaesthetist, in particular you as the Director of Anaesthetics, if you are involved in the procedure, is an example of something that you would become aware of, in the sense that even if you weren't the anaesthetist on the first operation, when you come to anaesthetise the patient for the second, third or fourth operation, whatever it may be, you are going to look at the chart and see the patient is coming back to theatre within the same admission, aren't you?-- Yes.

So that's one example of something that would become fairly quickly apparent if there was an emerging trend to yourself and to those working under you?-- Yes.

Did that become apparent to you?-- No. There were very few patients who would fit into these sort of descriptors you are giving me. I can think of two over the more than two years that Dr Patel was there. But then that's ones that would have been sort of seen by me and sort of mentally flagged by me. Again, if I am not actually doing the surgery and the patient comes back after hours, then I am still not going to be aware that this was done. I mean, there were indicators that one could report in these situations and certainly unplanned return to theatre is a surgical indicator of a problem, but we're not seeing all those reports because they are not coming back to us because they are not within my sort of remit of anaesthetics.

Doctor, the course of a patient through ICU is something else that might be an indicator. If you were having patients that are coming to ICU that you would not ordinarily expect given the nature of the procedure they had undergone, if they are being readmitted to ICU during the course of the same stay, or if their conditions when in ICU are seemingly catastrophic compared to the nature of the procedure they underwent, all of those sorts of things are things that if there was an emerging trend would become apparent to you, anecdotally at least?-- Yes, and having thought about this, I can only sort of run through about a handful.

Certainly nothing that was occurring to you at the time that set the alarm bells ringing?-- No. Unfortunately no.

Right. Mr Commissioner, having just endured perhaps the longest 10 minutes during the course of this inquiry, that's all I have, thank you.

COMMISSIONER: I think you have had a lot of competition from other counsel.

MR ALLEN: Excuse me, Commissioner, could I briefly deal with a matter upon which I have only received instructions since I sat down?

COMMISSIONER: Of course.

FURTHER CROSS-EXAMINATION:

MR ALLEN: Doctor, could I ask you to have a look at this document, please? I think it may have been shown to you, or a form of it, during your evidence. It is TH16 in - that's an annexure to Toni Hoffman's affidavit and you will see it is a document headed "ICU issues with ventilated patients"?-- Yes.

And if you flick over the page, you will see that second page continues with an account of events regarding Mr Bramich and a listing of concerns?-- Yes.

All right. If you could go back two pages?-- Right.

You will see that there is an email text which says, "See what you think of this and whether anything should be changed. Ta, T", from Toni Hoffman, Nurse Unit Manager?-- Uh-huh.

Then if you go back to the first page, then, of the bundle, you will see that there is a mail envelope properties in relation to a message on the 30th of July 2004 and you will see that the recipients include Martin Carter, opened at about 11 a.m. on the 31st of July 2004?-- Yes.

Now, do you accept that you were sent an email which you received on the 31st of July 2004 which included as an attachment that document headed "ICU issues with ventilated patients"?-- Yes.

Okay. And if you just go to the second page of the document which is attached, so the last page of that bundle?-- Uh-huh.

It reads, "My concerns are the staff in the ICU is expected to function outside the role of the Level 1 unit."?-- Uh-huh.

A complaint about the behaviour of Dr Patel, and then thirdly, "The interference of Dr Patel with this particular patient which delayed his transfer."?-- Uh-huh.

"My concern is that the personal beliefs of Dr Patel concerning the types of patients he can care for here actually endangers the lives of the patients."?-- Yep.

"As these patients who would be transferred to Brisbane are not being transferred early enough." And then finally, "A secondary concern of mine is the level of surgery which is performed. It should only be performed at a tertiary hospital."?-- Uh-huh.

Can I suggest to you that you did not dissent from those opinions at all when they were brought to your attention in late July 2004?-- My response to this particular document,

which I have now found is one of three of similar ilk that Sister Hoffman wrote, was to actually send her the Bramich report that I prepared for the audit.

Yes, and you sent that - I think it was about the 2nd of August?-- Mmm.

So shortly following receipt of this?-- Yep.

But what my question is, you did not communicate to Ms Hoffman any disagreement with the contents of that document she forwarded to you?-- I didn't send any agreement to it either.

So do we take it that you - well, are you able to tell us whether you disagreed with the concerns she was expressing at that time?-- Her concerns there, "The staff in the ICU is expected to function outside the role of a Level 1 unit.", well, I think that was the expectation that sort of we had because we were - I will start again. We were unable to transfer patients down to Brisbane freely, therefore we were outside the function. The function - the staffing levels in terms of both on the medical side, we were outside the guidelines for a Level 1 unit. The second comment about Dr Patel's attitude, I took her to be still referring potentially to the sexual harassment that was allegedly going on at the time.

Well, the comment read, "The behaviour of Dr Patel is intimidating, bullying, harassing and insulting the staff in ICU."?-- That was Patel.

All right. So you didn't disagree with that?-- Didn't disagree with that.

Did you take that up higher on behalf of ICU staff to Dr Keating?-- No, I didn't.

The next-----

COMMISSIONER: That wouldn't have been your function. That would be something the nursing staff would report to the Director of Nursing?-- One would hope so.

Yes?-- If I had realised, perhaps, how little of that was happening in terms of support from the nursing side, I would have been more proactive.

MR ALLEN: "The interference of Dr Patel with this particular patient", and that's reference to Mr Bramich, "which delayed his transfer"?-- I don't think we've actually proved he did delay the transfer.

Did you disagree with that proposition when it was put in late July 2004?-- Well, my response in that was to send the copy of my report to her.

Well, if you go up higher on the page when that was being dealt with in a narrative of events, there is reference to

Ms Hoffman saying, "I called Dr Carter. He agreed to transport the patient to CT". That was for the purpose of getting a CT prior to transfer, was it not?-- Correct.

"On return from CT, it was agreed the patient would be transferred to Brisbane."?-- The patient was always going to be transferred to Brisbane from before the CT. The fact that we had an opportunity to actually do a CT of the gentleman's abdomen to make sure we weren't missing anything going on inside the belly, such as a ruptured spleen or lacerated liver, then we took that opportunity. So there was no attempt by that procedure to delay his transfer.

No, I am not suggesting that. But it is the case that Dr Patel had earlier voiced comments that the patient did not need to be transferred to Brisbane and did not need a thoracic surgeon?-- I am afraid I wasn't there when that was said, so I can't comment on that.

If we just go back to the fourth concern listed, "My concern that the personal beliefs of Dr Patel concerning the types of patients he could care for here actually endangers the lives of the patients as these patients that would be transferred to Brisbane are not being transferred early enough."?-- Well-----

Did you express any dissent at the time of that concern?-- I can't see how those two statements are compatible. If he didn't think the staff could care for the patients, why wasn't he sending them to Brisbane?

Well, no, the concern being expressed is that Dr Patel feels he can actually care for patients in Bundaberg who should be transferred to Brisbane, and that that, therefore, endangers their lives because they are not transferred early enough?-- Well, that was her belief but I think that this patient would not have been accepted for transfer within the first two days of sort of having been admitted with - purely with fractured ribs, and it wasn't until things deteriorated on the Monday - I think it was a Monday - on the 27th, anyway, that he would have required sort of Brisbane-type treatment.

Doctor, the statement isn't being limited to Mr Bramich, it is referring to the "type of patients", and "endangering the lives of the patients as these patients that would be transferred to Brisbane". Now, did you dissent from that opinion at the time?-- Sorry, I am not with your question because this document - certainly if you start from the bottom of page 1 - in the last paragraph is specifically about Mr Bramich.

Yes, have you read the first page of the document?-- I have read - I have seen - I have just looked at the top half where we're generally talking, but the specifics at the bottom are about Mr Bramich.

Yes, all right. Look, could you go-----

COMMISSIONER: Doctor, whether or not Mr Bramich was an illustration of the problem, do you agree with the general proposition that Dr Patel was slow to permit his patients to be transferred to Brisbane to an extent that on occasion endangered the lives of the patients?-- He was certainly - I would agree with the first half of that premise that it was - with respect to the patients in intensive care, he was slow to agree to the concept of patients being transported, but if it had come to the endangerment of their life by them staying, we, as the anaesthetists, sort of arrange the transfer and made sure it happened.

Yes.

MR ALLEN: Just in relation to that, if you go to the page underneath the heading, so the first page of the two page document, and the fourth paragraph, "The director of the unit, Dr Carter, is usually supportive and proactive about transferring patients except when Dr Patel's patients are concerned."?-- Which I have already said that's not correct.

So did you communicate your disagreement with that-----?-- No.

-----when you received it? If you go back to the end of the document, the second page, the last concern is the level of surgery which is performed which should only be performed at a tertiary hospital." Did you disagree with that concern as expressed back then?-- Yes.

Did you communicate to Ms Hoffman your disagreement?-- Well, I told her I thought we could handle these patients.

I see. And were you contacted, as you recall it, by anyone in management who may have received that document that's now in front of you-----?-- No.

-----or your opinions? You weren't?-- No.

Could I tender the four-page document which is headed on the front "Mail Envelope Properties"-----

COMMISSIONER: Is this not already in evidence?

MR ALLEN: The attachment, the last two pages is. That document merely establishes the time it was received.

COMMISSIONER: But Dr Carter's already admitted that.

MR ALLEN: In that case, I won't seek to tender it. It is TH16, the last two pages of the document that were shown to the witness.

COMMISSIONER: Yes. And if it assists anyone, let me say that I don't feel that Dr Carter was under any obligation to express his disagreement with individual items in that document merely because it was sent to him under a cover of an email saying, "If you disagree, let me know", or whatever the

words were.

MR ALLEN: Look, I will tender the document because of the email that covers the document that's been sent.

COMMISSIONER: Exhibit 272 will be the email from Toni Hoffman to Dr Carter of the 30th of July 2004 showing it was received by Dr Carter on the 31st of July 2004.

ADMITTED AND MARKED "EXHIBIT 272"

COMMISSIONER: Thank you, Mr Allen. Are you finished now?

MR ALLEN: Yes, thank you, Commissioner.

COMMISSIONER: Does anyone other than Mr Boddice wish to ask any questions?

MR TAIT: I will have a couple of matters at the end.

MS FEENEY: No, thank you, Commissioner.

MR FARRELL: No, Commissioner.

COMMISSIONER: Mr Boddice?

MR BODDICE: Thank you.

CROSS-EXAMINATION:

MR BODDICE: Dr Carter, my name is David Boddice, and I am counsel for Queensland Health. Doctor, in your statement you deal with the complaints processes in the hospital and you also spoke about it in your evidence, and one of the things that you said was that the executive didn't consider complaints to your knowledge?-- The executive council, which I was a member of, is not the same as the executive.

That's what I wanted to clarify. So the executive council did consider complaints?-- No, we had a report saying - well, occasionally we got the report saying there have been a number of complaints, and the basic information that went down with this is if we don't actually send you the complaint, you don't need to have answered it. So it may have been something that was trivial, like somebody didn't like the colour of the soup, and that was the complaint coming into the hospital. But we were never made clear whether complaints were forwarded to us or not forwarded to us if it was applicable.

Could you just look at this document? Everybody has gone, so

I just might give it to you. You will see that's a set of minutes of the Executive Council, isn't it?-- Yes.

For the 5th of March, is it, 2004?-- Yes.

And you will see one of the parties present is yourself?-- Yes.

And you will see there is a highlighted item there about complaints?-- Yes.

And complaints being sent to you?-- No, the fact that they weren't, because if you read it it says, "Relevant complaints to be sent".

That's what I mean, that complaints were to be sent to you, is what it says?-- Yes, but - do you have any documents that were sent to me?

No, I am asking you?-- The answer is no.

I am wondering in relation to it-----?-- No, they were not sent.

So it was discussed at the Executive Council meeting?-- Yes, I brought it up.

And it was arranged that complaints were to be sent to you - relevant complaints were to be sent to you?-- That is correct.

Do you know whether it was discussed subsequently at that meeting - at a meeting of that council? At subsequent meetings?-- I can't totally recall but I can't recall receiving any complaints either.

All right. So when it says relevant complaints, what did you understand? They obviously weren't complaints about the bed linen or something like that was to come to you?-- One would hope not, but I never got any complaints. And yet on the - you know, I don't know whether relevant complaints were or weren't sent if I am not getting any complaints sent on to me.

COMMISSIONER: But what would you expect to be the relevant ones to you? Events relating to ICU or anaesthetics?-- Both, hopefully.

MR BODDICE: You are present at the meeting and it is an item that was obviously discussed at the meeting, so what did you - what was discussed at the meeting as what were going to be relevant complaints to be sent to you?-- As I understood it from the meeting, anything that wasn't of a trivial nature, such as a minor communication problem, or I don't know what, but even though I requested to have a look at the complaints, which is why this is on the agenda, I never received any of them. So one would hope that there were no relevant complaints.

So it was discussed at that time that was the arrangement, but you didn't ever receive any complaints thereafter?-- That is correct.

D COMMISSIONER VIDER: Doctor, if I understood what you had been saying earlier today you were making the point that you didn't get any feedback to the committees from the DQDSU about any of the activities or information that they collected. You were talking about adverse event reports, as well?-- Yes, I was. I mean, this relates specifically to complaints per se, but no adverse event forms ever came back either.

MR BODDICE: That was the next thing I was going to ask you. There is a difference, is there, between complaints and adverse event forms?-- A complaint is usually coming from patients. An adverse event is something that usually happens to a patient that is reported within the hospital. A complaint would come externally.

So when it's dealing with complaints it's intending to refer to complaints from patients as opposed to adverse events?-- Yes.

If I could just have that document back, thanks. Doctor, there was some evidence given by nurse Hoffman to the effect that you were seeking to have the ICU upgraded to a level 2 facility?-- She may have thought that, but that was never my intent. As we have gone through the guidelines you would be, sort of, aware for a level two unit you have to have an intensivist. We have to have an intensivist. We cannot be a level 2 unit.

I understand that. It's something that hasn't been put to you. I was giving you an opportunity to comment on that evidence that nurse Hoffman had given?-- I can just say that it is incorrect. There is no way we could have become a level two unit. There is no way that I would ask to become a level two unit.

Because you need the intensivist?-- You need the intensivist and I was not going to go away and do another set of exams.

COMMISSIONER: Nor were you in the position to attract one and include that in your budget?-- That is correct.

D COMMISSIONER VIDER: There were other things that you needed too, like permanent radiology reports, and those sort of things?-- There's a lot of things set down in the guidelines for a level two unit that we couldn't meet. Most of the things we could meet was the nursing staff on the particular unit, which I think are excellent.

MR BODDICE: In relation to patient P34 Mr Phillips, in your statement at paragraph 39, I hope this is the current statement - sorry, it's paragraph 38. You said, "I remember that there had been an attempt to transfer this patient to Brisbane for an oesophagectomy. However, as I recall there was a waiting list for several months before he could receive

the surgery in Brisbane", and you said in your evidence about this that you were unsure about-----

COMMISSIONER: Mr Boddice, that's been amended so it now reads, "However, as I recall from that conversation there was a waiting list", and Dr Carter has made it clear that he doesn't plan any direct knowledge of that. It's simply that he believes he was told.

MR BODDICE: And that's the point that I wish to raise. You then went on in your evidence to say, well, I'm a little unsure about that now, having looked at the file. Was the situation that when you did your statement you had a recollection that you had been told that the oesophagectomy couldn't be performed in Brisbane because there was a waiting list difficulty rather than having been refused to be performed?-- I'm totally unsure of what was said to me at the time now that I really want to go back to the notes and review them.

And so that's what you meant when you said, look, I just don't follow it any more because now having seen the file you don't even know whether Brisbane was involved at all in the matter?-- That's right. I, basically, came into reviewing this gentleman with that thought in my mind and when the notes were provided to me for the coronial inquiry I, sort of, became aware that there were - you know, there was no - seemed to be no documentation of what I had been led to believe and that, sort of, made me rather uneasy.

And I take it the documents that our learned friend Mr Devlin showed you today which showed that there was a Brisbane gastroenterologist who went up to Bundaberg, that may in fact be the Brisbane connection you were thinking about?-- No. That wasn't the implication, but as I said I'm so confused now about that particular area because I cannot find any documentation of it that I really want to go back and have another, sort of, full look before I come back and, sort of, offer Mr Devlin my advice on what I feel has taken place - I can prove.

In relation to transfers, you said that if you thought there was a necessity to transfer you would transfer?-- Yes.

In your statement you set out that, of course, there are other factors, such as family factors and things like that to be taken into account as to whether a person should be transferred?-- Yes.

And that may mean that the person might, because of those factors, be kept in ICU for longer than the 24 to 48 hours even though they're ventilated?-- Yes.

And they're, really, medical decisions to be made by yourself having regard to all the factors as you understand each particular patient. In relation to Mr-----

COMMISSIONER: Did you nod in response to that last

question?-- Oh, I agree with that, sorry.

MR BODDICE: So the policy is there but there's some flexibility, obviously, having regard to the particular patient?-- You have to look at the person as a member of a family. There are a group of patients who arrive in intensive care where they have had the NFR order put on them after they have come through the door, and you're left with the responsibility of these patients. If you're not going to transfer them on for ongoing care, which is going to improve their life lot, why transfer them with - and leave the patient's family with the need to organise a funeral down in Brisbane when they live in Bundaberg? I'm afraid it just does come down to something like that.

Or have the opportunity to visit in those last few days?-- Exactly.

And they're factors that you take into account when assessing what is best for the patient?-- Yes.

In relation to Mr Bramich, you say in your statement that at paragraph 85, that it was only after - after the postmortem that it was revealed that, in fact, Mr Bramich had suffered a fractured sternum?-- That is correct.

And that was significant, wasn't it?-- It would have given more likelihood of the degree of the injury. One of Mr Bramich's other problems is he had an abnormal heart rhythm. Now, that was preexisting. If that had been a new change on his cardiograph this would have been a greater indication that there was something, sort of, seriously going on in his chest and would have been a good indicator to transfer him, but apart - without being, sort of, a preexisting problem is, sort of, confusing the opportunity for finding a good diagnosis with him and a phone call down to Brisbane saying, well, we've got this gentleman with a flail chest, would you like us to send him, we would have got the response, as it did with another patient, of, "Why are you trying to send this to us?"

See, on the X-rays that you had in the hospital that showed broken ribs, but it didn't show the fractured sternum, did it?-- No.

Of course, a fractured sternum suggests quite a significant blow, doesn't it, in order to fracture the sternum?-- Yes.

And so in the circumstances where the patient initially appeared to recover or, at least, improve with a diagnosis of broken ribs there was real reason to be concerned when there was a sudden crash of the patient in terms of the patient's vital signs?-- Yes.

And you said that in that - it's against that background that it's understandable that Dr Patel may have considered a cardiac tamponade as a possible explanation?-- Certainly. As I said, it's something that should need to be investigated.

CT, itself, did not indicate, but the sudden loss of blood pressure it's worth having a look, but if you see nothing when you are looking with ultrasound, then there is no point proceeding with the pericardiocentesis.

You were asked some questions about the number of times, do you recall - it was suggested to you that there was some ten, sometimes 20 attempts in relation to the cardiac tamponade and extracting the fluid. The autopsy report suggests there were two punctures in the heart area and that what may have been the case, with what Dr Ashby said, that what people were seeing when they described 10 or 20 times is an attempt to move it around in order to try and get the fluid?-- I have to say that since I wasn't there I have no idea.

Certainly you would expect if there were 10 or 20 actual stabbings you would expect more puncture marks than two, wouldn't you?-- Definitely.

And in relation to patient P44, you were asked some questions about a brain stem herniation where Dr Patel had made a note of that?-- Yes.

Did I understand your evidence to be that - well, you didn't really look at that area because that wasn't, from your point of view, what your concern was?-- I didn't think it was worth looking at because if the brain stem has herniated the patient is dead.

So your concern was really looking at another area?-- Yes.

I take it when you asked for the report, the radiology report, you also asked for them to concentrate on the area you were interested in?-- Now, here we run into a problem because being somewhat naive I assumed that the radiology would be reported. It was a great shock to me to find out when I spoke to Martin Brennan that the radiology had not been reported because there was nothing in the notes. We then went to the hospital system and found that the X-ray had been taken, but not reported, and this is why I got a copy of the - got the X-ray report in two weeks ago.

COMMISSIONER: And when you did that did you give specific instructions as to the issues you wanted addressed or did you ask just for a report?-- I didn't want to suggest anything to the radiologist. I just said to her, "Please, could you report it? We're doing it for an audit".

Any competent radiologist would have noted a brain stem herniation if that appeared on the scan?-- That is correct.

MR BODDICE: So when you said before about you asked for the radiology report all you were simply doing was requesting that the report that hadn't been made now be made?-- Yes.

Yes, thank you, Commissioner.

COMMISSIONER: Thank you. Mr Tait?

MR TAIT: Thank you.

RE-EXAMINATION:

MR TAIT: Two documents referred to in Dr Carter's statement that I don't think are exhibits.

COMMISSIONER: Now, earlier Mr Morzone tendered all of the outstanding documents of which there are copies, but perhaps Mr Morzone have you checked this with Mr Tait?

MR MORZONE: Yes. I, in fact, did bring those to the attention of Mr Tait. So they're not included.

COMMISSIONER: Thank you. Can these be shown to the witness - to Dr Carter? Although, I suppose being a British consultant you are used to being called Mr?-- No, that was only surgeons. They were the barbers.

Oh, I see.

MR TAIT: Doctor, the first document there, are those the CT scans referred to in paragraph 76 of your statement?-- Yes.

I tender those.

COMMISSIONER: Those will be added to and form part of Exhibit 265.

MR TAIT: And, also, there's the postmortem report on Mr Bramich?-- Right, thank you.

I tender that, as well.

COMMISSIONER: Similarly, that will be added to and form part of Exhibit 265.

MR TAIT: Commissioner, I have spoken to Mr Devlin. He's been kind enough to provide me with the questions that he wanted addressed. I wonder if it would be suitable to the Commission to have Dr Carter provide a supplementary statement addressing those questions when he's had the opportunity to look at the documents rather than - and provide that to the Commission if he - and if he needs to be cross-examined further he can be.

COMMISSIONER: I was going to raise that. I really don't like the idea of sending witnesses away with homework. On this occasion it's probably a convenient way to do it, but to make it as convenient as possible for Dr Carter I would ask those instructing Mr Devlin and also Mr Diehm and, indeed, anyone else, but particularly those two that if there are any specific issues that you wish Dr Carter to address that there be a list of questions and a list of the material that you

wish him to turn his mind to in answering the questions and for our purposes, Mr Tait, I don't think we need a formal statement in response, just a letter from Dr Carter or even an e-mail either through your instructing solicitors or directly to the inquiry, whatever you prefer.

MR TAIT: I will tend to it. Mr Devlin's request is exactly that. Looking at this document they're the questions.

COMMISSIONER: You might run that past Mr Diehm to see if it addresses his concerns, as well. Mr Morzone?

MR MORZONE: No re-examination.

COMMISSIONER: Doctor, it has been an exceedingly long day, but we're very grateful for your assistance; particularly that you were the most senior and experienced doctor working with Dr Patel your evidence has been and will be invaluable to this inquiry. We are also grateful, though, for the very candid and frank and open way in which you have given your evidence and you leave with our very sincere thanks for your assistance. You are excused from further attendance.

WITNESS EXCUSED

COMMISSIONER: Mr Morzone 9.30?

MR MORZONE: Yes, I believe so, Commissioner.

MR BODDICE: Could I just raise one matter?

COMMISSIONER: Yes, Mr Boddice?

MR BODDICE: Earlier this week I made the offer in relation to the Skills Development Centre.

COMMISSIONER: Yes.

MR BODDICE: Tentatively we made a time for 8.30 next Tuesday morning at the Skills Development Centre and I can liaise with my learned friend Mr Andrews about where to meet and things like that.

COMMISSIONER: That's excellent. Can I also mention very reluctantly something else that we're still concerned about, the evidence of Mr Chase and the unfortunate need to go back to Bundaberg to deal with that. Because we have so little time what we're considering is having a very quick trip to Bundaberg next Wednesday, either in the morning or in the afternoon, just a half day trip to Bundaberg, so that we can deal with the evidence of Mr Chase and not have to deal with anything else and, hopefully, that means that very few counsel and parties' representatives will need to come along for the trip. I can't imagine, for example, that Mr Devlin or

Mr Allen or possibly even Mr Diehm would wish to participate, but that's, of course, a matter for you.

MS FEENEY: Commissioner, we have - we had notified counsel assisting that if the only reason for returning to Bundaberg was to hear the evidence of Mr Chase we would cross-examine by telephone.

COMMISSIONER: Things have moved on past that and those arrangements have been made.

MS FEENEY: Thank you, Commissioner.

MR DIEHM: Commissioner, I was just going to say apropos of that Bundaberg trip I think it unlikely at this point in time that I would have anything to ask of Mr Chase. I wondered whether and I will have to get instructions and consider this finally, too, but I just wondered whether if my instructions are such that we take the view that it's likely to be unnecessary for me to go to Bundaberg, that I not go and if something came up in the transcript that I could cross-examine Mr Chase briefly by telephone with your permission.

COMMISSIONER: Yes, yes, that would certainly be acceptable.

MR DIEHM: Thank you.

MR BODDICE: Could I ask it be possible and whether it would be easier if the evidence could be taken by telephone.

COMMISSIONER: Yes, all right. I have a real difficulty over this evidence because as matters stand either Mr Leck has given us untruthful evidence or Mr Chase has given us an untruthful statement. I don't want to be in the position of having to form that sort of credit assessment with a man that I have never seen and whose voice I have merely heard as a disembodied spirit over the other end of a telephone line.

MR BODDICE: Having heard the basis, I ask it be recorded I think the person should be seen in person.

COMMISSIONER: I'm afraid that's right.

MR BODDICE: I don't dispute that, Commissioner.

COMMISSIONER: Okay, 9.30 it is then.

THE COURT ADJOURNED AT 5.53 P.M. TILL 9.30 A.M. THE FOLLOWING DAY