Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 26/05/200

..DAY 04

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

THE COMMISSION RESUMED AT 9.33 A.M.

PETER JOHN MIACH, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Andrews, just before we resume the evidence, I think there are a few administrative or we sometimes say housekeeping matters that we need to deal with. The first relates to proceedings next week. It is presently contemplated that the head of the AMAQ Dr David Molloy will be giving evidence at some time next week. You will appreciate that Dr Molloy is an obstetrician and gynaecologist in private practice and obstetrics is at least one branch of medicine that waits for no-one. For that reason, the inquiry may have to move into a sort of day-night sitting mode, perhaps starting after lunch and going through until the early evening. So anyone who needs to make personal arrangements to accommodate should be prepared probably for Tuesday or Wednesday evenings of next week.

The second administrative matter relates to the sittings in Bundaberg. The facilities originally identified as suitable for the inquiry have been found to be rather too small. Fortunately, staff of the Attorney-General's department has managed to find us an alternative venue, which is at the Bundaberg TAFE College. There's a lecture theatre which seats I think 150 people or so. So that will be the venue of the sittings in Bundaberg starting on the 20th of June I believe.

The third thing relates to the CMC inquiry. I certainly don't want to pre-empt any announcements which may be made by the CMC but there have been discussions to take over this courtroom in the week after next. There are obvious advantages in that. One thing, it demonstrates the seamlessness of the interaction of this inquiry and the CMC inquiry. The other thing is that it will make the staff of this inquiry, make it much easier for them to be involved in observing the proceedings, and considering the evidence which is taken and Mr Andrews, in particular, will have a major role in that, and hopefully it will be useful too to the legal representatives of other persons interested in that inquiry if they don't have to relocate to other premises. I don't think a final decision or final arrangements have yet been made but I imagine the CMC will be making an announcement about that before very long.

Mr Andrews, is there anything else that we need to be canvassing at the moment by way of procedural or administrative matters?

MR ANDREWS: No, Commissioner.

COMMISSIONER: Thank you. Is there anything that anyone wants to raise before the evidence resumes? Ms Kelly?

MS KELLY: There was an authorisation in writing from the Director-General of Health for those disclosures to be made under section 62F of the Health Services Act.

COMMISSIONER: Yes.

MS KELLY: I'm hoping that it's produced.

MR BODDICE: I understand it was made last night. I don't have a copy but I will arrange for copies.

COMMISSIONER: Thank you.

MR BODDICE: I take that back, I now do have copies. I hand a copy over.

COMMISSIONER: Excellent.

MR BODDICE: Mr Commissioner, you also asked in relation to the Premier's statement to parliament and the Queensland Health statement. Queensland Health's submission was of course a preliminary submission and to the effect it was affected by what the Premier has stated in parliament, it must be read subject to it, and its final submission will of course have regard to the Premier's statement to parliament.

COMMISSIONER: I'm not quite sure what that means, have regard to. I mean, the difficulty as I see it is that whilst you are representing a department of government, there is an only one authority in this state that can advise the Crown in relation to policy matters and that's the Premier of Cabinet. Surely any submission made by Queensland Health has to be governed by what the Premier in Cabinet decides.

MR BODDICE: That's what I mean by have regard to. We will take it into account, obviously, what the Premier's position is.

COMMISSIONER: Hasn't it got to be more than taking it into account? Doesn't what the Premier say represent the policy of the government?

MR BODDICE: Yes, it does.

COMMISSIONER: Okay. We'll deal with that then.

MR BODDICE: The second thing that you asked for was in relation to whether I had instructions to represent the Minister. I do not have instructions to seek leave to represent the Minister.

COMMISSIONER: Where does that leave you?

MR BODDICE: Well, I represent - I have leave to represent Queensland Health.

COMMISSIONER: But how can you represent a department of government but not the Minister who is the head of that

department?

MR BODDICE: Well, with respect, the Minister has political responsibility for the department. The department, Queensland Health, is the organisational body that operates the hospitals on a day-to-day business. Their interest may well be separate and distinct, but I do not have instructions to represent the Minister.

COMMISSIONER: Look, I accept that. I accept that you don't have instructions to represent the Minister. I've been troubled from the beginning by this notion that a department of the government can be treated as a legal entity, even though it isn't, and represented separately from, for example, the Director-General, who is the operational day-to-day head of that department. But now to be told that you're representing a department of the government of Queensland without instructions from the Minister in charge of that department, surely that makes your position absolutely impossible.

MR BODDICE: No, with respect. I don't have instructions to seek leave to appear to represent the Minister.

COMMISSIONER: Are your instructions on behalf of the department approved or sanctioned or authorised by the Minister?

MR BODDICE: My instructions - as I indicate, I take instructions from the authorised officer, who is the Director-General.

COMMISSIONER: Yes.

MR BODDICE: I have no doubt that the Director-General has had contact with the Minister in relation to those instructions. I do not have instructions, however, to seek leave to represent the Minister. And in the Fitzgerald Inquiry, the Minister was not represented even though the Queensland Police department was represented.

COMMISSIONER: Mr Boddice, if you're telling me that you're purporting to represent a branch of the Queensland government without instructions from the Minister, who as you say takes political responsibility, well, it is more than that. As a matter of fundamental constitutional law, the Minister is the person in complete legal control and charge of that department. If that's the situation, I don't see how I can continue to allow you to stand there and pretend that you represent a branch of the government without the authority of the constitutional head of that branch.

MR BODDICE: With respect, Commissioner, I have not said I don't have the authority of the Minister.

COMMISSIONER: You haven't said that you do-----

MR BODDICE: What I have said is I don't have the instructions

to represent the Minister.

COMMISSIONER: You haven't said that you do have that authority.

MR BODDICE: Well, if, Commissioner, you require me to specifically obtain that instruction, I will obtain that instruction. I have instructions from the authorised officer of the department to represent the department.

COMMISSIONER: You have instructions from the Director-General.

MR BODDICE: That's so. But if you require me to get those instructions, I'll get those instructions. But what I was asked to obtain was was I seeking leave to appear on behalf of the Minister and I have indicated my instructions are not to seek leave to represent the Minister. And in my respectful submission, as you - with respect, Commissioner, you indicated on day 1 that there may be a potential conflict between-----

COMMISSIONER: Precisely, Mr Boddice, and that's why I cannot understand how you can purport to represent a branch of government without the authority of the person in constitutional control of that branch of government.

MR BODDICE: As I said, I don't say that I don't have that authority.

COMMISSIONER: And you don't say that you do. And let's not play with words. I mean, it's the same with this proposition that you're representing all of the past and present members of staff.

MR BODDICE: Oh, but-----

COMMISSIONER: How can you possibly do that?

MR BODDICE: With respect, Commissioner, it is no different - the nurses union has thousands of members.

COMMISSIONER: Yes.

MR BODDICE: Obviously the members they seek to represent here are those that are affected by matters within the Terms of Reference of the inquiry.

COMMISSIONER: And, Mr Boddice, you will recall that both the representative of the nurses union and the representative of the AMA, and, indeed, Ms Kelly on behalf of her client organisation made it clear that they were representing the particular entity, which is that association, together with any individual members whose names are notified to the Commission. Mr Allen isn't purporting to represent tens of thousands of nurses. He's representing the union of which those nurses are members. Ms Kelly isn't purporting to represent thousands of her client organisation's members. She's representing the organisation and any individuals whose

name are provided to the inquiry, and the same applies to Mr Tait representing the AMA. You cannot - you cannot - represent at the same time Dr Patel, a former member of staff within your own - within your own terms, the current witness, who is a current member of staff, Sir Llew Edwards, who was a member of staff of Queensland Health 20 years ago or however long it was.

D COMMISSIONER EDWARDS: Longer.

COMMISSIONER: Longer. You know, you might as well say that you're representing the late Sir Raphael Silento, who was Director-General in the '50s.

MR BODDICE: Well, Mr Commissioner, on page 25 of the transcript I raised this very point on day 1: "I am seeking leave to represent Queensland Health. What I have indicated is that that leave will extend, like Mr Tait, to when employees who come along who have not sought to be separately represented, I will be seeking leave to represent them, but at the moment I am seeking leave to represent Queensland Commonwealth."

COMMISSIONER: You haven't sought to represent the current witness, who is not separately represented.

MR BODDICE: That is because my instructions are that he was contacted to see whether he required representation and we were informed he did not.

COMMISSIONER: Well, Mr Boddice, I am withdrawing leave for you to represent any of the staff of Queensland Health, past or present, unless notification of the name of the individual staff member is provided to the Commission in advance, and that will put you in the same position as Mr Tait, Ms Kelly and Mr Allen.

MR BODDICE: As-----

COMMISSIONER: Do you wish to dispute that ruling?

MR BODDICE: No, I'm happy with that ruling.

COMMISSIONER: Thank you. All right. As regards your purported representation of Queensland Health as presently advised, I am minded to withdraw leave to purport to represent Queensland Health unless during the course of the day you can obtain some instructions which persuade me that there is some legal basis on which you can stand there and say you represent a department of government without the authority of the member of the executive council who is responsible for that branch of government.

MR BODDICE: I'll get those instructions.

COMMISSIONER: Thank you. Mr Andrews.

MR ANDREWS: Thank you, Commissioner. Dr Miach, do you retain your statement from yesterday?-- Yes, I do.

You're still on your former oath. When proceedings concluded yesterday you were speaking of a meeting that occurred on about the 20th or 21st of October 2004 with Dr Keating in which Dr Keating had asked whether you had any issues. You told the Commission what issues you considered Dr Keating may have been talking about?-- That's correct.

Was the topic of the catheter audit raised by either of you at that meeting?-- It was.

By whom?-- It was raised by me as far as I can remember. Almost certainly it was raised by me.

Can you tell us the conversation, please, as well as you can remember it?-- The - as far as I can remember, in fact, the issue of Dr Patel had come up because as I mentioned yesterday - in relation to another matter which I believed had to do with a lady with the carcinoma of the breast. While we were talking about Dr Patel, in fact I almost certainly - I would have said, and I can't remember specifically, that I had - I continued to have issues with Dr Patel and I said, you know, that, "I actually gave you that audit some time ago on the peritoneal dialysis catheters." He said, "What audit?" I said, "The one that I gave you some months ago which I haven't heard anything about", and he said, "I don't remember that." And I said, "Well, I do because, in fact, I brought it to you personally and handed it to you." And he said, "I don't remember that at all." And I sort of said, "Well, I certainly do because, you know, my memory is still quite reasonable and I remember specifically bringing it to you." And the conversation went on for a while about my saying yes and Dr Keating saying no, and I would have been prepared to just leave it that, two men disagreeing on a topic, but there was some comment made which quite irritated me I must confess. It was - there was an intimation that - first of all, that my memory wasn't very good and, secondly, that I may not have been 100 per cent truthful with my statement. That I'd given the audit and I didn't say anything, but that left me, you know, quite - you know, quite irritated I must confess.

And on the 21st of October you received an e-mail and at paragraph 97 of your statement you've set out what that e-mail said. But as I understand it, you don't - you haven't, on this trip from Bundaberg, brought with you the e-mail and in that respect your statement which refers to the PJM3 is inaccurate. Paragraph 97?-- Yes.

You speak of an annexure to your statement being a copy of the e-mail from Dr Keating of 21 October 2004?-- That e-mail I made available in Bundaberg to the combined sitting of the CMC and also of the Commission, at which Jarrod was there, so I supplied a number of other documents, which I - I don't have copies of here, to those parties and that statement is in fact - I believe it is a direct statement of what was actually written in that e-mail, but that e-mail is available.

COMMISSIONER: Mr Andrews, this doesn't trouble me at all if the documents aren't physically present in Brisbane at the moment. I'm sure that they can be added to the statement at a later time and that will overcome any difficulties.

MR ANDREWS: Thank you, Commissioner. That's most convenient. After your meeting of the 20th or 21st October, did you supply to Dr Keating a copy of the audit?-- Straightaway. The audit was available, so I hunted it out and I actually brought it up to him either that day or the following day, I can't be specifically certain about that, but I brought it up to him and again handed him a - handed it to him, personally.

Now, did you ever hear from Dr Keating anything in response to the hand-over of that audit in October 2004?-- No, I did not.

By October of 2004, were peritoneal catheter placements still continuing within the Bundaberg Hospital?-- I believe they just started and I know that because I asked for an e-mail or I asked for a fax of the exact dates that we commenced doing peritoneal catheters again and I think in October is when we started putting in peritoneal catheters again.

Would you look, please, at this letter on the monitor?-- That's the letter that I received. That's the fax that I received from Baxter, that's right.

Does that set out the dates of procedures which occurred at the Bundaberg Hospital being insertion of peritoneal dialysis catheters between the 19th of October 2004 and the 3rd of May 2005?-- Yes, it does.

And the letter is headed "Baxter". Is there a Baxter Group-----?-- Yes, there is a Baxter Group.

Did you, during 2004, make contact with that group for the purpose of encouraging that group to arrange for public patients to have peritoneal catheters inserted?-- I initiated discussions when I came back from - from my sabbatical leave overseas, but the Baxter representative, the same as a number of other, in fact most representatives of the pharmaceutical industries or - in fact, they - they make an appointment or they turn up - they turn up announced in hospitals quite frequently. It is part of the way they work. So the Baxter representative, in fact he would have been coming to the Bundaberg Base Hospital repeatedly. It is very likely, in fact, that I saw him and spoke to him before I left to go to England but, certainly, I initiated or I continued or I took an interest in trying to develop another program when I came back from overseas, and that would - I came back in April, so I would have initiated things April or May.

Should I deduce that by the 19th of October 2004 you had reached some arrangement with Baxter?-- The arrangements - the arrangement was - there was reached with Baxter. It was reached a long time before October 2004. The actual insertions of catheters in fact commenced, as I see

here, on the 19th of October 2004.

Who was the person inserting the catheters?-- Dr Brian Thiele.

Now, by the 19th of October 2004, Dr Thiele was not employed at the Bundaberg Hospital, was he?-- No, he was not. He was strictly in private practice.

So was he attending the Bundaberg Hospital as a VMO?-- No, he wasn't. He did not have an appointment as far as I know as a VMO although I do believe that once in a while, if there was an urgent vascular problem, he would attend. But that was - I'm fairly certain that he did not have a formal VMO appointment to the Bundaberg Base Hospital.

COMMISSIONER: Is there any reason why Bundaberg Base Hospital wouldn't take advantage of apparently a very experienced vascular surgeon by giving him a VMO appointment?-- He had a VMO appointment until quite recently. In fact, it's fair to say that I did everything in my power as a physician to try and keep that appointment going because, in fact, I found him very useful in doing vascular access and some other types of surgery, for example, Tenckhoff catheters. For a variety of reasons in fact he left. I don't know the exact reason, although I've actually spoke to him about that. As a physician, as a Director of Medicine who was involved in this program, I was quite annoyed and upset that in fact - as you say, Commissioner, that in fact - that he left. And I understand that he left and, you know, I may stand to be corrected but the conditions that he was experiencing in theatre and cooperation with various staff, administrative and others, made it untenable for him. He said, "I don't have to sort of cope with this sort of performance." So he left, which I think was a tragedy, really. It was a major problem for the hospital.

Are you aware of any attempts by, for example, Mr Leck to try and make arrangements that would enable him to remain as a VMO?-- I'm not aware of that at all but-----

Or Dr Keating?-- No, I'm not aware of that either. But I would have been surprised quite frankly, and that's just one man's opinion, but I would have been surprised if attempts were made to have him stay.

D COMMISSIONER EDWARDS: Would you say the services in your view are not safer as a result of his not staying?-- The renal services certainly, because I could no longer use his expertise, his knowledge, his technique to help public patients in the public hospital. When I saw private patients, then it was easy because, in fact, I would send him over into the private sector and that would have been good, but it would have been extremely helpful to the hospital and to the renal unit if in fact he remained on staff.

The seven patients whose particulars appear in the letter of 24 May 2005, were there peritoneal dialysis catheters inserted

at a different hospital in Bundaberg?-- They were. They were inserted at the Friendlies Private Associate - Friendly Associate Private Hospital.

And the complication rate arising from those seven procedures, how does it compare with the complication rate arising from the six audited procedures done by Dr Patel?-- There were no complications related to the procedure in these seven patients at all. There was one patient who we were not able to maintain on peritoneal dialysis but it had nothing to do with the insertion of the catheter. It was another anatomical problem that he had which made it impossible for us to continue with peritoneal dialysis and that was a pre-existing - a condition that he had which you would never diagnose beforehand.

Is it the case that the seven patients referred to in this letter were treated by you either at the Bundaberg Hospital or at the hospital at Hervey Bay?-- Yes, yes, that's - one or the other because, as you know, in fact, I look after the Wide Bay area, which encompasses Bundaberg, Hervey Bay and Maryborough.

Now, did you - you received no objections from the executive at the Bundaberg Hospital when you arranged for the treatment of - I beg your pardon, for these procedures at the Friendlys Hospital?-- I received no objections from the Bundaberg Base Hospital.

Can you tell us when Dr Keating commenced as Director of Medical Services at Bundaberg Hospital, what contacts you had with him initially?-- I can't remember the exact date that he started in Bundaberg Base Hospital but there was a meeting set up as a welcoming meeting by the senior staff and I think it was attended by a majority of senior staff, so that was my first contact with Dr Keating. After that, as I mentioned yesterday, I had further contact with him, mainly to try and improve and get some cooperation with trying to improve and maintain the Department of Medicine which is what I'm primarily involved in, interested in and trying to develop and as I mentioned yesterday, my attempts to try and organise a routine meeting at his convenience in fact was turned down.

Now-----?-- I think I mentioned this yesterday.

Dr Keating, when he came to the hospital, did he have something to say about the on-call rostering?-- The on-call rostering was something that has concerned me for a long long time and continues to concern me, so I had major concerns with the rostering in the hospital as far as medicine was concerned.

Please tell us whether these concerns predated or post-dated Dr Keating's arrival?-- They occurred after his arrival when the rostering system was changed.

Would you tell us please what the rostering system - what features were changed after Dr Keating's arrival?-- To make it sensible for the attendees at this meeting, I think I should actually give a background on in fact what actually happens in departments of medicine both in Australia and overseas. It also happens for surgery because, as I say, I'm involved with surgery and I deal with them, but there is a hierarchy in medicine, there are the consultants who oversee their units, they're responsible - patients are admitted under them, they are responsible to make sure that the patients are treated properly, they oversee things, they do routine ward rounds and they do routine reviews, usually every day, sometimes the patient is sick they may do it more often than that. Underneath the consultants, there are what's called Registrars. Now, Registrars are in fact extremely experienced doctors who have not usually attained the specialist qualifications but who in fact work in medicine and they effectively run the medical services in hospital, their training position, they have a lot of experience and eventually once they get their fellowship, then they become consultants themselves and everybody, before they become a consultant, in fact goes through this period. Underneath - in Bundaberg we don't have Registrars, we have a poor man's version of a Registrar which we call a PHO, a Principal House Officer, they're quite variable in the regions and in fact

some of them are very good in Bundaberg, some of them are quite marginal, that's life. Underneath them are in fact there are more junior doctors and they're called, in some states they're called Residents, up here they're called JHOs, Junior House Officers or Interns and they work in conjunction with the PHOs. Now, one of the chief functions of a PHO of a Registrar is to ensure that patients are admitted properly, that they're diagnosed, that there is - that they're treated appropriately, that their management is correct and if there are any issues, in fact, they automatically refer to the consultant and there's also a consultant on-call. The point I'm trying to make is that in fact for the best possible practice of medicine, the systems all over Australia and all over - in England, in fact, as you know I just spent some time in England last year, exactly the same in some of the middle eastern hospitals because I was Director of Medicine in a large military hospital in Saudi Arabia, the system is the same, I've worked in Paris, the system is exactly the same, is that's the structure and the reason that that structure exists is because in fact when a sick patient arrives at a hospital, then it's extremely important for the community, for the patient, for everybody for that patient to be fielded by the best possible available doctor and that in fact is a Registrar or a PHO, and that was the system until it was changed. Now, in Bundaberg, we've got three PHOs, in other words, if they were to be put on-call, in fact, you would have a one in three roster which for a regional centre is not too bad, it's not as good as in a major hospital where there are more staff, but in a regional hospital a one in three call is quite reasonable, and what happens, in fact the PHO starts working at 8 o'clock in the morning and he sort of admits until 8 o'clock the following morning and there are numerous advantages of that: first of all, as I mentioned, the PHOs can be quite variable and the consultants - what I do when I have a PHO, I observe him for the first few weeks, I know what he can do, I know what he doesn't know, I know whether he can read an ECG, I know whether he understands what electrolytes are, I know when he has some someone with heart failure, or when he has someone with liver failure, you observe these people and then you in fact behave appropriately. If you get rung up in the middle of the night and you know that this gentlemen knows very little about liver failure and he rings you about a liver problem, then you're on your guard, you know that in fact this man may be struggling so you're much more - as much more sensible, you know if there's a problem, you get up and you go and see the patient, but that's because you actually know the PHO. The PHO in fact learns medicine from the continuous cross-pollination from the consultants, so it works very well and it works all over the world. Now, the system that was changed is in fact is the PHO admitted between 8 o'clock in the morning and 5 o'clock at night and after 5 o'clock at night - between 5 o'clock and night and 8 o'clock the following morning it could be open slather. The onus on the admissions was put on the Accident & Emergency staff with some help from some of the medical staff if needed be. Now, the Accident & Emergency staff are in fact quite variable, sometimes they are PHOs but it's of no use to me if he's a PHO in psychiatry and someone develops a heart attack, there's no

use to me if he was a PHO in obstetrics and someone develops a liver failure, so the mere fact that someone's called a PHO doesn't mean anything, but - and some and - so the admissions in fact overnight were made by Accident & Emergency staff and, you know, people would be admitted, in the morning you'd come in and in fact sometimes there'd be - there'd be misdiagnosed, mistreated, mismanaged and you'd have to start all over again, and that was quite counterproductive. I mean, it hurt everyone, it hurt the patients, it hurt the junior staff who were put in a invidious situation, it hurt the PHOs, it hurt the consultants and that's what it was changed to.

D COMMISSIONER EDWARDS: Only in Bundaberg or throughout the State?-- No, just in Bundaberg, just in Bundaberg.

COMMISSIONER: Whose decision was it to change that?-- Dr Keating.

And was any explanation given for that change?-- I brought up, I brought up this issue because it concerned me and it still continues to concern me. I brought it up at a number of meetings, I brought it up at the medical staff advisory committee which sat - sits once a month, so in fact it was within a few weeks of this change in policy that was established I brought it up, and I remember quite clearly having a discussion with a number of other doctors, most of whom remain fairly silent, but it was a concern to me so I said what I think should have been done but I got nowhere. But I mean, I was told that "You need uniformity in a system" and by that I mean that you have patients admitted by the A & E staff, we belong the medicine, to surgery, I don't think it applied to obstetrics and gynaecology and not paediatrics, but it applied to surgery and medicine. I said, "Look, this is counterproductive to medicine." I stated in clear terms what I saw the issues to be. I was told well, this is what - this is the way it is, medicine is changed. Now, you know, I mean, I know medicine, I've been involved in medicine all over the world all my life, I know the changes, I know if a patient has a heart attack today or six months ago, it's the same patient, same heart attack, so you know, medicine doesn't change but that was the excuse. The thing that concerned me was that this process was introduced unilaterally, there was no discussion, no communication, no advice, no interest, it was just sort of this is what we do and this is, and it still goes on.

MR ANDREWS: Dr Miach, may I interrupt for a moment?-- Of course you can.

The person who said to you at the medical staff advisory committee meeting that uniformity was necessary and that medicine had changed, who was that person?-- It was Dr Keating.

And as I understand it, though there might be PHOs who are attending to the after hours admissions, it's your opinion that the PHOs who should be doing so should be either surgical or medical PHOs?-- Absolutely, that's the system that occurs

all over Australia. I mean, I haven't worked in every hospital in Australia but I've seen a selection of them, I've seen what they do overseas and that's exactly what happens.

Did you make that point at the medical staff advisory committee meeting? I mean, the point that it should be a surgical or medical PHO?-- The point I made that it should be a medical PHO, I stay out of surgery, that's somebody else's domain, what I'm interested in is I know about medicine and I made the point specifically that as far as medicine is concerned, this is the way it should be. What I was told is in fact if the PHO goes home at 5 o'clock and sleeps all night, then he wakes up in the morning, in a bright eyed and bushy tailed and he comes to work and he sort of can do everything, it doesn't work like that in real life, it doesn't work like that in real life because if you come into hospital in the morning and you're confronted with half-a-dozen patients that you don't know, that in fact you need to re-admit all over again that may have been misdiagnosed, mismanaged, mistreated, it doesn't help anybody. But that's one of the reasons that, you know, that I'm told - in fact, it was written to me, the fact that the fatigue leave is less, I mean-----

I - please explain?-- Sure.

Who expressed the view that the new rostering system meant that there would be less fatigue leave?-- That was very well generally recognised, and in fact, I - subsequently it has been expressed in a number of meetings and there's even some correspondence telling me that the fatigue leave is a lot less than it was.

COMMISSIONER: And this is correspondence from people in the glass tower?-- Yes.

In the administration section?-- Yes, that's exactly right, that's exactly right.

You've mentioned that Dr Keating was telling you that this is - medicine's changed and so on. During your time at the hospital, what actual involvement did Dr Keating have in the practice of medicine?-- Zero, administration but as far as being involved in any clinical decisions, I don't believe there was anything. One of the things that concerned me is that there didn't appear to be any interest in finding out what was going on in the ward. For example, in the past people would come into the ward, they would actually ask, they would see, they would talk to the staff. That happened, that happened twice as far as I'm aware. Once when there was a complaint from a patient on dialysis who said that no doctor ever came to see him and that was, that was a reaction to the fact that we had a very good PHO who left and he went to Nambour and he had an interest in renal medicine, he was intelligent, he got a lot out of it, but when he left, then there was nobody there. Some of the junior doctors in fact don't understand renal medicine, they find the tubes and blood and access and anaemic people quite frightening, they don't

know the technique so they stay away from them, and patients, quite rightly, at least one of them was concerned about that, and Dr Keating came up to explain to him that the situation that, you know, that there was a poorsity of doctors. That's the one time I remember. And then a second time quite recently after this, this whole issue arose with, you know, with Dr Patel.

Mr Andrews, you might care to take a seat for a moment because I really want to explore some of these things that Dr Miach's been telling us about. Let's go through the hierarchy again. At the top layer you've got the consultants and a consultant may be either a member of staff like yourself or a visiting consultant?-- That's right.

And the expectation is that the consultant will be a fully qualified specialist who would be just as qualified if not more qualified than a specialist in private practice?-- Oh, the specialist's exactly the same.

Yes?-- Exactly the same, the specialisation in Australia as far as qualifications for medicine, the ultimate which people try to achieve is the Fellowship of the Royal Australasian College of Physicians.

Yes?-- And so the consultant physicians in Australia have that degree.

Yes?-- In Areas of Need, sometimes doctors come from overseas, as you know, and in fact, they work as physicians under the supervision of an Australian physician, for example, like Dr Strahan and myself.

Yes?-- Now, those physicians in fact we, we all keep a fairly close eye on, in fact, we see how they perform and I write assessments of them for the hospital and also for the College of Physicians because these doctors who come from overseas, in fact, they desperately would want to get full registration to be able to practice autonomously in Australia, either in Queensland or Victoria or wherever you like.

Yes?-- So, but when they come into a hospital into a place like Bundaberg Base Hospital and they practice as consultant physicians but they are under observation.

Yes?-- Which is what we do, and in Bundaberg, in fact, there are four, there are two Australian physicians, Dr Strahan and myself, and there are two South African physicians.

Yes?-- Of varying experience.

And those South African physicians have come up in under the Area of Need system?-- Yes.

And even though they're not yet members of the Australian college, that's something they're working towards?-- Absolutely.

And something that you're supervising them with a view to their achieving it at a later stage?-- Absolutely.

All right?-- But it's fair to say that if they're deficient, then you know, they get, they get assessed appropriately.

Yes, all right. What systems seems to emerge from the evidence we've received though is that there's another system under which a doctor qualified overseas is brought into Australia simply to become an SMO, a Senior Medical Officer, and then given a position in a Queensland Health Hospital which is the equivalent of a consultant's physician but without going through either the Area of Need system or attaining an Australian equivalent qualification. Have you come across that?-- Yes I have, I mean, I've read the newspapers and I know some of these physicians, it mainly applies to surgery as far as I'm aware.

Yes?-- Medicine is a bit different, that in fact, the practice of medicine is different to the practice of surgery, it has to do with diagnosis, with tests, with putting things together, it's very different to surgery. Certainly what I think you're referring to applies more to surgical practice in Queensland than in the medical practice.

I mean, it's obviously one of the great matters of concern in this inquiry that Dr Patel was brought into Australia simply as a Senior Medical Officer and then given the designation of Director of Surgery without either having Australian qualifications as a surgeon or going through the Area of Need process where he would be subject to the supervision of an Australian qualified surgeon?-- Sure.

I realise that you're not a surgeon and it's outside your area, but are you able to express any views of your own regarding the propriety or the acceptability of that practice?-- I think it's totally misplaced. I mean, I think when someone comes to Australia, I mean, there's an onus on the system, whatever that might be, and there's two or three layers of system to ensure that when a surgeon or a physician practices in a certain area, that in fact he has certain standards, that's what I believe, that this is what I do in medicine. What - I'm aware of some of the issues in surgery, but as you intimated yourself, you know, I'm not involved with that.

Yes?-- But I don't agree with it one little bit to have surgeons coming into the country and then de facto being upgraded to a consultant and given cart blanche to do whatever surgery that they want. Personally, I don't agree with it, I think it's a mistake.

I assume you don't have the same level of reservations about the Area of Need system where at least the foreign-trained or overseas-trained specialist is subject to a regime of supervision and examination by specialists in that field?-- I'm sorry, could you just repeat that?

All right. Just contrasting the two situations?-- Sure.

We've got the physician with, for example, Dr Patel who's brought into the country simply as an SMO and immediately Queensland Health gives him the job of being Director of Surgery at the hospital?-- Sure.

There seems to be a difference between that and the Area of Need system where at least there's a formal process that a overseas-trained practitioner is put into a position as, for example, a physician at your hospital and is subject to a regime of oversight by qualified physicians like yourself?-- Sure.

And requirement to sit for the college exams and so on?-- Yep. That's a good point. I mean, Area of Need is, as far as I'm concerned, in fact does not negate in any way the competency or the expertise or the diagnostic skills, the technical skills of anybody. I mean, there are pretty good people overseas that in fact can work here but I think the onus should be that in fact that they prove themselves to be able to work at a level comparable to Australian levels. That happens in medicine at least where I'm concerned. In surgery, I don't think it does happen, but you know, as you mentioned yourself, I'm not particularly qualified to be more specific than that, but it is a concern.

Well, all right, I won't pursue that any further, but you also referred to some of the descriptions that are used in hospitals, the PHO, Principal House Officer, JHO, Junior House Officer, we've already heard about VMOs, Visiting Medical Officers; where does a person with the title SMO, Senior Medical Officer, fit into that hierarchy?-- That's at the same level, we don't have SMOs in medicine, I think they - they're higher than that, an SMO in fact is at a higher level, dependent on the degrees and on their stated experience, so it's higher than that, it's higher than a PHOs, it's probably the same level of a Registrar I would think.

Yes, but below a consultant?-- Absolutely, absolutely.

Yes?-- Now, some SMOs from overseas in fact, they may be as good in certain areas as some of the consultants in Australia, I have no doubt about that, but the title of SMO is below that of a consultant physician or a VMO.

Well, how does a man like Dr Patel - perhaps you can't answer this - but how does a man like Dr Patel who's brought into Australia by Queensland Health on the footing that his job is going to be just a SMO, Senior Medical Officer, suddenly find himself in charge of an entire surgical department?-- Who knows? I don't know but that's a very good question. I mean, I don't know how it happens, but it does happen.

Sir Llew?

D COMMISSIONER EDWARDS: Dr Miach, are regular audits done routinely relative to surgical performance and outcomes in,

say, your hospital?-- Again, I'm talking about surgery, I believe they are, but, you know, I'm not, I'm not-----

And are they made public to the medical staff obvious?-- I've never seen them but I mean, it's fair to say that if a surgical audit came out I may not be interested in it. I mean, I should be but I've never seen one, but you know, they occur in medicine, they're on the roster, I do the roster and certainly do that in surgery, I'm not positive because I don't have much to do with that.

If they're not there at the moment you would feel they would be a very wise move?-- Absolutely. I mean audits are extremely important. In the good old days in the past we used to do autopsies, we used to learn a lot from autopsies. Autopsies in fact, you learn a tremendous amount. These days in fact they're not done which I think is a mistake, but you know, that's water under the bridge and I don't think that's going to come back, but certainly that was an excellent way of auditing to actually find out exactly what happened to the patient, and we do audits and the hospital should do audits. The unit should do audits and I suspect that in Bundaberg most of the other units do audits as well so you can always be better, you can audit every day if you want, but the reality of life is that you do audits on a regular basis and you structure the audits according to the way the sorts of things that you're interested in, complications, mortality, whether you could have done better, what happened, why didn't you do this and those sorts of things.

D COMMISSIONER VIDER: Dr Miach, could I just ask you a qualifying - clarifying question? You've mentioned during your discussions that there are some doctors who are only working in the private sector now and not doing any public work. Would you have an opinion as to the availability of medical specialists in Bundaberg? I'm getting the impression that there are a considerable number of doctors who with appropriate qualifications with service to people of this region, forget about which system they are in, public or private?-- Yep.

Just the availability of medical staff?-- Yep.

I'm really just wondering if there was a different system, is there available enough specialist doctors in this region without it having to always be an Area of Need?-- No. I mean, the College of Physicians and the nephrologists and everybody in fact have work force surveys and I know, for example, that as far as the College of Physicians is involved, that a population of approximately 10,000 is enough to service or, you know, to support one consultant physician, general consultant physician. Now, in Bundaberg, I don't know the population but I do know the population in the Wide Bay because as far as nephrology is concerned, the population of the Wide Bay area which is serviced is somewhere approximately 200,000, so you would actually need 20 physicians and they don't exist. Now, in Bundaberg there are four physicians, you could actually have - well, there are two Australian

physicians and there's another cardiologist who practices in the private sector but there are three physicians and you've got a population of about 60,000 there. When you add in some of the surrounding cities or towns, it's quite large, about 70, 80,000 so there aren't enough physicians and that's nobody - I mean, in Queensland it's very well known that there is a poorsity of specialists all over the place, especially in the regional areas and that's very well known. You can actually split them up into the different categories: cardiologists, gastroenterologists, nephrologists, paediatricians and everything else, they're deficient in everything. The best off seem to be paediatricians, they're the ones who seem to be the better than anybody else, but there is a major shortage and that's well known. So - sorry.

COMMISSIONER: If I can follow up from my colleague's question?-- Yep.

Given that there is a shortage of specialists and a need to bring in overseas-trained people to fill that shortage, isn't it still the case that in an area like Bundaberg, at least there are a sufficient number of fully qualified and Australian-trained specialists that if they were holding VMO positions in Bundaberg Hospital, they would provide an appropriate level of supervision to foreign-trained specialists?-- Well, talking from medicine, in fact that's exactly what happens, there are two physicians and that's Australian physicians, there's Dr Strahan, who's VMO. In fact, he left the public system but I managed to get him back so he practices VMO but he, you know, and there's also the cardiologist. So all of the physicians in Bundaberg in fact practice in the public system so that works very well. The surgeons are a different story. You know, some surgeons only practice in the private system.

Yes?-- I know some of them but not all of them because I have very little to do with them.

But there are certainly a number of fully qualified Australian-trained surgeons in the Bundaberg region who, had the appropriate procedures been adopted with Dr Patel, would have been available potentially as VMOs to supervise him as an overseas-trained surgeon?-- Absolutely. There's a young trained Australian physician who works exclusively in the private sector, there's Dr Thiele who currently works exclusively in the private sector, there's one or two surgeons and I think they're both getting closer to the retirement age who are also in the private sector, but they could profitably also work in the private - sorry, in the public system as well, you know, with the two surgeons that I mentioned, in fact, they could work in the public system quite easily.

Moving back to something from your evidence earlier, I didn't want to interrupt your evidence when you were giving it, but you spoke about providing a copy of the audit of the catheter placement to Dr Keating, and your evidence was that you provided a copy to him in the first half of 2004 and then in October of 2004 he denied having received it and you provided him with another copy?-- That's right.

After you gave that to Dr Keating in October 2004, what if any feedback did you get from Dr Keating?-- Nothing at all.

Did you raise it with him again?-- No, I didn't. The reason I didn't was because, in fact, from past experience it wouldn't have done any good, and in October it wasn't an issue, as far as I was concerned, because, in fact, I already instituted another program which was working very well. And I let people know in the system that Dr Patel wasn't to have anything at all to do with my patients, so I effectively insulated all of the patients that I came under the control and warned the people who worked with me to do that. So as far as medicine went, I took another area - I took other steps. First of all, I made sure that the patients were protected. Secondly, I made sure that, in fact, they were having proper treatment, and that's the reason that I got involved with this Baxter program. My chief preoccupation and concern was to actually make sure that patients don't get harmed and are sort of managed appropriately, and that's what I did. I didn't bring it up - I didn't get any feedback from Dr Keating, but, you know, it was irrelevant to me, firstly because I'd instituted other procedures and systems.

D COMMISSIONER VIDER: Dr Miach, the Commissioner has gone back to the area of the peritoneal catheter audit and I have a curiosity. As the Director of Medical Services, is it your normal practice to keep e-mails from the Director of Medical Services, because this is an email from October 2004 which you have been able to produce in 2005. Was there a particular reason why you kept that email?-- No. What - no, there isn't. If you look at my email account, in fact, it has got about 4 or 5,000 on them, which I haven't bothered cancelling. That's the reason. I mean, I have other things to do. I don't sit in front of a computer. I come and I sort of see what's there, sometimes days out of phase, and then, in fact, I leave. I don't bother playing around with keys, cancelling stuff and the rest of it. So it is all there. It is all there from years ago. There is about 5,000 there now.

COMMISSIONER: If it is anything like my email inbox, you have invitations to buy degrees overseas and to prescribe generic Viagra?-- Absolutely. There is a number of different types of Viagra these days. That's the reason that the e-mails are available. In fact, I sat there - when this inquiry commenced, I sat there one day for one or two hours scrolling through everything and sort of photocopied and printed out the e-mails that I thought in fact may be relevant, but I keep everything, mainly because I am too - I don't bother cancelling anything.

Mr Andrews, sorry to have interrupted you again.

MR ANDREWS: At paragraph 13 of your statement?-- 13?

Yes. You say that you're an examiner and censor of the Royal College of Physicians. I understand that to be the Royal Australasian College of Physicians?-- Royal Australasian. The Royal College of Physicians is in fact - refers generally to the English colleges. That's what it refers to, but this is the Royal Australasian College of Physicians.

In an answer to the Commissioner a few minutes ago, I understood you to say that there were some surgeons in the Bundaberg area practising privately who would be available to act as VMOs at the Bundaberg Hospital and you mentioned a couple who were near to retirement, and you said, as I recall it, and there is one physician, one young physician. Did you mean one young surgeon or-----?-- Well, to be more specific, there are two surgeons in - two surgeons I was referring to in Bundaberg is a young surgeon that has just started practising in the last year or so. There is also Dr Thiele practises mainly in vascular surgery, and there is two other surgeons which I don't know very well. One attends the hospital sometimes on the on-call roster, I think, and there is another one which I don't know very well at all.

Apart from the Medical Staff Advisory Committee meeting at which you raised your concerns about the rostering system to Dr Keating, did you ever again raise your concerns about the rostering system?-- A number of times. I can't remember whether it was two, three or four times, but that was - that has been my - one of my major preoccupations. I certainly went to see him on a number of occasions and raised that again. I never got anywhere.

And-----

COMMISSIONER: Sorry, Mr Andrews. I was going through one of the files produced by Queensland Health yesterday and something came to my attention. I see that on Christmas Eve last year, 24 December 2004, Dr Keating writes to Dr Patel offering to extend his employment for another four years. Did Dr Keating consult with you, particularly in the light of your audit of the catheters?-- Absolutely not. I knew - from the press I knew that in fact it was extended. That's what the press said. But the four year thing is news to me, the first I have heard of it. But certainly, I mean, those sorts of issues were never discussed with me. It was very rare to actually discuss medical things with me, so surgical issues would have been off the radar completely.

Would it be unfair to ask you what advice you would have provided to Dr Keating?-- The advise I provided to everybody around me, I sort of said, "Don't go anywhere near this chap. Absolutely not." I mean, I told that to the locums that did the work for me. I told everybody. I insulated patients, I did my own audit, I submitted to the appropriate channels there were issues, there were problems there, they were

identified. I stopped using him. I told everybody not to go near him. So, you know, but as far as getting my opinion on him as far as surgery goes, I mean, that was never an issue.

D COMMISSIONER EDWARDS: Your views are well known to the administration of Bundaberg Hospital at all levels?-- The - I assume so, but, you know, I don't - on the executive there are a number of people, certainly the Director of Medical Services-----

Was he aware of your views?-- Absolutely. I let him know. In fact, I supplied audits. I know for a fact that every time you spoke to the administration you wanted facts, you wanted evidence, you wanted facts. So I supplied the facts. I actually did the audit. You know, I supplied the facts. It just didn't do any good. I supplied it myself once, the nurse sphere supplied the same facts to go up to the executive through another stream in the hospital. Nothing happened to that. I supplied it a third time some months later and nothing happened to that. So, you know, supplying facts wasn't an issue.

MR ANDREWS: You didn't speak to Dr Leck about these matters, though, did you?-- I don't think so. I didn't have very much to do with Peter Leck.

The appropriate person for you to make these complaints to was Dr Keating as your line manager?-- My line manager, my immediate superior. I am responsible to him, so, in fact, I went through him. There was another instance that I went through him, which may come up later, and in fact nothing happened. Then I took a different approach and eventually got back to me again, but I think this may come up later.

COMMISSIONER: Just continuing through this file - and I will have these documents marked as exhibits in due course when copies have been obtained - but the next letter is one of the 2nd of February 2005 from Dr Keating offering Dr Patel a temporary position of locum general surgeon. Again, I take it you weren't consulted before that was offered?-- No, absolutely not.

How can a person who is banned under Queensland law from calling himself a surgeon be given a position of locum general surgeon?-- I don't know.

No doubt Dr Keating will tell us.

MR ANDREWS: There was an occasion when Dr Keating discussed medical matters with you and that was with respect to the treatment of peritonitis, is that correct?-- Yes, in fact he didn't discuss it with me, he sent me a letter. And it is worthwhile going through the background of this. This - when people are treated with peritoneal dialysis, there is a tube that goes inside the abdomen, and a particular problem which occurs predictably is infection, peritonitis infection inside the peritoneal cavity. It can be quite serious. There is a protocol on how you treat this peritonitis and the protocol we

model our protocol on, it is a protocol developed by an international group of experts in peritoneal dialysis. So the protocol in fact is modelled on that. As it so happens, one of the PHOs who worked for me treated the peritonitis, but he got the dose of the drug wrong. He got the decimal point in the wrong spot, so the patient received 10 times the dose of a drug, and that's what happened. The dose was written down wrongly and that's what the nurses did. The patient received 10 times the dose and she developed, you know, side-effects of this. And this particular patient went to her legal advisors and eventually in fact something was done. I don't know the issue. But I received a letter telling me to change the protocol, and, you know, there is nothing wrong with the protocol. The protocol is a protocol that's used by everybody, it is well recognised, there is no problems with it. So ordered me to change a medical protocol for no obvious reason, because a PHO got the decimal point in the wrong place. It is quite bizarre. So, in fact, I didn't bother changing it, of course, but I didn't even bother going back to Dr Keating. I just forgot about it because it was such a strange occurrence.

Did Dr Keating ever speak with you about it?-- Never.

When setting up the Baxter program, you did make Dr Keating aware of the fact that you were proposing to do so?-- I sent letters. The way I went about it is, in fact, I knew that the Baxter people were interested. I first of all made an appointment to see Dr Thiele, and I went to speak to him to make sure that he could cooperate with the program, and once he said yes in principle, then I wrote letters advising people that in fact these - this is what might be reasonable to do. And I sent copies of those letters to Dr Keating, to Dr Terry Hanelt, who is the Director of Medical Services down in Hervey Bay. I sent it to Mike Allsop, who is the district manager down in Hervey Bay, and I also sent it to the Chief Executive of the Friendlies hospital, who is Allan Cooper. So I just sent them this letter saying, "I am interested in doing this and I will keep you informed." I then organised - there was a list of dates that were given to me or that we developed - I don't know how it came about - on the dates in fact there might be reasons to hold this meeting, and a date came up - I think it was some time in June; I can't remember - and we held this meeting.

Dr Keating attended?-- Yes, he did.

And you - as a result of that meeting it was arranged that there would be a catheter access program whereby Dr Thiele would insert the catheters at the Friendlies hospital on patients, though they may have been public patients of the Bundaberg Base Hospital?-- Yeah.

And that Baxter would subsidise part of this process?-- They - the Medicare - if they were available for Medicare, registered as a consultant through that, in fact that would be accessed. If there was any supplementary payments, including, for example, theatre fees, or including day fees, anything in

fact that the patient would normally have to pay in the private system, was picked up by Baxter. So, in fact, it was cost neutral to the patient. The patient didn't have to pay anything.

And do you recall Dr Keating's attitude to this new system?-- I don't think he objected to it. I think he was quite neutral to it. My approach is that, in fact, if it sort of said the hospital - if the hospital didn't have to pay for anything, in fact, it would be a major incentive to support it. My idea was, in fact, as I mentioned before, to actually make sure that patients get the best possible treatment under whatever system, and this is what I did.

So it was good for the patients and it would have saved the hospital money?-- Well, it - they didn't have to pay for anything. It was actually paid for by Baxter.

Yes. Was there another issue raised with Dr Keating about vascular access in the hospital?-- Yes, yes, yes, there was.

And what do you mean by vascular access? Perhaps while - before you explain that, I tender the letter from Baxter of 24 May 2005.

COMMISSIONER: That will be exhibit 19.

ADMITTED AND MARKED "EXHIBIT 19"

MR ANDREWS: Would you look, please, at this expanded patient key, doctor? Do you understand that key, on its second page, to add the names of the patients referred to in the Baxter letter at about P60 and following?-- Yes, I do.

I'll substitute that at an appropriate time for the original patient key, Commissioner.

COMMISSIONER: Just to keep the record straight, if you hand up a copy and I will have it marked as the replacement for Exhibit 5.

MR ANDREWS: Thank you. Vascular access, I was hoping you would explain what you mean by it?-- Vascular access in fact has to do with gaining access to the circulation with large needles. To be able to do that, to be able to dialyse a patient you need to be able to remove large volumes of blood, pass it through a filter and then sort of pass it back into the patient again. To be able to do that, the surgeons specifically do an operation in which they join two vessels, usually in an arm, usually in the forearm near the wrist, sometimes at the elbow, sometimes in other spots, but that's what a vascular access is, the creation of an access so you are enabled to dialyse a patient.

COMMISSIONER: Mr Andrews, just for the record, the replacement Exhibit 5, that's the updated patient key, all of the patients listed in that document will be subject to the non-publication order previously made, and just to reiterate what that involves in general terms, the names mentioned in that list may be made available to the press and media but not published either in print or in the electronic media without the permission of the patient concerned, or in the case of a deceased patient, without the permission of the next of kin or family of the deceased patient.

MR ANDREWS: Now, where a patient requires vascular access, or required it, was there a problem that could hypothetically involve your having to insert numerous temporary catheters?-- That's correct. I am not quite sure - I can't remember exactly whether we discussed this yesterday, but I'm - the whole thing makes a bit more sense. I am prepared to give a background on how the whole system works, so it actually fits in.

Would reference to your letter of the 8th of November 2004 to Dr Keating assist?-- I have got a copy here.

I will have it put on the monitor. The patient whose name is described in that letter, Commissioner, will have to be given the code P67.

COMMISSIONER: All right. Before this goes into evidence, we might have a bowdlerised version prepared under which the name of the patient is replaced with the code you have just mentioned, and that way it can go straight out on the Commission website and otherwise as a document available for general scrutiny.

MR ANDREWS: Thank you, Commissioner. Does this letter raise appropriately an example of the problems relating to vascular access that you brought to Dr Keating's attention?-- It does.

Was there an opportunity to save considerable cost by seeking to have procedures done at the Bundaberg Base Hospital?-- You can save a tremendous - a significant amount of money if you can have the procedure done locally. If you can do it in the Bundaberg Base Hospital, then it would be ideal, but you would have to have the appropriate surgeon to do that and there wasn't one at the Bundaberg Base Hospital. But there was a surgeon in Bundaberg, two minutes', five minutes' walk at another hospital.

And what was it you were proposing?-- Well, it struck me that, in fact, if you have got vascular access - vascular surgeons in Queensland, in fact all over Australia, are at a premium, and it struck me that if in fact you had a vascular surgeon in Bundaberg, then it would be strange that you couldn't use him. I mean, if you had an excellent vascular surgeon and, in fact, he could do the operation, then, in fact, the hospital and the community should avail themselves to it. And I gave an example of this young man who didn't have an access. Again, he was an indigenous man and his

attendance to clinics was not ideal, but he ended up exactly the same as the lady that I mentioned yesterday. He ended up on dialysis with no access and he needed treatment. To keep these patients going, in fact, you insert temporary catheters, which I do, but unfortunately where you insert something infections is always a problem all over the world and this is the reason why in fact you try not to insert them. But to keep people alive and to keep people going until you can institute something more permanent, that's what you do. But you always run into trouble, which is exactly what happened to this patient here. He kept sort of having infections, he kept coming into hospital. I referred him to Brisbane many months previously, but every time he had an appointment to go down there he had an infection, they wouldn't accept him. So the whole thing - it was quite a problem and it struck me if you could do the procedure in Bundaberg, you should do it. And this is what I wrote this letter for. I sort of said, "It would be a good idea if we could avail ourselves to Dr Thiele doing a fistula there." That letter was written - what was the date of it - on the 8th of November 2004. Never got an answer. Never got a reply. And I sent a copy of the letter also to - I am sorry, to Peter Leck. I never got an answer. So I was-----

From whom did you never get an answer; Peter Leck or Dr Keating?-- Neither of them. Neither Dr Keating or Peter Leck. So I was left in limbo. I had an issue, and, you know, I am writing letters and I am getting no response at all.

So do I understand it that for this particular patient, because he kept getting infections, he could not be sent to Brisbane for treatment in a public hospital where he might have been given more permanent vascular access, and yet you had a vascular surgeon some minutes away from the public hospital in Bundaberg and you were hoping to encourage the public hospital in Bundaberg to facilitate treatment by this-----?-- Absolutely.

-----surgeon in private practice?-- Absolutely. I gave an example of this patient, but this thing happens all the time. And the lady that was brought up yesterday with the amputation is another example. It happens all the time. It has happened two or three times just recently. You know, patients are sick, they don't know they are sick. They actually come and see you and, in fact, they have missed the bus by about two or three years, and you have got to treat them, which is what happens.

I see from your letter that you observe that "the vascular surgeon, Dr Brian Thiele, would be happy to help the hospital in this regard." What was it that was proposed; that the patient would be treated away from the Bundaberg Hospital by Dr Thiele or that Dr Thiele would attend the Bundaberg Base Hospital as a VMO to attend to the procedure?-- Before I write these letters, exactly the same as I did with peritoneal catheters, I went to see him. There is no point writing the letters if in fact he has no interest in doing anything. I am wasting my time. I went to see him and had a chat with him.

He said, "I would be happy to do them but I doubt whether in fact I'd do them in the Bundaberg Base Hospital." Because he was a VMO there and he left because of issues. So I knew that he was not enamoured with the Bundaberg Base Hospital. I knew he didn't like working there, I knew that in fact it was an issue. What I was proposing is, in fact, for these accesses to actually be done in the private sector. That's what I was - that really doesn't state that, but, in fact, that's what I was proposing. But that was an initial letter so I could discuss the issue further.

COMMISSIONER: Given, as your letter points out, that inpatient treatment of this patient had already cost the public system over 11 and a half thousand dollars and it was obviously going to continue to cost the public system at that rate, what you are suggesting is even though it involved treatment in a private hospital, it would have been cost saving in the long run?-- It would have saved - it would have cost saved a tremendous amount of money. More importantly, the patient would have been treated properly, he would have had an access and he wouldn't have been subject to all of these admissions, all of these complications. All the procedures I did, all of these inevitable infections, so they could have been done outside, in fact it would have saved everybody a major headache, specially the patients.

Perhaps most of all improved the patient's quality of life?-- It would have helped the patient. I think that's exactly right.

Yes?-- That's the whole idea of trying to, you know, develop a service which is available locally.

Yes.

MR ANDREWS: Did you raise this issue with a superior of Dr Keating?-- Well, I - there is - there is a committee meeting for the central zone of Queensland. The central zone of Queensland in fact involved all the Brisbane hospitals, it involves Nambour, Rockhampton, Bundaberg, Hervey Bay, and I sit on those committees to discuss issues relating to dialysis. And an issue which is always evident is the vascular access. So I brought it up. You know, I knew exactly where I wanted to take it. I actually brought it up and sort of said, "Look, we have a vascular surgeon in Bundaberg. We'd like to use him. In fact, it would relieve the pressure on the Royal Brisbane Hospital, it would save patients, it would save money." And Dan Bergin, who was at the meeting-----

Is Dan Bergin the zone manager?-- He is the zonal manager.

Of the central zone?-- Of the central zone.

And does that make him in the hierarchy the superior of Dr Keating?-- He is - he is an administrator, so, in fact, the direct superior would be Peter Leck, but he has an interest, you know. So I brought it up at this meeting. I

said, "We have a surgeon in Bundaberg who could do these procedures. You know, patients are suffering." He said, "Why don't you do it?" I sort of said, "Well, I brought it up through the administration of my hospital. In fact, I wrote them a letter. I never got a reply." He said, "When did you write it?" I said, "From memory, some time in the end of last year, you know, September, October, November. I don't know." In fact, it was the 8th of November. And he said, "Well, that's strange that you can't do that." So he said, "Send me a letter. Send me a copy of the letter.", which I did. That's the whole reason I did that, in fact, was to be able to get an invitation from Dan Bergin to sort of send in my letter. So that's exactly what I did. I sent him a letter. Lo and behold, one or two weeks later, in fact, I get a call that there is to be a teleconference to discuss the issue of vascular surgery on the Wide Bay. And, you know, Dan Bergin would have contacted the administration of the Bundaberg Base Hospital and they set up a teleconference.

Who participated in that conference? Dan Bergin?-- Dan Bergin. He was down in Hervey Bay, myself in Hervey Bay.

Dr Keating?-- Dr Keating by teleconference in Bundaberg, Peter Leck in Bundaberg and Mike Allsop in Hervey Bay.

And I gather the discussion was about whether to use Dr Thiele to provide vascular access?-- Absolutely. I mean, I was totally aware that Brian Thiele was not happy to operate at the Bundaberg Base Hospital, and the reason that I wanted this teleconference held because I wanted to ask a number of specific questions, very direct questions to get approval or otherwise from the bosses of the central zone. And the major thing that I asked is, in fact, if it is not possible to do these procedures for whatever reason in the public system, can we do them in the private system. Dan Bergin said, "Sure." And I sort of - and I said, you know, "I would prefer to have them done in the public system, but if they can't be, you know, if the patients' interests are at stake", they knew about these problems, and they said, "Yes, if you can't get them done at the Bundaberg Base Hospital, we'll support to have them done in the private system."

Would a general surgeon be able to provide this vascular access or-----?-- No, no, you can't.

No?-- These vascular access in fact ideally are done by vascular surgeons. This is one of the issues with Dr Patel as I mentioned yesterday. In fact, he did a couple of these and there were - and one of them were major issues. But, no, they're done by vascular surgeons.

COMMISSIONER: Mr Andrews, I can't see the date on that letter in its present position, can you tell me.

MR ANDREWS: I believe it's the 8th of November.

COMMISSIONER: '04.

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: I will reserve for that document Exhibit 20 but I won't actually admit it into evidence until it's been expurgated so that the patient's name is replaced with the relevant code.

MR ANDREWS: Thank you.

COMMISSIONER: Is that a convenient time to take the morning break?

MR ANDREWS: It is.

COMMISSIONER: We will resume in 20 minutes.

THE COMMISSION ADJOURNED AT 11.01 A.M.

THE COMMISSION RESUMED AT 11.26 P.M.

PETER JOHN MIACH, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Dr Miach, I understand that you are the only nephrologist in your geographical area?-- Yes, I am.

Did you speak at a meeting attended by Linda Mulligan, Darren Keating and Robyn Pollock about the need for help?-- I was at a meeting, the four of us, as you mentioned and that meeting had to do with formalising an arrangement which had in fact had existed for quite some time. As I'm the only nephrologist, I look after patients in a large geographical area, mainly the Fraser Coast and Bundaberg, the Wide Bay. When patients become sick or they need more intensive care, I usually transfer the Hervey Bay patients, the Fraser Coast

patients, to Bundaberg. I do the acute management there and once they're well, then I send them back to Hervey Bay and keep looking after them there on a weekly or fortnightly basis. The reason for that meeting was to formalise that arrangement. It in fact gave me another title, Director of Renal Services of the Wide Bay or something like that. I pointed out in my suggestions that the renal services in fact are expanding and there were a lot of - there was hundreds, absolutely hundreds of patients that I look after and I travel every week three hours by car to come up and down Hervey Bay. I used to do it in two hours but I got caught three times in two weeks for speeding so it's three hours now. So, in fact, I suggested that in fact - that I would agree with that - formalising the arrangement. It would be reasonable at that stage to try and recruit or try and get some help in either a renal PHO, which is probably rare as nephrologists in this part of the world, but at least some help. But I got nowhere with that and, certainly, I don't think that anything came of that.

If you'd had a renal PHO, would it have been an opportunity for such a person to further his or her training under you?-- The only - the only things that we don't do on the - in the Wide Bay area as far as nephrology goes is the acute transplantation. The acute transplantation is only done in Queensland in one hospital which is the Princess Alexandra Hospital. All the other hospitals in Brisbane don't do that. But nevertheless, when patients have a kidney transplant, they get transferred back to their units where they came from. And certainly the number of transplants that have been done in Bundaberg and Hervey Bay has increased significantly. The reason for that, I suspect, is that people at the PA know that I set up a transplant unit in Melbourne and sort of managed one and, in fact, it did very well. That's public record. So they're done more and more mainly because there is someone in the region that can actually continuing managing them. So that's - that's the-----

Well, my question was whether if a PHO had been advertised for, a renal PHO, to work in your department?-- Yes.

Would it have been of any advantage to the PHO?-- Absolutely. Absolutely. The range of nephrology is in fact exactly the same as any other unit apart from kidney transplants.

Would there have been a public benefit if a PHO had been obtained?-- A major public benefit because for the following reasons. At the moment I do all of the - I review all of the new patients that are referred to me and I have a waiting listing at the moment in Bundaberg of about a year, year and a half, and there are problems with that. If someone has significant kidney failure and if you don't see them for a year, they turn up sick, and then it makes the whole thing worse for everybody. I see the new patients but I also see the review patients. If I had a PHO or some help, a lot of the review patients that I have seen would be managed in consultation with me by the PHO and I would have more time to see new patients and make sure the whole system worked a lot

better. So, in fact, help from the PHO or anyone would be extremely advantageous to the community.

When one wishes to become a physician to receive accreditation from the Royal Australasian College of Physicians, is it necessary to train under a consultant such as yourself?-- It's routinely done, absolutely. That's exactly what happens.

COMMISSIONER: That would ordinarily happen in a teaching hospital?-- Usually, but I - the rules and regulations of the College of Physicians, and I haven't refreshed my mind on them for quite a while, but basically, if there is a complement, if there's a certain number of consultant physicians in a certain area, that is of a major interest to the College of Physicians. And also too, the way a PHO or registrar in fact would work is that they would rotate up from one of the teaching hospitals in Brisbane for a certain period of time. They would never be - come up there, in fact, if they weren't accredited.

Yes?-- To come up there in fact they would have to be accredited, and then the College of Physicians has certain criteria for that. Now, if you've got a number of physicians there, I think it's the first thing, and then in fact they would consent or the hospital Brisbane would consent. That's what I was actually working - the idea was to get a number of physicians and now we have four physicians, which is better than two. Two are Australian physicians and you have got two super specialists in cardiology and also in renal medicine. So that is the time to try and get some help from the rotate up a registrar from Brisbane. And I had discussions with one hospital, not the hospital that we're allied to, the Royal Brisbane Hospital, but from the PA. I actually spoke to some people there about the possibility of having a rotating registrar and they said in principle, yes. But to be able to do that, in fact you need to have some sort of a sensible structure in the hospital. You need to sort of have doctors who work properly, you need to have a library, you need to have sort of a climate of understanding or research of teaching, of discussion, and I was working for that. But I - you know, in the last couple of years, I've forgotten about that because, in fact, medicine instead of improving in fact has stagnated.

Dr Miach, something that flows out of that, and again you may not feel that you're the best person to speak about this but I would certainly be grateful to hear your views if you have any, one of the suggestions that's been made to this inquiry is that the numbers of overseas trained doctors in Queensland hospitals who do not have qualifications to Australian standards is not only prejudicial to the interests of patients but has made it very difficult to keep up the numbers of those training for future specialists careers. For example, the situation in Bundaberg with Dr Patel in surgery was such that the college would not have allowed a registrar or other trainee to work under him because he simply wasn't up to Australian standards?-- Sure.

Qualified as a surgeon. Do you have any comments that you'd wish to make on that area of interest?-- Well, certainly - I don't know how best to answer that, that concept. Certainly I think if you have - for whatever reason, if you have Australian qualified specialists in whatever field, then I think it helps because the colleges themselves, especially medicine, in fact they're fairly strict with what, you know - and they usually listen to the physicians who assess these people. So, certainly I think, if there's support from Australian qualified people, I think it helps to attract, you know, rotating registrars or rotating staff, but again, and I'm a bit hesitant to make too many comments on surgery because I'm not involved in that area but in medicine, you know, certainly it would help. And my impression is on the complement of physicians that we have in Bundaberg at the moment, that the likelihood of getting a rotating registrar or PHO from Brisbane in fact would be reasonable, but provided there is an infrastructure there which is sensible, which at the moment I don't think there is. So, you know, I stopped my negotiations once - you know, once the structure was changed and I'm basically referring to these rostering business which I think is a major issue.

Mr Andrews.

MR ANDREWS: At the meeting attended by Linda Mulligan, Darren Keating, Robyn Pollock and yourself, when you asked about the possibility of a PHO, was there any response?-- Well, there was a phrase which was repeated to me twice which-----

By whom?-- By Dr Keating. He sort of said, "Peter, you have to understand that this is a business", and I said, "I didn't" - I'm rarely stuck for words and this time I was, and I said I didn't understand and he said, "Well, you have to understand that this is a business." And I said, "Well, that's where the problem is, you see. I think it's a hospital", and that - you know, that - that rocked me a little bit a must confess.

When the Patel issued was aired in the media, did you have any further conversations with Dr Keating?-- Yes, one. It was interesting, it was a strange meeting. I was actually involved - I was in the renal unit, which is stuck to the medical ward, doing some procedures or talking or looking at patients. In fact, he came up one afternoon to that area, up in the ward, which is - which was somewhat unusual because, as I mentioned before, he was rarely seen on the ward, and he sought me out and we sat in my little office and we just started talking in general terms about the Patel issue, and I wasn't quite sure - I wasn't quite sure, you know, where - what was going on, what was the discussion about, where it was heading, all the rest of it. But anyway, I talked, you know, how unfortunate it is that patients have been hurt and the rest of it and I'm not quite sure what he wanted but part of it - at the end, in fact he made a comment which I regarded as a veiled threat. He sort of said, "You have to understand that what goes around comes around", and I said, "What" - again, I was a bit lost for words and I

said, "Darren, you and I see things very, very differently", and that was it. And that - you know, that's another thing which I won't likely forget in a hurry. The issues are that, in fact - you know, I regarded it as a threat but it was so bizarre. What's the point of threatening me? I mean, I'm not vulnerable. I don't - there were doctors who worked - who kept working for me who wanted to support me and I sort of told them specifically, "You stay out of this thing. I know you support, thanks very much, it's much appreciated. I understand - and I've got your support, I understand that. But stay out of the limelight in this situation because you're vulnerable. There are still issues, potential issues with your visa, potential issues with your registration. You're vulnerable to Queensland Health." So I said, "Stay out of it." I said, "I'm not vulnerable. They can't do too much to me." That's what they've done. But you know, this threat, again, irritated me.

Your concern that they were vulnerable to Queensland Health, now, that's a large organisation, were you talking about any particular person?-- No, no. I mean, I think there was a number of physicians, namely, one of the last appointees who were appointed by the hospital who are under my supervision, and they - you know, they're quite intelligent, they're very astute and they saw what was going on, but I said, "Stay out of it."

The point being you're Queensland Health?-- Yes.

So was Dr Patel. What do you mean they were vulnerable to Queensland Health?-- My impression was that the reason I spoke to them like that is because I don't know the administrative issues involved as far as renewing visas, renewing registration. I mean, a significant part of it is my assessment of them. I mean, I fill in these forms and I tick the boxes whatever I think, but I suspect those documents go elsewhere. I think they need to be supported or endorsed or otherwise by the administration but I don't know exactly what happens. But I made them aware, because of those issues, to sort of stay out of the limelight.

Was there any-----

COMMISSIONER: I'm sorry, Mr Andrews. Just to follow up on that a little, a number of these doctors that work under you have come to Australia as area of need specialists; is that right?-- Yes.

The effect of that is that they have no right to conduct private practice as specialists?-- One of them does. Again, there are so many issues with the HIC, with the colleges, with the specialised colleges, with visas, with the previous degrees in their countries of origin, with previous experience, whether the colleges, the administration, will accept those. There's all of those issues which are sort of very difficult to get around, but certainly some of them can. You know, the cardiologist, for example, is able to build under his name, you know, patients in cardiology but he's

somewhat senior to the other doctor who's in Bundaberg at the moment.

Dealing with the situation of an overseas trained specialist who is working for Queensland Health and unable to perform - to see private patients, I guess there'd be a sense that they're almost like a bonded slave to Queensland Health: they can't work for anyone else and their only option is to go back to where they come from?-- Commissioner, you hit the nail on the head in exactly the same way I would have expressed. If they work in Queensland, they have to work in the public system under supervision, and that's the issue. That if they - the people who come out here in medicine, in fact they work very hard and they try to get their qualifications to have a little bit of autonomy, a little bit of independence, but while they're working in area of need in a public hospital and they can't practise outside because of HIC provider numbers and the rest of it, that in fact they're basically working for Queensland Health and they will decide whether they work there or not. They hold the purse strings. So these doctors frequently feel, you know, a little bit besieged.

And I would guess that that makes it very hard for them to complain too if for example, and this may not be an appropriate example, but say a doctor was concerned about hygiene standards; very difficult to make a fuss about that if the only person to whom they can make a fuss to is the person that can, in effect, deport you from Australia?-- That is the point, which is the reason, the exact reason, for my comments to them. I sort of said, "There are issues in the background which I'm not aware of, administrative issues", and I said, "If you have any issues, come through me because I'll complain, I'll talk." You know, "I belong here."

Yes?-- You know, these doctors, they have - they've left their country of origin, they've got young children. You know, it's very difficult for them to cause a fuss.

Particularly, one would think, those that come from parts of the world that may be less desirable to return to?-- People leave their country of origin for certain reasons and in South Africa for example there are reasons, for example if you have a number of young children, that they are important to them. But what you're saying is perfectly correct and I'm aware of some of those issues and that's the reason I gave this advice that I give to these people, sort of stay out of.

D COMMISSIONER VIDER: Dr Miach, is this the first time in your working life that you have given such advice to staff working with you?-- Absolutely. Where I came from, the system is very different. But here, you know, I'm aware and I'm concerned for them. You know, you need to support these people as much - especially if they're good. You know, the only people that are going to support them are the physicians they work for. I suspect no-one else will. That's the reason I give the advice that I give them.

D COMMISSIONER EDWARDS: Are reviews made of their performance within the hospital?-- Yes.

That go perhaps to the medical superintendent or to whom, and what happens if those audits or those reports show low standards of medical care?-- Well, that's - that's happened. I mean, I assess both internally and there are set forms that I fill in quite routinely, every two or three months, but there are also forms that I fill in as required by the College of Physicians, much more extensive, but I fill in all those forms. If they're not satisfactory, and there's one - there's one that was completely unsatisfactory. But most of them in fact are reasonable, they're safe, and if they work under supervision, I think they're quite reasonable. I tend to sit down with them when I fill in these forms and I assess them and I show them what I do. I sort of say, "I'm going to tick this because of A, B, C, D and E", and at the end we discuss the issues, how to actually improve things, and I do that quite routinely.

Do other specialists do that too or is there a risk that you may be isolated or are there not too many other people like you?-- I don't know, but the forms are a standard form. If a young doctor, for example a JHO or a PHO, works for another physician and he has been working for them, then in fact the other physician might do. But we usually discuss things. They usually ask me, I ask them. And if I have to sort of fill in a form, I will talk to the physician who they have been working for. So, in fact, it is a fairly fair system. As I say, if they're good in fact, they get ticked good. But if they're not good, they don't get ticked good. And as I say, there are occasions that actually happens. I remember one chap that I marked down completely.

But they could still stay in the system though?-- Well, the decision - the decision to leave the system or stay in the system rests with the administration. You know, I give my opinion, I give my advice, I sort of-----

It is possible, with that advice that you gave, that some of those doctors could still be practising?-- It's possible. It's possible.

COMMISSIONER: Thank you.

MR ANDREWS: Was one doctor you assessed a Dr Qureshi?-- Yes, Dr Qureshi, I did assess him a few times, and I suspect you may know Dr Qureshi by now. But this was a gentleman - I wasn't totally convinced he was a doctor at all, but maybe I'm totally wrong and I'm doing the gentleman a disservice. I know for a fact that if you want to buy a degree in Hong Kong or Bangkok, it is a piece of cake. You buy your degree and the rest of it. But this - this man was unbelievably incompetent. As well as that, he had a number of other major flaws to his character. He initially worked in the accident/emergency department and they sort of threw him out of that. I think there were a lot of complaints from everybody. He then worked in the intensive care department

and they threw him out of that as well. He had nowhere to go so, in fact, he arrived in the Department of Medicine, and I knew about this chap but I sort of looked - I said, "I don't" - I said, "I don't want this chap to work here. He's sort of totally useless."

To whom did you say that?-- I said it to Dr Keating. But I, you know - well, he was there and I sort of said, "Look, if you want to pay him, put him in the library and get him to read a book but he's of no use to me." But, you know, I used to assess him and I always used to mark him down and I used to have these amazing discussions with him and he expected to be able to practise medicine at the same level that he practised wherever he came from, and I said, "This is Australia. These are the standards that we expect and this is what, in fact, you need to do." But he never accepted that. But then other issues started arising with this chap which never directly came to me but they actually came to me eventually. Mainly from the nursing field. In fact, he was caught sexually molesting and sexually harassing some of the patients and including one - one of the staff. Those complaints went through the nursing field but - you know, they came to me some days later and I had very - I had a lot of difficulty figuring out, you know, how he was still there. I mean, that sort of thing is - if that happens, you fire someone on the spot or you sideline him or you do whatever but, in fact, he was still there - he was still there.

After you mentioned to Dr Keating that Dr Qureshi was useless and might be better employed in the library reading a book, what was the response from the Director of Medical Services?-- I can't specifically remember but, I mean, he was still there. These - these comments of mine were done both verbally but they were also done via these assessment forms. So there was a number of reasons that in fact would have come - but nothing - nothing happened.

Well, after he had been sent, that is Dr Qureshi had been sent, to your department and you'd expressed your criticisms of him, did he go to any other department or did he remain with you?-- No, no, he remained - he remained in the department until a certain episode.

And was that a sexual harassment episode or a-----?-- Well, the police turned up to sort of arrest him and someone tipped him off and off he went. He went off into the blue - into the mists.

Well, you can't be sure that someone tipped him off. He may have-----?-- Perfectly correct. Perfectly correct.

Yes.

COMMISSIONER: But before that, the police arrived to arrest him, there had to be a number of complaints of sexual molestation or harassment that you were aware of?-- I found out that there were three.

Yes?-- There was one, was one of my patients. There was another patient in intensive care and also one of the nursing staff.

Had these complaints to your knowledge been communicated to the hospital administration?-- They went through nursing - through nursing administration. They have their forms that they fill in and I would almost certainly be 99.9 per cent in fact that they would have gone up into the executives.

Were any steps taken as a result of those complaints?-- Not - not that I'm aware of.

I think an earlier witness, it would have been Ms Hoffman, told us at one stage Dr Qureshi had to be chaperoned?-- Yes, I'm sorry, you're quite correct. An edict came out - in fact, it was asked of me last time and I forgot at that stage. Absolutely. In fact, it was indicated that he needed to be chaperoned if he had to do anything with a female patient. So that's correct.

Can you tell us from whom this edict was received?-- I can't be specific, I don't know, but it had to do with a medical staff so - I mean, I assume, and I could be wrong, that it actually came, the edict came from Dr Keating but I can't - I'm not a 100 per cent certain on that.

Just to narrow it down, I'd take it you'd be the only person with authority to issue such an edict?-- It wasn't me that did it.

To your own staff. So it had to be someone higher up the tree than you?-- Yes, absolutely. The complaints never went through me. In fact, they - they went through the nursing channels as far as I'm aware. I knew about it because of the Nurse Unit Managers in the wards in fact speak to me and they let me know. There's usually a relationship if a medical staff is involved in any - any issues, then I get to know about it. But it came to me some days later.

One can see the sense in having, for example, a nurse chaperone when a doctor's performing intimate examinations, and I'm sure no-one will have any difficulty with that, but it does strike me as unusual to have an edict that this particular doctor on your staff can't go anywhere and see any female patient without having someone in attendance?-- It is unusual. Most doctors in fact when - these days when they examine patients, it is usually the done thing that in fact there's a nurse involved. So that's just commonsense these days. But most - most doctors, especially if they examine, you know, a female patient, in fact would have - would ask for someone to come in. But, no, edicts are usually not - not issued to doctors.

And in your experience, a doctor who is alleged to have molested, sexually molested, a patient not once but on a number of occasions, on patients or nurses, would ordinarily

be stood down pending an investigation?-- I would expect so. If it had anything to do with me, I would have fired him on the spot. I guess they would have sidelined him or something or other but, you know, to be able to sort of continue in whatever role he was, I mean, it was quite unusual.

Thank you.

MR ANDREWS: Was there an occasion when you checked Dr Patel's CV?-- Yes, I did. Yes, I did.

Why?-- Dr Patel struck in me a discordant note. There was, you know, there was a discordant note.

You've told us that that happened quite early in his time at the-----?-- Yes, that's right, I gave examples on why, on why that was.

Can you recall when you went to check on his CV?-- I can't recall the exact date, but when Dr Keating went on leave, I don't know for how long or whatever, the Acting Director of Medical Services was another doctor who I know quite well, and I said, "Look, can I come up and have a look at Patel's CV?", and he should, "Sure, not a problem", so I went up there and had a look and the CV looked reasonable to me, I didn't spend very much time on it, but in fact, you know, I had no major queries with it. One of the things that thinking about it which was a little bit out of keeping in my mind is the following, which again, alerted me that there was something going on that the CV itself looked quite reasonable but I do know for a fact that when you actually work in a major teaching hospital in the United States or in England or in Australia and you're involved with teaching and you're involved with research, it sort of frequently happens in some of these large institutions in the United States that people publish articles. Now, surgeons don't publish as many articles as physicians, but for what it's worth, I mean, there's dozens of articles that I've published but that's not an issue, but I don't remember seeing any articles published by this man. Again, I didn't - I can't remember whether he did but it sort of struck me as being somewhat unusual that someone of his experience, of his background, of his endeavours in the past in fact would have very little or any of that, and that, that's a specific issue which I found a bit strange. It may be totally irrelevant but that's what struck me as being a bit strange.

Was there any significance to the fact that it was the Acting Director of Medical Services you approached rather than Dr Keating?-- I don't think I would have got anywhere with Dr Keating, I'm sure, you know, I wouldn't have even thought of approaching him because I don't think I would have been shown his CV, I would have been told, "What for? It's none of your business, he's a surgeon" and all the rest of it, but I wanted to see his CV so I did do that and I read it inside the office with the Acting Director of Services there and I, you know, I just read it and then gave it back to him and he put it back in the file.

Now, you didn't ever take a complaint to Mr Leck because that wasn't the appropriate procedure?-- No, my immediate superior was Dr Keating so if I had any issues, in fact, I'd take it up to him.

Did you ever fill in an adverse event form in the hospital or see them filled in?-- Oh, there's a whole industry of sort of

adverse events forms, everybody fills in everything. That's not the issue. You know, if I had a complaint, in fact, I'd go straight and sort of discuss it with people. It means at least they knew I did it and again, correct me if I am wrong, I may be wrong, but complaints forms, in fact, they were filled in, they went somewhere and who knows where they went, it's sort of some big black hole I think. I mean, I never received any feedback on adverse events. In fact, some of the issues were brought up at some of the clinical forum meetings which I also went to.

How often were the clinical forum meetings held?-- Once a month.

And what issues were brought up at those meetings?-- There were issues which were particularly relevant to the practice of medicine, in fact, they were meetings mainly with the clinical directors, in medicine, it was myself and plus the nurse unit managers, so in fact, that would have been the senior nurse in the rehabilitation department, in the medical ward, in the renal ward and also in coronary care unit, which sort of is combined with the intensive care unit there, so they're the four nurses that in fact would come.

And did you ever receive feedback on complication rates or complaints from patients?-- No, no, in fact, the minutes, I think it was me but I might be wrong, I instituted a system of the minutes of those meetings to electronically be automatically sent to the executive, so people got those notes and the issues which concerned me were issues that I think were relevant to medicine and so those minutes electronically went up, I never heard anything about them.

Well, was there any reason to expect that the executive might have given you feedback on your minutes?-- Well, it depends what was in the minutes, the sorts of issues that I was interested in in fact was something called the risk register, set up a risk register with the initiative I think was quite reasonable and our risk register had to do with the fact that patients weren't being seen properly because of the lack of medical staff, that the fact of junior medical staff, that they didn't answer their pagers because they were away, so the number of medical staff were significantly down. That's what I included in the risk register and that went up there. But we never got anything back and I remember at another meeting, the clinical - the Executive Council Meeting which sat also once a month on a Friday, I was probably speaking a little bit more than I usually speak at his council meetings but I sort of said, "Look, I'm interested to know why we don't get any feedback on these minutes that we send you up", I mean, there where issues which are relevant to the hospital for the practice of medicine and we never get anything and silence and Peter Leck was - who usually chairs that meeting but he wasn't there on that particular meeting, it was chaired by Dr Keating, and I specifically asked, you know, "Why don't we get feedback? So what we're saying, we want to know what's going on?", but nothing, and he sort of said, "I'll discuss that with you on a personal basis a little bit later on.", and I

said, "Fine.", and but, you know, it was unusual to get any feedback on complaint forms or anything else.

Did you discuss it with Dr Keating on a personal basis later?-- What-----

As he'd suggested at that meeting?-- No, no, no, we didn't, no, we didn't.

Is there an occasion when you reviewed a particular patient who had a problem testing certain enzymes?-- Yeah. Once in a while I, you know, I was sent letters to make general comments or specific comments on aspects of patient management and I had a few of those, I can't remember them all. I usually read what was required, I went through the chart, went through the notes and through the documents and answered to the best of my knowledge on what I thought the issue was and this is what, this is what I did.

Did you report that to the executive?-- No, I wrote a letter, I wrote a report and I sent it to Dr Keating who actually sent me the request, so I filled it in and, you know, I wrote the report and sent it on.

Did Dr Keating give you any feedback?-- No, not on that occasion, no.

Would you normally expect a response to a report that you'd written?-- On that particular occasion, no, so I think it was quite appropriate, I mean, he wanted a report, I wrote it and he sent it off and that was it, so that wasn't, I wouldn't have expected an answer to that one.

You gave evidence of assessing some of the persons in your department, for instance, you assessed Dr Qureshi?-- Yep.

Was it appropriate for anyone to assess Dr Patel or was his position sufficiently senior that it meant there should be no assessment of him?-- Well, the immediate superior to Dr Patel, exactly the same as me was Dr Keating, that's the thing, he was the clinical Director of Surgery, I'm a Clinical Director of Medicine, so we all know where the, where the reporting is there. We - there is a-----

Should Dr Keating have assessed Dr Patel at some stage?-- Well, there is a system called credentialing which is done by the Bundaberg Base Hospital, I suspect, by most hospitals, even though it was never done to me in 25 years that I worked in a mayor hospital in Melbourne, as I go through the system here, so there is a system of credentialing where doctors' qualifications, credentials are identified and whether there's any issues there, so it happens in medicine, so I assume it happens in surgery as well, and that's usually done by - it's chaired by the Director of Medical Services, but when I - when I'm involved in having the - looking at the credentials of a physician to work for me, when I was credentialed, I actually left the meeting and went outside and the credentials met so that's what happens there. What actually went on in surgery I

don't know, I suspect it was the same thing that went on in medicine.

D COMMISSIONER VIDER: Mr Andrews, could I just ask a question? You've indicated, Dr Miach, that on the risk register there were more administrative or clerical rather than clinical things that might have been identified a risk?-- The risk register, there were a number of things but the specific issues that I was concerned and that I made sure that they went on was the fact that the nurses, quite correctly and quite appropriately were discussing, you know, "When I call a doctor, he's never there, I can't - there's no answer and then I find out that in fact he's been rostered off." If there's an issue in the renal unit, which frequently happens, in fact, you know, you call someone and they never come because they're not there, so that was a particular issue with them because I thought patient management was suffering because of the lack of appropriate or number of staff that was there. So that's what I put. That was a technical issue, if there was a deficiency of staff, you would try and appoint more staff but they were the issues relevant to medicine.

I'm trying to get a feel for where the results or outcomes of clinical audits may then have been discussed. I'm not hearing you discuss where there were clinical forums on infection rates, return to the operating theatre, whatever you like, that were relevant to clinical departments and I'm not getting a feeling that they were discussed, and you virtually did the loop to then follow it through to see where you had a better outcome than what you first identified as the problem?-- Well, if you take the example of infections, for example.

Yes?-- The infections is an issue that, you know, every renal unit in fact has lived for for many years. To try and prevent infections, in fact, there are strict procedures of asepsis, you know, patients are sort of routinely monitored for certain infections, hepatitis, HIV, all sorts of things, so that's set down - sorry, and that actually goes through and that in fact is looked at, you know, routinely in that particular area. Where there are issues that arise unexpected then, for example, as in the peritoneal catheter audit, that's what happens, I get the staff to look at that, in fact, we've looked at catheter infection but that's a specific issue.

Yes?-- Now, I assume that in surgery if there are issues that the same thing there is done, and when these audits are done, we discuss it, it's applicable to the specific area of medicine. For example, the renal unit, now I wouldn't have discussed that in a clinical science forum because a lot of people wouldn't have been interested in it, but I would have done an internal audit with the staff, but that's right, the audits weren't routinely discussed.

Thank you, Mr Andrews.

MR ANDREWS: I have no further questions for Dr Miach.

COMMISSIONER: Now, there is a few things I'd like to canvas

and I suspect my colleagues will do as well so you're welcome to take a seat.

MR ANDREWS: Thank you Commissioner.

COMMISSIONER: Dr Miach, I don't say this out of flattery, but I think it would be a fair observation that a town of the size of Bundaberg and a hospital the size of Bundaberg Hospital is very lucky to have attracted a doctor of your seniority and experience; that would be quite uncommon, wouldn't it?-- But nephrologists are unusually in country areas in Queensland.

But even apart from the fact that it's a fairly small area of specialisation, simply to get someone of your standing in the community, in the medical community is generally a big ask for a regional hospital?-- Perhaps fortuitous, as I mentioned yesterday, there are certain reasons that I went there not expecting to stay. The fact that I'm a nephrologist in fact benefits the community in that area.

Yes. Are you able to suggest anything that can be done within the administration of Queensland Health generally that would assist in attracting more people like yourself to Queensland hospitals?-- My observation, perception, impression, idea is that in fact working in Bundaberg Hospital is not a friendly atmosphere.

Yes?-- You know, if you get one mosquito that bites you, it's not a big deal, but if you have 10 million mosquitos bite you, then it is a big deal, so if I was to tell you a number of small issues that in fact by themselves don't mean much, but the total of them in fact are significant. One of the things that - let me give you an example what I'm talking about. For example, Bundaberg Base Hospital set up a rural clinical school which is an excellent idea, there's a certain number of clinicians there that can teach patients properly, yet there was no library there. Now, how you can actually have a clinical school without a library is just amazing. In fact, there was something there that was called a library in an old building in a corner detached from the hospital. The University of Queensland came up to this place which was called the library and they sort of said that there was not one usable book in the library. So I decided to, you know, institute or put a library in the hospital and I wrote letters and I brought it to the, you know, to all sorts of meetings. The resistance that I had was amazing. You'd expect, you know, in areas of medicine, of learning, you need books, that they sort of said, "Computers are fine enough" and computers are fine but you need a library, you need people to sit down, to read, to discuss, so a little library was put in and, in fact, it has a reasonable compliment of books now, it's very well used, it's - you know, there are people in there reading and studying all the time, that exists, but the tensions I had to go through to have a library put in were just amazing. You put a ton of effort for a milligram of result. That's crazy. A lot of physicians, a lot of doctors aren't going to put up with that and they're just - you can talk forever about the examples. There was a major chasm, there was a major gorge

between the administration part of the hospital and the clinical part of the hospital, the two never met, they met at these Friday afternoon sessions. They were a proforma and nothing was ever discussed, everybody went their own way. There has to be an amazing cooperation and goodwill between the administrative part of the hospital and the senior clinician, whether they be surgeons, clinicians or whatever they are, and they doesn't exist. Decisions are made, for example, in this rostering thing which I think is a disgrace quite frankly, without any consultation at all, you know, medicine suffered, it was put in unilaterally by someone who didn't understand medicine, who's never been a physician for one microsecond without any consultation with anybody, and you can keep going and going and going and this is the reason that I think that physicians or clinicians find it difficult to practice in these country areas.

We've been told from a number of sources in the investigative phase of the inquiry that the biggest incentive for experienced Australian specialists to come and work in the public health system in Queensland isn't the money, even though public health doctors in Queensland are amongst the lowest paid in the country, it's the working environment and particularly the bureaucracy that they have to deal with?-- Absolutely. You know, money is not an issue. I mean, every time doctors end up in the press there's money, but you know, I mean, if I wanted to make money, I'd be going to the private system tomorrow, I'd make a hell of a lot more than I do now, but the reasons that doctors work in the public system are is an amalgam of reasons: there's a collegial atmosphere, there is a distinct will and a distinct wish to actually try and help patients, most doctors will actually try and do that. The thing that has irritated me or angered me more than anything else in this episode is that patients were damaged and the rest of it, you know, the other issues I don't think - you can cope with that, but you know, when patients are hurt and you care for them, it's very difficult, I can tell you.

Doctor, I've asked you about attracting more Australian qualified specialists to Queensland Health positions. Can I ask you a similar question about attracting larger numbers of qualified specialists, particularly in provincial areas who are already in the private sector to work as VMOs?-- I think most of them, my impression is that most of them would jump at the opportunity, if one or two sessions in the public system, I think they would do that. There is, for example, I know there's a neurologist - we don't have a neurologist in Bundaberg - there's a chap that sort of deals with nerves and brains and those sorts of things, he flies up from Brisbane once a month or whatever and he spends two or three days in Bundaberg, then goes back. Now, he's intimated to me that he'd like a session in Bundaberg Base Hospital. That would benefit the hospital immensely, the students would actually learn a bit of neurology. I mean, I teach them neurology but I'm not a neurologist. If a neurologist taught them renal medicine, they'd learn that too but they wouldn't learn as much as they'd get from me. So the fact the benefit of having people work in the public sector is immense, neurologists

could work there. There are ENT surgeons in Bundaberg which might work in the public system, there's other surgeons in Bundaberg that might do it but it has to be made attractive to them. I mean, the doctors aren't going to work in the public system if there's a hostile and sort of unpleasant environment.

You've touched on the fact that the medical practitioners are keen to make a contribution to the community. If I can speak for a moment on behalf of a profession that's perhaps not so well known for its altruism, if all of the QCs in Queensland said that they'd work one day a week for Legal Aid at Legal Aid rates, I'm sure the Legal Aid organisation would jump at that. Why is it in your experience that Queensland Health isn't accepting these specialists' offers with enthusiasm?-- Well, I think they'd have to pay too much money. I think it's more than that. For example, if you were to attract an orthopaedic surgeon to the public system, you would have to pay him a wage, which is not a big deal, you know, a VMO one session a week or two sessions a week, but with him in fact comes his experience, you would actually have to support that surgeon or physician, whatever you like, in fact, you would need to invest in hip joints, in knee joints, in sort of prosthetic things, in specialised nurses, and that costs money. You know, one of the things when I came to Bundaberg tongue in cheek I sort of said, "You know, if you wanted to save money, you made a big mistake appointing me.", which is true, because I in fact expanded the renal unit, I dialysed a lot of patients, and every time you dialyse a patient, you have to pay about 60 or $70,000 a year, so in fact, it has to do with money.

But even if you leave aside situations after you're speaking about bringing in new areas of specialisation, surely there's an advantage in having a fully qualified Australian surgeon performing surgery in Bundaberg Hospital rather than a man brought in from overseas who is not qualified to Australian standards?-- Absolutely. They've been Australian surgeons in Bundaberg, there was - there was a surgeon there called Nankivell, I know the name well because his nephew is a nephrologist like me. He practices in Sydney now. He was an excellent Australian surgeon, absolutely brilliant. I mean, he was balanced, the diagnostician cared for patients, they worked that man into the ground and he left. He sort of specifically asked for a bit of help and absolutely nothing. Absolutely nothing. So he left, you know, he now works on the Gold Coast and instead of being on-call seven nights a week, he's now on-call one in six, you know, one week in six, so he left. If it was made attractive for him, he liked the area, he would have stayed there.

In your evidence this morning you referred to the paper production industry within the hospital, complaint forms and forms for this and forms for that and I noticed in your statement you also refer to the fact that the number of committees that you're on: Executive Council Committee, Clinical Science Forums, Director of Bundaberg Health Promotion Unit, the Ethics Committee, Audit Committee for the

Friendlies Hospital, Central Zone Renal Committee and so on. Does it ever occur to you that the administration of health has just become too weighed down with paper and red tape?-- All the time, all the time. But I try and support these committees. I mean, I go to some of those committees you mentioned, I don't think they're very useful at all but I fly the flag, you know, a representative there. I don't know what for, but some of those committees achieve something. For example, the Bundaberg Health Promotion Unit unit has specifically to do with cardio rehabilitation and that is a productive meeting. The audit meeting at the Friendlies Hospital is another productive meeting. I mean, they've done a good job, they could have done their audits internally but they got someone from outside so that they could have been independent and I actually see what happens and I make any comments, so some of those meetings are quite productive but I agree with you 100 per cent, a lot of them are totally useless.

Sir Llew and I were talking during the break, and I'm sure he won't mind my referring to the conversation about a doctor who's I think quite famous in this State, Dr Des O'Rourke, who was at one time Medical Superintendent at Bundaberg and then became Medical Superintendent in Toowoomba, and so far as we can tell, he ran the entire hospital with more beds than there is today with the assistance of one secretary and still practiced medicine, still performed operations himself?-- Absolutely. The - on the local hospital web site, which I've taken it off now because I can't find it anymore, but I actually got a reprint of it when I came, I made the mistake of reading some of the stuff that they sent me and I really - it was just amazing. But on the Bundaberg Hospital web site these are the statistics and I may be a few out of the - but there was a total workforce of approximately 600. 50 per cent of those, about 300 of those were in fact nurses, and that's actually nothing, I think there should be more nurses, I think they do a wonderful job, so 50 per cent were nurses, there was a total of 46 doctor positions from the most junior to the most senior, and this is sort of JHOs, VMO, sessional people to the clinical directors, but there were a total of 46 and there were 77 administrators. And you know, I brought this up in one of my discussions because it sort of, it irritated me, I sort of said, you know, you don't need two - almost two admin staff to every doctor in the place. I sort of said for a place like this, you would need one or two competent people to run the whole thing and they're the statistics and I still have them. It was quite amazing.

We've also been told not only at your hospital but at others, senior medical people, senior clinical medical people, that is, people actually working on the hospital floor have to hand write their own reports or do their own typing whilst people in the hospital administration have secretaries laid on to do that sort of work for them. Do you find you've got a shortage of clerical assistants?-- No, I mean if I - when I see patients, I dictate letters and in fact they're typed and that happens both in Bundaberg and in Hervey Bay, so in the area that I work in, in fact it's quite adequate, so we don't hand

write reports, I just dictate things as I see them, they're typed, I correct them and in fact they're sent off and that's - in the area I work, that's not an issue, that works quite well.

Thank you for that. I also wanted to ask you about complaints handling procedures, and as we understand it at this stage, and no doubt we'll hear a lot more about it as the inquiry goes on, there is a formal process for people external to the hospital, mainly patients or patient families, for their complaints to be handled, but so far as you're aware, did you encounter any system for you to, for example, escalate a complaint if you weren't getting satisfaction from Dr Keating or from Mr Leck, to ensure that your concerns were sent up the system?-- No, there is a distinct discouragement to go outside the system. Personally, if I'd had a complaint, as happened in this catheter business that we've been talking about, I mean, if there's a complaint, I'll bring it up to the appropriate authorities. If nothing's done, then I'll do it myself.

Yes?-- That's the way I operate. You can get sort of snowed under in complaints and no-one doing anything. The example I gave here, that there in fact this - there was an issue with catheters, I went through the motions, I sort of gave it on a number of occasions with the administration, nothing was done, patients were suffering and in fact I took an alternate mechanism, I actually went outside the system and had these catheters put in, they're working very well, that's one example.

Yes?-- But people are discouraged to take complaints outside the system and the discouragement is more obvious to some people than others and it depends on the seniority and what, you know, what they do.

All right. Sir Llew?

D COMMISSIONER EDWARDS: Doctor, from reading submissions and listening to witnesses and so forth, it seems to me that in simple form, the hospital systems are full of committees that never seem to report in detail back to the people at the workplace: nurses are working enormously hard and having the most contact with patients in a very efficient way, doctors are giving a lot of their time outside of their commitments, but yet you can't even get letters responded to, you can't even get information back down from administration?-- That's right.

That's the impression I'm getting from reading information, complaints are increasing and waiting lists are getting longer. In simple words, is there a - I know I can't ask you for a solution - but is there some major factor this committee - this Commission should be looking at in an attempt to reach a resolution so patients get better care, nurses are given more consideration, doctors given more encouragement to better their commitments and standing? Is there some simple message that we should receive from you in that line from your

experience and what you've told us?-- It's very difficult. The culture in certain hospitals, certainly in Bundaberg in fact needs to be changed. I mean, doctors need to be appreciated somehow. There should be - if there are doctors available, in fact, that they should be used, doctors in places like Bundaberg, Hervey Bay, Mackay, Rockhampton, they're at a premium. I think it's bizarre that they actually work in a system and in fact they're available and they're discouraged from joining the public system to actually help patients. I think most doctors in fact would want to do that, but the onus and the responsibility and the people who hold the purse strings are the administrators, so that's something that could be done. There should be a much more productive interaction between the clinicians and the administrative part of the hospital. A lot of these committees are useless but you can set up a committee, for example, in which you discuss practical matters.

For example, you flesh out the lack of staff until you sort something out. You know, you discuss level - you discuss equipment. But the whole thing is bogged down with - you know, with papers, with forms and the rest of it. I mean, if I want to take one day of conference leave, I mean, I have got a folder that in fact is about that much that I have got to fill in, you know. It is bizarre. Where I came from - and that's not ideal either - I would fill in one form. I will say, "I will be away for one day. I am going to this conference." People trust you. You know, in Queensland Health, specially in Bundaberg, I suspect in the whole lot of it, you know, people think all doctors are out to rip them off. Well, they are not. I mean, I lose, for what it is worth, tens and tens of thousands of dollars every year, because, in fact, I can't be bothered putting in claim forms. So I don't think doctors are interested in money. But, you know, having to - they are discouraged in a thousand small ways of, you know, contributing to the society, which I think is a pity. I think it is absolutely bizarre.

Can I just go a bit further? It seems to me, listening to various people so far, and also reading the submissions, that the power of the administrative bureaucracy in hospital systems is frightening. I put myself very clearly in that camp at the moment. Is there a way that you as a clinician can suggest that this Commission consider a management style or a scheme that would assist in, at least reduction of the administrative nightmare and bureaucratic-----

COMMISSIONER: Excuse me, Sir Llew. Mr Tait, I see you are sneaking out very quietly. I wondered if you could stay for just a couple of minutes?

MR TAIT: Certainly, Commissioner.

D COMMISSIONER EDWARDS: So I am just wondering if you have a suggestion that could be placed before us?-- How to improve the system?

I guess not so much - I think what I am trying to say is that from evidence given so far, it seems that there is an abundance of material going up to administration, and I think you even said it yourself it is not being responded to, you are not getting replies. We hear the nurses working their hearts out?-- Yes.

Intensive care and so forth. We hear doctors. And then we see beds being reduced at Bundaberg when, indeed, there is a waiting list one and a half years long?-- That's right.

Who are making those decisions that bring about a situation to which you have been referring?-- Well, the amorphous people in Brisbane, I suspect. They know very little about clinical - they have no idea what happens in Bundaberg. This is part of the reason that this whole business has risen up. My impression is in fact they get messages or they get orders from down here, and again I might be wrong, and they probably go to the point, "Look, I don't really mind what you do, just

make sure that the budget is on thing and I don't want to hear any complaints." I suspect they are the two issues that in fact is. And when you have a system like that and you get sort of clinicians, senior clinicians, surgeons, physicians that in fact voice their concerns, nothing happens.

And nurses?-- And nurses as well. Absolutely. I mean, as a physician - I am talking mainly from management - but, you know, the nurses work under duress. They do an amazing job, the nurses, as far as I am concerned. They are at direction but they don't get supported. So you know, what you are asking is extremely important. Being able to answer it in a coherent, sensible, logical, structured manner is not that simple.

D COMMISSIONER VIDER: Mr Commissioner, could I make-----

COMMISSIONER: Just excuse me for a moment. Mr Tait, the reason I asked you back was simply this: I appreciate that you are not appearing for Dr Miach - I am not sure whether he is even a member of the AMA - that's of no interest to us - but it did seem to me there may be a community of interest between Dr Miach and the doctors whom you represent.

MR TAIT: Yes.

COMMISSIONER: On that footing, even though we're not - we're going to postpone any cross-examination, I wondered whether there would be any additional evidence-in-chief that you would wish to lead from Dr Miach while he is here.

MR TAIT: I had not proposed to, no.

COMMISSIONER: Did you wish to think about that?

MR TAIT: I will, and I might speak to Mr Andrews.

COMMISSIONER: Yes, thank you.

D COMMISSIONER VIDER: Dr Miach, I would be just interested in a comment. In paragraph 127 in your submission is where you make a statement "Darren said to me words to the effect 'Peter, you have to understand that this is a business, it is not a hospital.'"?-- Yeah.

I would have thought it was the business of a hospital to be looking after the sick. What would your interpretation then be of what is the business of the Bundaberg Base Hospital?-- To make money, to come in on budget. That's my interpretation of it, quite simply. Patients are a secondary consideration. And most physicians, most nurses, most people who work in fact would see it 100 per cent differently. But you can't run a hospital as a business, irrespective of what anybody tells you. In fact, the hospital is there to serve a community. Patients don't come in with a sign on their forehead, you know, "heart attack". When they come in, in fact, they have hundreds of other things you have to tackle. So that's my interpretation of it. It has to do with money, which I think

is a pity. I think is totally wrong.

COMMISSIONER: Mr Andrews, is there anything arising out of our questions that you would like to deal with now?

MR ANDREWS: No, thank you, Commissioner, but there are some administrative matters that have to be dealt with before the witness leaves the box.

COMMISSIONER: Well, as regards his statement, just to keep the record straight I propose to reserve exhibit number 21 for his statement when Dr Miach has had an opportunity to satisfy himself that it is entirely in order, sign off on it and attach to it any attachments which are necessary. I am quite happy for everyone, including the press and media, to have the current draft as long as everyone understands that Dr Miach hasn't yet signed off on it finally.

MR ANDREWS: I see that the current draft needs an immediate edit at paragraph 133 because it contains the name of a patient.

COMMISSIONER: Yes.

MR ANDREWS: Who is on the key as patient P23. And Dr Miach overnight did make a number of handwritten changes to the draft which he holds. I imagine that they could be edited within the next couple of hours and made available today so as to save the problem.

COMMISSIONER: I am not particularly concerned. I mean, frankly, I think it is more important that Dr Miach be made available to go back to his patients in Bundaberg rather than worrying about formalities like that. And no doubt we will be seeing Dr Miach again when we're in Bundaberg, so it is entirely a matter for you. If it can be finalised in the near future, all the better, but I am just not concerned about those sort of formalities.

MR ANDREWS: Thank you. And exhibit 20-----

COMMISSIONER: 21.

MR ANDREWS: Exhibit 20 has now been edited to remove the patient's name and to insert P67.

COMMISSIONER: Right. If you hand that up then that will be marked. That's the letter from Dr Miach to Dr Keating of the 8th of November 2004, copy to Mr Leck. Exhibit 20.

ADMITTED AND MARKED "EXHIBIT 20"

COMMISSIONER: Yes?

MR ANDREWS: They are the only matters to bring to your attention.

COMMISSIONER: Right. Mr Andrews, I wonder whether I and the other Commissioners could see you just for a couple of minutes out the back. We won't take the luncheon adjournment just yet. But, ladies and gentlemen, we will only be a minute or two, I am sorry.

Doctor, thank you so much for your coming down and giving your evidence. You are free to go. It will be necessary for you to make yourself available for cross-examination at some stage but we'll do our very best to accommodate your convenience?-- Thank you very much, Commissioner.

Thank you for your time.

THE COMMISSION ADJOURNED AT 12.38 P.M.

THE COURT RESUMED AT 12.40 P.M.

COMMISSIONER: Mr Ashton, you are representing Mr Leck, aren't you?

MR ASHTON: Yes, Commissioner.

COMMISSIONER: Is he present or available in the precincts of this room?

MR ASHTON: No, he is not, Commissioner.

COMMISSIONER: Do you know if he is far away?

MR ASHTON: I am sorry?

COMMISSIONER: Do you know if he is far away?

MR ASHTON: Well, he is in the city. I mean, he is in the City of Brisbane.

COMMISSIONER: Yes, all right. Well, will you convey to him that we will want him present after the lunch break to go into the witness-box.

MR ASHTON: Yes, certainly.

COMMISSIONER: Thank you. We will rise now.

MR BODDICE: I have those instructions you asked me about this morning.

COMMISSIONER: Yes.

MR BODDICE: I have instructions that the Minister was aware and authorised the Director-General to engage counsel and solicitors to seek leave to appear for Queensland Health and its employees at this Commission of Inquiry.

COMMISSIONER: All right. But not - he is not giving you instructions?

MR BODDICE: Well, he has authorised the Director-General to do that.

COMMISSIONER: Yes, all right. I will amend your leave to appear so that it is on the clear footing that you are representing Queensland Health as instructed by the Director-General of Health and not as instructed by the Minister for Health, so that there is no doubt that when you are speaking in this room, you are speaking pursuant to the Director-General's instructions and not those of the Minister.

MR BODDICE: I shall convey that amendment.

COMMISSIONER: Thank you. We'll adjourn now until 2 p.m.

THE COMMISSION ADJOURNED AT 12.42 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.06 P.M.

COMMISSIONER: Mr Ashton, as I indicated before lunch, before Mr Andrews calls his next witness I propose to call Mr Leck for the purpose of ascertaining some information relevant to the inquiry's ongoing investigations.

MR ASHTON: Yes, Commissioner. Mr Leck is here, of course.

COMMISSIONER: Thank you.

MR ASHTON: Commissioner, he asks that I explain his casual dress. He was in the city and in the shortness of time couldn't return-----

COMMISSIONER: There is no difficulty at all about that.

MR ASHTON: Thanks, Commissioner.

COMMISSIONER: Mr Leck, will you please enter the witness-box and take the oath or affirmation?

PETER NICKLIN LECK, SWORN AND EXAMINED:

Evidence expunged consequent upon the order of the Commissioner, the Honourable G Davies AO, made on 08/09/05 that all the evidence taken by the BUNDABERG HOSPITAL COMMISSION OF INQUIRY pursuant to COMMISSIONS OF INQUIRY ORDER (No. 1) 2005, other than the evidence of Mr Leck and Dr Keating and exhibits tendered during their evidence, be admitted into evidence.

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WITNESS STOOD DOWN

COMMISSIONER: Mr Diehm, is your client present in Court?

MR DIEHM: Yes, he is.

COMMISSIONER: All right. We will take a five-minute break and then go through the same process with him.

MR BODDICE: Commissioner, before the break, we do have some

instructions about Dr Fitzgerald.

COMMISSIONER: Oh, yes.

MR BODDICE: My instructions are that Dr Fitzgerald as Chief Health Officer was appointed an investigator under part 6 of the Health Services Act on the 21st of April 2004 for a three-year period and as such he has general power to investigate clinical issues and can act independently of the Director-General when asked to investigate by others. So there is not a need for a formal appointment of him as an investigator if he's asked by others to investigate something.

COMMISSIONER: Thank you for that. We will take a five-minute pit stop.

THE COMMISSION ADJOURNED AT 3.58 P.M.

THE COMMISSION RESUMED AT 4.05 P.M.

DARREN WILLIAM KEATING, SWORN AND EXAMINED:

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THE COMMISSION ADJOURNED AT 4.32 P.M. TILL 9.30 A.M. ON MONDAY, 29 MAY 2005