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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 12/08/200

..DAY 40

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THE COMMISSION RESUMED AT 9.34 A.M.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: Morning, Commissioner. Commissioner, can I start by setting out the proposed order of play today.

COMMISSIONER: Yes.

MR ATKINSON: It is this, that first of all I intend to call Dr Kees Nydam. My learned friend Mr Boddice indicated that he has made arrangements for Dr Lucky Jayasekera to give evidence by telephone, I understand, at 3.30.

MR BODDICE: What happened was I spoke to Ms Gallagher, who's acting for Dr Jayasekera, and she has indicated that he will be available from 3.30 this afternoon if Dr Nydam finished earlier than that.

COMMISSIONER: Candidly my only concern is that it would be a pity to have to bring Dr FitzGerald back for a third time. So, is he still planned for this afternoon?

MR BODDICE: No, he's planned for first-up Monday, as I understand.

MR ATKINSON: That is a space that's available on the roster.

COMMISSIONER: Splendid. I am sure that suits everyone then. All right. Day 40.

MR ATKINSON: Commissioner, may I call Dr Kees Nydam.

CORNELIUS MARTINUS JOHANNES NYDAM, SWORN AND EXAMINED:

COMMISSIONER: Dr Nydam, please make yourself comfortable. Do you have any objection to your evidence being filmed or photographed?-- No, I don't.

Also, Dr Nydam, before you begin your evidence, I'd like to express to you our personal apologies. I would ordinarily regard a social and fairly lighthearted conversation as a private matter, but there was an insistence that I disclose details of our conversation in Bundaberg, and I did so. I apologise if that's caused you any embarrassment?-- It hasn't, no. Thank you for your apology, Mr Commissioner.

Thank you.

MR ATKINSON: Doctor, could you tell the Court your full name?-- Yes, my full name is Cornelius Martinus Johannes Nydam.

All right?-- That's abbreviated to Kees.

So you're known as Kees Nydam?-- That's right.

I should say, doctor, my name is Atkinson?-- Thank you very much.

Doctor, have you provided two statements to this Commission?-- I have.

Can I show you a copy at least of your first statement. Could you look at that document, doctor, and tell me whether or not it's your signature at the base of the body of the statement?-- Yes, it is.

Can you say, doctor, whether or not the contents of that statement are still true and correct to the best of your knowledge?-- Yes, they are.

I tender that statement.

COMMISSIONER: The statement of Dr Nydam will be Exhibit 273.

MR BODDICE: Commissioner, I should have indicated we seek leave to appear on behalf-----

COMMISSIONER: Such leave is granted. Thank you, Mr Boddice.

MR ATKINSON: Commissioner, I might ask if that document can be left with Dr Nydam. He doesn't have a personal copy. That's right?-- That's right.

Doctor, would you also look at this document. Can you tell the Commission whether or not that's a supplementary report, supplementary statement that you provided?-- Yes, it is, that's correct.

Again, doctor, are the contents of that statement still true and correct to the best of your knowledge?-- Yes, they are.

Doctor, if we can just put everyone in the frame, you graduated with your primary degree in 1976?-- That's correct.

You actually went to Bundaberg for the first time as an intern, I understand, in 1977?-- That's correct.

And you worked there for six months?-- Approximately, yes.

And then you returned to New South Wales?-- That's correct.

You gained a Fellowship in the College of Emergency Medicine in 1986?-- That's correct.

I understand you had some involvement in setting up the college?-- I was one of the early pioneers, yes.

You have worked in various locations as a Director of

Emergency Medicine?-- Yes, I have.

You came back to Bundaberg for the first time, at least on a clinical basis, in July 1999?-- That's correct.

When you first arrived, doctor, was it Mr Leck or Dr Thiele who was the manager?-- Actually Dr Thiele has never been the manager. He was the superintendent. When I arrived there he had already given notice and he had already left. The Acting DMS was John Wakefield and the district manager was Peter Leck.

All right.

COMMISSIONER: Mr Atkinson, sorry to interrupt your train of thought, I have been reminded that we had actually already given an exhibit number to Dr Nydam's statement quite some time ago. That was Exhibit 51. So, we might leave that as 51A and they can be supplementary - leave that as 51 and make your supplementary statement Exhibit 51A.

MR ATKINSON: Thank you, Commissioner.

Doctor, you're a member of Chapter of the College of Physicians that deals with addictive medicine?-- I'm a fellow of that chapter, yes.

And since you came back to Bundaberg in 1999 you worked as the Director of the Drug and Alcohol Unit?-- The clinical director.

Sorry, are there two directors?-- No, but the role of the director is strictly clinical. It is a clinical role.

And in addition to that role, you have worked as the Director of Clinical Training?-- I am the Director of Clinical Training, yes.

All right. You have acted up as the director - the DMS for a period of 18 months between Mr Wakefield's departure and Dr Keating's arrival?-- That is correct.

But there was a longer period of time between those two men, but 18 months was when you were the superintendent, and currently you act as the Assistant to the Director of Medical Services?-- I'm no longer the assistant.

Right. That's just recent, is it?-- That's as of - I can't remember the - I can't recall exactly the date, but probably about two or three months ago.

Doctor, can you tell us, that role as the Director of Clinical Training-----?-- Mmm.

-----what does that entail?-- It is a role that primarily makes me the representative of the PMEFQ, which is the Post-medical - Post-graduate Medical Foundation of Queensland. That particular organisation through the Queensland Medical

Registration Board has a certain responsibility for the care of interns. That responsibility for the care of interns is actually vested in the position of the Director of Clinical Training. The reason that I jettisoned or was relieved of my role as the assistant to the Director of Medical Services was that as a result of this Commission, one of the things that the Medical Board has done is that it has extended the duties of the Directors of Clinical Training to also include the interests and the supervision of overseas trained doctors in junior roles. Having been told that I now had that responsibility, it seemed to be a conflict of interest to be responsible for junior staff's supervision, training and also to have it seen to have an interest in the notion of rostering and keeping people on a roster. I felt there was a conflict of interest.

COMMISSIONER: Dr Nydam, you mention that initiative by the Medical Board. From your standpoint was that a good and useful initiative?-- I think it was, yes. I think it was excellent.

Yes. Thank you.

MR ATKINSON: Doctor, in your role as a trainer, at least between I think, 2000 and 2004, let's say, you trained interns?-- I didn't - the training, even though I participated in a significant amount of the actual training, the role really is to organise the training program to ensure that the interns are trained, are properly supervised, and aren't just thrown in to a 100 per cent service role so-----

That's - sorry?-- Yes, I do train them but I train them in cooperation with a whole lot of other extremely good people.

And that's something that you're quite enthusiastic about?-- I am. I have always been, yes.

You see yourself as having something of an avuncular role with the interns?-- Look, I don't what the word "avuncular" means.

Uncle-like?-- Uncle-like. I think it's a kind of a mentor role, yes.

All right. Doctor, do you carry on induction courses when interns or other junior doctors arrive at the hospital?-- There is an orientation process. Orientation of junior doctors is an interesting thing because everyone has areas of interest that they think are important in terms of the orientation. If you gave everyone their say, orientation would probably last half of the term. So, I have a - I certainly have a role in the orientation, but the orientation occurs from a whole lot of different aspects.

I'm really wondering whether there's a coordinated induction program?-- There is. When you talk about orientation, in my mind orientation can cover clinical aspects of the job, can cover the HR aspects of the job, can cover the rostering

aspects of the job. There are so many aspects of orientation. I'm responsible for the clinical orientation or the coordination of that.

All right.

COMMISSIONER: Doctor, has there been a separate approach to orientation for doctors coming to the hospital from overseas as compared with doctors who are already familiar with practice of medicine in Australia?-- The PMEFQ, who are the organisation that - that is responsible for all of the directors of training, have seen this as a weakness for quite some time and we have been pushing towards that. The process of orienting overseas trained doctors is a real challenge. It has by no means been done perfectly in the past. Once again, as a result of the process led by the three of you, there have been improvements on that process already on the drawing board.

The suggestions we have heard to date indicate that there are a number of aspects required to be addressed in relation to orientation. One may be language in that even if an overseas trained doctor speaks fluent English, he or she will need to understand the way Australians use English and particularly in a diagnostic context-----?-- Mmm-hmm.

-----how an Australian patient is likely to describe his or her symptoms and conditions. A second suggestion is cultural issues, ranging from the traditional Australian male reluctance to admit that he or she feels poor, to issues dealing with aged people in our society and different racial groups in our society. A third thing is administrative and particularly Australia's grossly complex medical administration system with both Federal and State funding sources and so on, and fourthly is the purely clinical acclimatisation to the extent that there may be technology or practice or routine that would be different from other hospitals. Do you agree all four of those areas are of concern?-- I certainly do.

And are there other areas that you would identify?-- That probably covers all the main ones. And culturisation is a big one.

Yes?-- Communication - I mean, a third of medical practice is actually based on the art of communication and there's an important cultural element to that. I think you have summarised the areas very, very succinctly.

Thank you, doctor.

MR ATKINSON: In that period that I'm interested in, from 2000 to 2004, you coordinated the clinical induction?-- I was responsible for the interns.

Sorry, just-----?-- This position is responsible for interns.

Prior to the new changes there was no formal induction course

for foreign doctors?-- No. I'm talking about the position of Director of Clinical Training. Now it includes junior ranked overseas trained doctors.

Previously there was no structured induction course?-- It wasn't - I mean, it happened, but it happened because of - more because of good grace and because we thought it was an incredibly good idea, and there was no requirement to have someone specifically represent the clinical supervisory interests at a junior level of overseas trained doctors.

And in terms of nonclinical issues, there wasn't any structure to an induction course for overseas-----?-- There is a structured orientation. The structured orientation involves orienting people to - how to fill in a time sheet, how to change their - change their position on a roster, you know, complaints, accommodation, all of those nonclinical aspects.

All right. Bigger issues who the major tertiary hospitals are?-- That isn't - that isn't specifically addressed in the orientation. That more or less occurs, I guess, through a process of osmosis.

And similarly, as the Commissioner alluded to, some of the subtleties, for instance, of the Commonwealth/State funding and the reasons why the State or the Commonwealth might try to shift costs on to each other-----?-- Yes.

-----that might not be immediately apparent to junior overseas trained doctors?-- I'm still trying to grapple with a total understanding of that. I don't know how I would orientate others.

COMMISSIONER: So are we, doctor?-- Mmm?

So are we.

MR ATKINSON: Doctor-----

COMMISSIONER: I have the impression that within Bundaberg there've been a few quite specific international sources of doctors, one of those, for example, being South African?-- Mmm.

And that has made it possible for those people to group together and support one another, so that, for example, Dr Berens may be the most senior South African doctor at the hospital and he shows other South Africans the ropes when they arrive at the hospital. Is that your experience?-- Yes. I mean, there is informal orientation which occurs within - you know, social groups. I think what has occurred is that when I first came up to Bundaberg in the middle of '99 the vast majority of junior and doctors either came from the UK or they came from Ireland, or there was the odd one from Germany or from Holland, and by and large their, I guess - you know, inculturisation to the medical systems was really not that hard, okay. About three or four years ago there was a change. The source of doctors from the UK significantly dried up and

it was necessary to seek recruitment from other sorts of places. There were - as well as the UK and Ireland, there also was steady stream of Anglo-Saxon trained South African doctors. That dried up and we were looking at an - at a significant shift in the sorts of people who were coming in. They were from the - they were from places like the Philippines, they were from places all throughout Asia, all throughout India, who may have originally transferred to South Africa, so may have had five or 10 years work experience in South Africa under the new regime, all right. The inculturisation problems with that cohort of doctors, the communication problems, because even they were from South Africa, English may not have been their first language, became a whole new problem.

MR ATKINSON: It sounds like the inculturisation or the induction course at least hasn't kept pace with the shift in the source of overseas trained doctors?-- Somewhere you need to have a balance between orientation and service - professional development and service. In order to orientate people, I think, properly they would really need to undergo something like a three month intensive orientation program before commencing in a hospital such as Mackay, Townsville, Bundaberg.

What would you cover?-- The systems simply aren't in place for that to occur.

COMMISSIONER: And the resources aren't in place either?-- And the resources aren't in place either. And also the timeframes.

You have told us about the situation with interns and now with junior overseas trained doctors. It strikes me that those problems will be at their most acute with a senior overseas trained doctor. After all, it's Dr Patel who has brought us all here for two reasons. One is that if that person doesn't understand the system, the consequences are going to be much more serious?-- Mmm.

And, secondly, it's very hard for someone who has a position such a Director of Surgery to be seen to be ignorant and to be needing to ask questions of his interns or his Australian trained nurses because he simply doesn't understand how things work in Australia. So, it strikes me that whilst I accept what you say, that there have been very useful proactive steps taken already, the level at which any sort of future model has to be aimed is at the highest levels, rather than at the lowest?-- Absolutely. I'd have to agree with that.

D COMMISSIONER VIDER: And, doctor, one of the observations that we could make from the evidence that has been presented here to us was the fact that for whatever reason it would appear that Dr Patel did not understand the method of the relationship here between a Principal Medical Officer, the one in charge of the patient's care, and the person that may be asked to give an opinion, because we have certainly got evidence before us where Dr Patel was asked for an opinion,

but without going back to the primary medical officer he took over the care of the patient, and then that has resulted in some unfortunate outcomes and significant consequences. Now, without any orientation, to know the system - we don't know whether he knew what the accepted protocol in Australia was or whether he didn't?-- What's the question? I mean, that's a statement.

My question is an observation?-- Okay. I guess my observation is that that - unfortunately clinicians are all flawed. Clinicians are all flawed because they have a personality.

Not only clinicians?-- Those sorts of - you know, interpersonal miscommunications, I have observed them to occur amongst Australian clinicians trained here and schooled here and operating here for 25 years. So, I'm not sure if that particular aspect is isolated to people coming from a different culture. I have always viewed, either correctly or incorrectly, that for all practical purposes Dr Jayant Patel came from the United States.

MR ATKINSON: But-----?-- That's where a lot of his clinical practice prior to coming to us had been carried out. I think the interrelationship between senior clinicians in the United States, in terms of the culture, would be pretty much the same as it is here.

COMMISSIONER: Although we have had suggestions, for example - and we heard evidence only yesterday from Dr Carter - that in the United States it may be the case that an intensivist or the person in charge of intensive care unit wouldn't have the degree of independent decision making about a patient in ICU as compared with the suggestion here where it is seen as a multidisciplinary exercise, and that the surgeon who is the primary carer for the patient is expected to consult with, and take the advice of, and act on the recommendations of the intensivist?-- Once again, I can only give you my observations and you could probably do no worse than ask intensivists themselves. For a couple of years - for about three years I was a clinical director of a critical care, which included an intensive care. One of the most frustrating jobs in terms of clinical management is in intensive care-----

Yes?-- -----where you may have three or four clinicians, some with huge egos, some who are alpha males, some who are a little bit more submissive, each with a tremendous amount of sincerity and total pure heart, seem to be trying to act in the best interest of the patient, but there is a mismatch. The idea of trying to get an effective running team looking after patients in terms of the multidisciplines of medicine, surgery, endocrinology, what have you, is a continuing challenge and really depends on leadership and people who have special talents above and beyond the talents as a mere clinician. One of the problems that I think occurs with intensive care is that the top level intensive carers have got intensivists who are specifically trained in the discipline of intensive care and do nothing else.

Yes?-- That sort of situation really only occurs in some, certainly not all, tertiary level intensive cares. Where you have got anaesthetists looking after intensive care, they certainly have got expertise in areas critical to the management of an intensive care patient but they certainly - it could - you know, it could - it could be argued really is suboptimal. So you have got people with slightly different skill sets not really totally - I am looking for a word - not absolutely 100 per cent confident in their own skill set because they are not trained as intensivists, trying to work as a team where there are multiple problems.

And at the same time in a primary level ICU, such as that in Bundaberg, also with significant clinical responsibilities outside ICU?-- Absolutely.

And therefore being, at best, only a part-time intensivist?-- Absolutely.

Doctor, you have really hinted at least at, I guess, one of the most fundamental problems with any public health care

system, whether in Queensland or anywhere else in the world: we ask the most brilliant of our students, as the flower of our youth the most intelligent motivated members of the oncoming generation, to work in a system and then we say, "Well, you can't have ego, you can't have drive, you can't set out to do things the way you want to do them. You have got to work within a structure." And it actually does concern me quite seriously that the form of administration we now operate deprives people of the chance to develop and exploit their skills, and we have people like Dr Aroney, who gave evidence a few days ago, who feels that he has been driven out of the system because he had to work within guidelines that he didn't think were consistent with the best interests of his patients. Is that an experience that you find across all areas of health administration?-- I guess I would have to make two observations, if I may?

Yes?-- The overall canvas of medical care is pretty large, is pretty vast. We have traditionally - over the last 15, 20 years, we have been developing people with subspecialty knowledge to a very, very high level. Translating that into the metaphor of a canvas, what you have got is you have got people who know exactly what one square inch looks like. Now, if I was to produce a one square inch block of paper, and half of that was black and half of that was white, and ask people what that is, I guess you would have to be pretty intuitive to work out what the answer is. If I give you a couple more squares, then you might be able to guess that what you have got is a part of a picture of a zebra but you still don't know in what direction the zebra is going. I think the problem with clinicians who are particularly subspecialised is that they know everything about their area but they don't see the larger picture. The problem is as our technical knowledge is advancing, the question is who has the sight of the larger picture. I think traditionally health departments have gone along the lines of the people who have that kind of knowledge are the public health specialists, and there has been a tradition of public health specialists, of moving into senior bureaucratic positions within health organisations. I am not talking about Queensland, I am - you know, just as a general statement. You then have a very, very interesting question. With all due respect to Con Aroney, who I have a tremendous amount of admiration, you know, for, to put - to put a defibrillator into every patient makes sense at the micro level, but in 20 years' time, if we have been successful in convincing people to stop smoking, that won't be necessary. So you have got a kind of interesting conversations between, you know, the youngs of the world - and I am talking about John Scott - those sorts of interesting discussions. Your observation in terms of the new trainees, how are we going to train them, the universities - and I am talking about the teaching academics in charge of curriculum development at the universities all over the world - some time ago I undertook to do a Masters in Medical Education. If you look at the curriculum development, then one of the huge challenges in terms of the future is to convince clinicians the importance of being members of teams because the old style training certainly did not emphasise teams, it emphasised

individuality. A little bit like the airline industry where originally they trained pilots to sort of fly by the seat of their pants, highly individualistic. Nowadays, if you want to train a pilot, you do not get yourself a colourful charismatic pilot, you get yourself a pilot who knows how to be a member of a team. And that's the cultural shift which is happening. That's the cultural shift that the universities are trying to get their students to embrace. We're not really there yet. Maybe the people with a lot of drive and imagination will have to become architects.

Doctor, having led you off on to this sidetrack, I would like to pursue a point it raises. Another issue that particularly Dr Nankivell brought to our attention when he was giving evidence, relating to the way in which medical graduates are educated now. The starting point is, as we all understand, that graduate numbers have been frozen for two or three decades in Queensland. There are only 230, or thereabouts, coming through a year. 20 or 30 years ago a majority of those would be male graduates who would expect to spend their entire working lives in the profession and feminisation of the medical profession undoubtedly has had great advantages in other respects, but it means that some proportion of the graduates may not choose to remain in the profession throughout their working lives. On top of that, Dr Nankivell points out that in his time, a medical graduate could be practising as a doctor in his or her mid-20s. Nowadays, with the subspecialisation, that same graduate is likely to be in his or her mid-30s before training is complete and before they are let loose on society as members of a specialist discipline. That seems to me to suggest that we've left out of the picture a significant group of clinicians that are needed in our society who are the generalists. I know, for example, Townsville is coming through with a program for rural doctor training which will fill that gap, but is that consistent with your perception, that the focus on training intensively competent subspecialists has both contributed to the workforce shortage and contributed to a lack of generalists that are perhaps urgently needed in rural parts of the State?-- I think if you look at the figures, the male/female ratio of graduates in courses such as medicine in the 60s is about the same as it is now. I don't think it has changed. Certainly in the year I graduated it was about 50/50. So I don't know that the feminisation per se is an issue. Irrespective of whether or not you are going to become a subspecialist cardiologist who only does angioplasties or a general practitioner, I need to - I need to stress that in my opinion the role of a general practitioner is a hell of a lot more difficult.

Yes?-- And requires a hell of a lot more training in order to do it well. But notwithstanding that, it takes - according to the AMC, the Australian Medical Council, it takes about 12 to 13 years from entry into a university course to produce a standalone independent practitioner of any ilk, generalist or specialist, it doesn't really matter. I think one of the problems is that in the olden days, a lot of people who went into the medical profession were content to work 70, 80, 90

hours a week. Nowadays, you know people are more interested in having a life, and I think - it was interesting, I was over in New Zealand, and what they were able to work out was that if every medical practitioner worked one extra hour per week, there would be no medical manpower shortage. In other words, I think one of the problems is the number of hours worked has significantly decreased. I guess, you know, going around the countryside to conferences, looking at education and everything else, for the last 20 years there has been a dialogue between the professional groups and the Federal Government - it is the Federal Government who largely funds university positions - about the fact that there is going to be a shortfall. The Federal Government line was that the shortfall won't have an impact because we are developing changes in work practice and those changes in work practice will see new careers arise so that the same sorts of numbers, you know, in terms of a formula, are totally different. What's happened is the anticipated work practice changes haven't occurred, clinicians are working less hours. I think they are the main contributors. Probably why do doctors go into subspecialties? They go into subspecialties because procedures pay. There is no value in the overall accounting system of medicine of intellectual content. The premium for service payment is on the performance of a procedure. This has been the history of medicine since about 1938 when private insurance started to become a reality. Now, if you are going to be paying a premium on the basis of procedures within a culture, then that's what you are going to get. You are going to get procedures. You are not going to get preventative strategies, you are not going to get communication, you are not going to get team playing. You are going to get a whole lot of guys who will be running head long into doing procedures. I am not saying that's a good thing or a bad thing, that's up to - you know, that's up to the politicians and at the end of the day it is up to the public in general, but these are some of the interesting questions. If you want to stop subspecialties from happening, stop rewarding procedures as a premium.

MR ATKINSON: Doctor-----

COMMISSIONER: Sorry.

D COMMISSIONER EDWARDS: Isn't all this, though, a political system? We have now developed within the country, as has happened in many other countries, South Africa, Great Britain, and so forth, where the general practitioner becomes, really, a medical clerk rather than doing some of the procedures that he did many years ago and fully looked after the patient, and my friends tell me that they spend a lot of their time outlining the risks the patient is going to have rather than trying to treat the patient - taking time to treat the patient. I am getting the impression that from general practice, we're training doctors to become referral people rather than having a total care of patients, and this is happening, as I said, in many countries in the world. Have you a view about that, because I get the impression it is going to get worse in that line?-- Sir Llew, my impression is

that general practitioners are far too well trained for what they do 90 per cent of the time. I think this was one of the concepts originally why the Federal Government was looking at the creation of new types of careers. A lot of the - there seems, if you read the literature, a lot of dissatisfaction amongst general practitioners, and I think that is because the work that they do most of the time is far beneath what they were trained for and what they are capable of. So, yeah, I agree with you.

MR ATKINSON: Doctor, it is fair to say from those exchanges that throughout your time at Bundaberg - and certainly now - you have a keen interest in quality issues surrounding medicine?-- I think I have a keen interest in anything that improves clinical outcomes.

And that's-----?-- And that's quality.

-----clinical competence checks, training, recruitment?-- Yes.

All those issues come under the broad heading of quality?-- Yes, they do.

You mention in paragraph 53 of your statement, the big one - I don't need you to go to this unless you want to - but when the Bramich thing erupts or arises in July 2004, and there is rumours and obviously some dissension within the hospital, a memo is sent from Dr Keating to Drs Carter and Patel asking for them to provide reports to you?-- Mmm.

And you mention in the paragraph there the memo came to you unheralded?-- Mmm.

You simply assumed that you had been requested to undertake this "given my history in dealing effectively with quality issues and your role as an educator"?-- Mmm.

All right. That's consonant, I guess, with the fact that if one looks at seniority within management, there is Mr Leck, and then Dr Keating, and then yourself, I would have thought, and you are the one-----?-- Well, in terms of the organisational structure, I was a clinical director, so was Martin Carter. If I can give you a history of why the system - part of that job was carried on to my job description, would that be appropriate for the Commission?

COMMISSIONER: Yes.

MR ATKINSON: You are talking about the assistant DMS job?-- Yes. When John Wakefield was in that position, it became obvious to him that the job was more than what would reasonably have been required from one person. He couldn't cope with all the workload that was required. At that stage, things such as the preparation and the writing of legal reports, because accidents had occurred and you get lawyers requesting reports, was incredibly onerous, and really my position as assistant to the Director of Medical Services was

specifically targeted at the preparation of those reports, which traditionally is a role for the Director of Medical Services. The other part of that job description was in the absence of the Director of Medical Services, to fill in for that position. The position of Assistant Director of Medical Services was an admission that one man on his own could not do the job but my role in that position was exclusive of the executive function of the hospital.

I am wondering whether-----?-- So in terms of organisation, I was a legal clerk.

But in terms of education - in terms of the manager and the director, you as, if you like, the assistant or the clerk, you are the one, though, with the specialist qualification as a physician?-- I'm - you have-----

I am wondering whether you were something-----?-- You lost me-----

I am wondering whether you were something of a confidante for Dr Keating and Mr Leck?-- I would hope so. I would hope so.

COMMISSIONER: Doctor, isn't that something bizarre, though, about a system in which a person with your years of training, qualifications, expertise and, candidly, your ability to provide clinical services to people at Bundaberg, has your time utterly wasted doing the job of a clerk?-- I accept as a given that there is a lot of things in this world that are bizarre, Mr Commissioner.

I mean, I-----?-- Look-----

-----don't want to underrate the difficulty or importance or complexity of the clerking job you are doing, but it seems to me that the whole - everyone would be better off if someone was being paid $50,000 a year as a clerk to do that job and you were allowed to look after patients, which is your primary skill?-- If I could be just a little bit cheeky?

Yes?-- I wasn't just a clerk to the clinicians, I was a clerk to the barristers and the solicitors, that I was helping assist their patients.

Yes?-- So I was a pretty cheap lawyer. I guess the important thing is if you have a case before the Court, you want to have the best possible evidence describing your injuries.

Yes?-- It is an important thing within the overall process of patient care. I think to call it a clerkship is probably to undervalue the importance to the patient.

It was your word, doctor, but I understand where you are coming from. I just wonder whether things couldn't be better organised so that to the extent that that sort of job requires technical, clinical or intellectual input from medical practitioner, that can be provided without giving you the drudgery of doing the low level clerking duties that go with

it?-- I guess I didn't perceive it as drudgery for the simple reason that when you are forced to review a case, it also gives you a fantastic opportunity for clinical audit.

Yes?-- As an educator, I need to work out where things can be improved, and writing these letters, after a consideration of clinical notes, provided a very, very fertile ground for the education which I was quite interested in. Maybe clerk was the wrong word. I guess the reality is that traditionally this is what a superintendent would actually do. There is a tremendous amount of drudgery associated with the job of being a Director of Medical Services, and the point that I hope you are trying to make is in any future changes we try and get rid of a lot of the dross that Directors of Medical Services are forced to do and let them get on with their real job.

Well, that's certainly at least part of my point. The other point is in a hospital that is said to be short of doctors - and I am sure is - it does seem close to tragic to have two fully qualified medical practitioners, yourself and Dr Keating, really dedicated to administration rather than providing medical services directly?-- The letter writing accounted for about three hours per week.

Right?-- Three hours - in terms of three hours per week as a source for clinical teaching, was a very valuable investment.

And, indeed, doctor, what you seem to be saying to me is exactly what I would like to see to be the outcome, namely that involvement of clinicians in bureaucracy is structured in such a way you get a benefit from it, as well as being a drudgery, and it is not taking you away from your clinical duties more than is absolutely necessary, and you seem to be telling me that's more or less what happened?-- If I can be frank, I get a little bit concerned in the way that certain doctors are referred to as a bureaucrat and others aren't. Initially I thought that was a little bit offensive but now I am coming to the point that the use of that concept really underscores someone who really doesn't understand. I love clinical bureaucrats and I think that they ought to be valued, and without them we wouldn't know which way the zebra was facing.

And, indeed, thinking back to our conversation in Bundaberg, doctor, I think you made the point to me again - and perhaps in a lighthearted way, if you watch the television program Mash, that the whole system breaks down if you don't have a Radar O'Reilly to ensure-----?-- Exactly.

-----things are where they need to be at the right time?-- Exactly.

Mr Atkinson?

MR ATKINSON: Doctor, one - the barrister for the patients, Mr Mullins, was cheeky enough to suggest to Dr Molly many weeks ago that personal injuries litigation is one type of quality control measure on doctors?-- Uh-huh.

I understand what you are saying to the Commissioner is it is useful to look through files that are the subject of legal interest as a quality control measure?-- Yes.

That really underscores your general interest in quality issues around the hospital?-- Yes.

I wanted to do this with you this morning, doctor, if I can: there are a number of points in the history of Dr Patel where a quality control measure might have worked or might not, and I wanted to go through them with you and discuss if the system failed, and, if it did, why it did and how it can be fixed?-- Sure.

I guess even before I do that, even that exercise is premised on the idea that Dr Patel fell below the standard of a reasonably competent surgeon on a number of occasions. I know that you wrote a letter of support for Dr Patel in March 2005?-- That's correct.

And to be fair to you, doctor, (a) I've got the letter with me if you'd like to see it, and (b) most of the letter is concerned with process rather than substance, but you do say this in the letter, of course: you say you would have been happy for Dr Patel to operate on your family, and my question - I'm sorry it's so long-winded - is knowing what you know now, do you still take the view that he was a good surgeon, or are you not competent to really have an opinion on that?-- Look, as an underscore to quality, the question that I always ask myself is would I be happy for someone to treat a member of my own family. When I wrote that letter the question that I asked myself - and I've got three young kids - was would I be happy to have Dr Patel remove their appendix. That was the question. That was the yardstick. My answer then was yes. With what I know technically my answer would still be yes. The problem I have - and this has only been borne out as a result of retrospect - all right - is that any person who lies, who misrepresents themselves, who makes a positive effort to defraud who they really are, has got a level of morality that excludes them from any interest no matter how technically brilliant they are. So my answer is coloured by what subsequently has come out.

In other words, is this right: knowing, as you know now, that the doctor failed to disclose the disciplinary proceedings in America-----?-- Yes.

-----you can't help but have doubts about his integrity, and that would exclude him from being a treating surgeon-----?-- I would not allow him to operate on my kids if they had appendicitis.

COMMISSIONER: Doctor, the evidence we heard yesterday from Dr Martin Carter accepted that Jayant Patel was very competent at run-of-the-mill surgery, but he got out of his depth in the more complex surgery. If, for example, a member of your family needed an oesophagectomy, would Dr Patel - leaving aside the moral and ethical issues that you mention, would you have considered him competent-----?-- No.

-----to perform that level of surgery?-- No.

MR ATKINSON: Doctor, the first watershed I wanted to take you to is the appointment of Dr Patel as the Director of Surgery. Can we go to that? In your time - you start, of course, in July 1999 - initially the Director of Surgery would have been Pitre Anderson?-- That's correct, yes.

He had a falling out with management?-- That's one way of describing it, yes.

Charles Nankivell took the post after him?-- I don't - yes.

All right?-- He accepted the post. I don't know that there was ever any formal process, but he certainly accepted the post and that was the position which he had.

He became the Director of Surgery, but he resigned in January 2002, Dr Nankivell?-- I'm not sure of the exact dates, but yes.

And then after him Dr Sam Baker became the Director of Surgery?-- That is correct.

And he resigned for his part on 20 August 2002, and then you had to set about looking for a new director?-- That's correct.

Those three men - Anderson, Nankivell, Baker - they were all Fellows of the College?-- That is correct.

And when you went to look for a Director of Surgery, you were looking for a Fellow of the College?-- No, when we were looking for a Director of Surgery we were looking for a Director of Surgery.

All right. You're not aware, in all your time since graduating in 1977, of a hospital where the Director of Surgery was other than a qualified, recognised surgeon and a member of the College?-- I don't know of any specific examples, but I can imagine that there would be.

COMMISSIONER: Would it have been your preference to have an Australian recognised surgeon as your Director of Surgery?-- My preference would be to have the best person that we could recruit.

Yes.

D COMMISSIONER VIDER: Doctor, wouldn't the person have to be a member of the College to have you retain your traineeships for training surgeons?-- Not necessarily. What - I have been - in fact thinking back to it, Prince Henry/Prince of Wales hospitals, who are one of the key tertiary hospitals in Sydney, for a time recruited an overseas cardiologist as the clinical director because he was the best person for the job. He had all of the credentials. He was able to bring skills that at that particular time weren't available in Australia. So whilst I respect that the colleges play a very, very important role in quality control, if you've got someone from overseas who hasn't got a college credential, I don't think that should exclude them from being employed. In terms of acceptability for retaining the status of a training hospital, it is quite feasible to have a non-Australian credentialled person, but have another member of the faculty as the College supervisor of training, and you can do that, and that has been done.

MR ATKINSON: Doctor, as the Director of Medical Services it fell to you to organise and arrange the recruitment of a

Director of Surgery?-- That's correct.

And in the selection criteria for that director, he or she was required to have qualifications as a general surgeon acceptable for specialist registration by the Medical Board?-- That is - well, I guess if you're holding the piece of paper then that's-----

Sorry, doctor. I don't mean to put you at a disadvantage. Doctor, that's the balance of the document?-- No, I'm just looking for that particular - which particular dot point are you referring to? Can you just-----

The one that talks about general registration - registration as a specialist or registrable as a specialist?-- Yes. I guess - yes, you're absolutely right. That's what it says there.

I might tender that document, Commissioner. It's not on the record yet. Thank you, doctor.

COMMISSIONER: Now, I initially said Dr Nydam's statement will be Exhibit 273, but just so that everyone has the figures the same, we already had Dr Nydam's statement as Exhibit 51. His supplementary statement I therefore marked as 51A. So this document will be Exhibit 273, described as Position Description for Director of Surgery, Bundaberg Health Service District.

ADMITTED AND MARKED "EXHIBIT 273"

MR ATKINSON: Can I suggest this chronology to you - and I should say I have the Director of Surgery file here if you need to have reference to it?-- Sure.

Can I suggest this chronology: you advertised for a Director of Surgery three times in 2002. The first time, I think, may have been actually before Dr Baker resigned. The second time you advertised there was a closing date of 16 September 2002, and the third time you advertised there was a closing date of 2 December 2002?-- Mmm hmm.

Can I show you these documents? They are just notes from the file, but they show-----?-- No, I accept those. I have-----

They show the closing dates and that you're the contact person?-- Yes, absolutely.

When you advertised the first time you got three responses - sorry, when you advertised with the closing date of September 2002. The first was a man called Boris Strekov?-- That's correct.

He was working at the Mater, I think, in Brisbane?-- That's correct.

He had some impressive references from there. The second was Dr Lucky Jayasekera?-- That's correct.

He was working as a staff surgeon at the Bundaberg Base at the time?-- That's correct.

He was quite impressive himself. He had been a Fellow of the Royal College of Surgeons in Edinburgh since, I think, 1983. I've got his CV here?-- Is that a question or is that a comment?

MR ATKINSON: Okay. You're right.

COMMISSIONER: I think Mr Atkinson is taking you through the chronology, asking your confirmation or otherwise as to the points he's making?-- I think the issue about credentialling from the Royal College of Surgeons in Edinburgh - it needs to be noted that that is not recognised in Australia as a - an accreditable qualification.

MR ATKINSON: All right. In a sense I could have left that alone, because Dr Lucky had also been a fellow of the Royal Australian College of Surgeons. He had passed his AMC exams in 2000, and I think he became a Fellow of the College shortly afterwards?-- Exactly.

All right. You had those two applicants, and you had one third one. I think he was a navy man from Fiji?-- That's correct.

The third man didn't meet the selection criteria?-- Mmm hmm.

The first two did?-- Yes.

And indeed you made a note, I think, that the first two satisfied all the selection criteria very clearly?-- That's correct.

Now, the people on the committee were yourself, Dr Anderson, and I think Mr Leck?-- That's correct.

And amongst you you chose Dr Strekov?-- That's correct.

But he declined the position?-- That's correct.

Dr Lucky was still working at the hospital, of course?-- That's correct.

You advertised again on 2 December?-- That's correct.

Sorry, you advertised with the closing date of 2 December, and you recall, of course, that Dr Lucky doesn't resign until the 28th of December?-- Is that the time that he leaves or is that the date that he hands in his intention to resign? Because you are required to give three months' notice.

Well, doctor, it's in your statement, but I can tell you that you will find that he continued in the hospital after 28 December. So in your statement you mention that he resigned on the 28th in paragraph 32-----?-- I'm not doubting that that's in the statement. I need clarification, because I'm not sure exactly if I was talking about handed in his letter of resignation within the context of my statement or left employment. I'm just asking you to check that for me.

COMMISSIONER: Mr Atkinson, it's almost time for the morning break, so perhaps it would be fairest to give Dr Nydam an opportunity to check any of the records that he feels he needs to. I certainly don't want him feeling that he's at a disadvantage in attempting to answer these questions without having all the facts.

MR ATKINSON: Certainly. I'll speak to Mr Boddice as well.

COMMISSIONER: Thank you. We'll break until 11 o'clock.

THE COMMISSION ADJOURNED AT 10.42 A.M.

THE COMMISSION RESUMED AT 11.09 A.M.

CORNELIUS MARTINUS JOHANNES NYDAM, CONTINUING
EXAMINATION-IN-CHIEF:

COMMISSIONER: I mention we will have to rise at about 12.45. Earlier in the week Senior Council Assisting was approached by the office of the new Health Minister who expressed a desire to meet us as a matter of courtesy. Mr Andrews and the three Commissioners will be meeting with him. Needless to say, there's no intention to say anything contentious and that will not happen. I thought I should put on the record that that meeting is occurring.

MR ATKINSON: Thank you. Continue?

COMMISSIONER: Yes.

MR ATKINSON: Dr Nydam, we were talking about paragraph 32 of your statement where, of course, you say that on 28 December 2002 Dr Jayasekera resigned from the hospital, and you were asked whether that meant that he left on this day or whether he handed his resignation in. Given that we know from the matters we discussed over the break that his name is in the minutes of meetings-----?-- Yep.

-----in 2003, you'd accept, would you, that he must have tendered his resignation on 28 December?-- I accept that refers to the letter of resignation.

Now, keeping the chronology, there's a first ad that has a closing date of 16 September 2002. The selection panel chooses Dr Strekov rather than Dr Lucky?-- That's correct.

There is a letter to Dr Jayasekera, which I will just show you, dated 15 October 2002 when he's told that he hasn't secured the position?-- Mmm-hmm.

He continues to work, of course, at the hospital as a surgeon. You have another advertisement with a closing date of 2 December 2002?-- Mmm-hmm.

There are no applicants?-- Mmm.

That's right?-- That is correct.

Right. When that process is going on, all the time Dr Lucky is there?-- That's correct.

You have already worked out that he fulfills every one of the selection criteria. I take you, doctor, to paragraph 33 of your statement. You made the point in the preceding paragraph that Dr Lucky resigned on the 28th of December, and then you say that in paragraph 33, "Dr Strekov subsequently declined

the position. Given that Dr Jayasekera had resigned from the hospital, we needed to recruit an additional surgeon." That's a mistake, isn't it? Dr Lucky didn't resign?-- I guess what I mean is he had tendered his resignation.

COMMISSIONER: Well, doctor, what we now know from the chronology is that the tendering of the resignation actually occurred after the closing date for the second round of applications. So, at the time when Dr Lucky tendered his resignation it would be wrong to say that that was, as it were, subsequent to the Russian doctor's declining the position.

MR ATKINSON: Yugoslav, because we do have a Russian doctor coming later.

WITNESS: Look, I obviously had informal discussions with all of the staff every day.

Yes?-- I would have told Lucky exactly the outcome of the first interview. I would have told him if he wanted feedback then he was quite within his liberty to get that feedback. What you have got to remember was that the decision to offer the position to somebody else was the decision of the interviewing committee.

We accept that entirely?-- All right. What you also need to be aware of is that Lucky and I had all sorts of conversations. Lucky did not indicate that he was interested in applying at the second round. There is no application at the second round. Lucky had already indicated to me informally - I don't remember the exact timing chronology - that Lucky's interest in applying for that position was really on the basis that I had encouraged him, that Pitre Anderson had encouraged him, but in his own heart he wanted to move closer to Brisbane.

Yes?-- He subsequently obviously found a job closer to Brisbane and he took it.

Doctor, I think, cutting to the chase, the point is this: we have heard from Dr Anderson, who was as we know was on that selection panel, that whilst Lucky wasn't the first choice he was considered to be an acceptable option, he would have had the position if there was not a better alternative. Do you agree with that?-- That's not entirely my decision to make.

No, of course not?-- I had certain reservations about Lucky. We discussed them freely. One of the problems with Lucky that he encountered was that Lucky had previously worked at the Bundaberg Base Hospital as a trainee registrar. He had established a - you know, if you like, a persona of being a trainee registrar. He had mentioned to me on more than one occasion that he felt uncomfortable with that particular relationship, and that his heart really wasn't in to applying for that job.

Doctor, accepting all of that, as I do without hesitation, the

fact is that both you and Dr Anderson urged him to apply for the position of Director of Surgery?-- Mmm-hmm.

Presumably because both of you thought he would be competent to perform the job?-- I urge everybody to apply for a position because I think it's a part of their professional development to experience the process of a formal interview. I accept the fact that the more interviews that you have the more polished a performance that you would give. If you're asking me right now whether or not I would recommend Lucky for that position, my answer would have been no.

When the Yugoslav doctor from the Mater hospital turned down the position, which must have been prior to the 2nd of December-----?-- Mmm-hmm.

-----was any thought given to re-offering the position to Lucky?-- Not from my own personal thoughts, no.

All right?-- It was not an option.

And why was that not an option?-- Even though he had the necessary criteria-----

Yes?-- I did not at the time think that he was the most ideal candidate for lots of reasons.

Yes?-- Not only concerning his level of skill.

MR ATKINSON: Doctor, would you look at this document. It should come up on the screen in front of you, doctor?-- Yes.

Perhaps----?-- Except it's the wrong way around.

It's not so much the scale as the alignment.

COMMISSIONER: No. That's it?-- Yep.

MR ATKINSON: There's the three candidates there. Dr Lucky seems to fit every single criteria?-- If you read up the top, this is the - this is the application analysis. This is based on a review of the applications, not on the basis of interview.

Right?-- It was on the basis of these calculations that the two up the top were invited to the interview process.

And I understand what you said, it's Dr Strekov you were more impressed by?-- Mmm.

But Dr Lucky certainly as a Fellow of the College, someone who'd passed his AMC exams, someone who had very extensive experience in Sri Lanka and the United Kingdom, fitted all the criteria?-- He met the selection criteria.

And when Dr Strekov pulled out of the race, there was only one horse on the track?-- That's correct.

You hadn't had any other offers except Dr Roland, who was unacceptable anyway?-- That's correct.

Right. And yet you elected to go forward without a Director of Surgery?-- No, what I elected to do was to readvertise.

Right. And you readvertised prior to 2 December without speaking to Dr Lucky about inviting him to take on a position?-- I spoke to Lucky on numerous occasions. We spoke about whether or not I thought he was appropriate, whether or not he was still interested. So, to say we didn't speak is incorrect.

Right. Sorry, I meant to clarify it by saying you didn't offer him the position?-- I did not offer him the position, that's correct.

You didn't offer it to him after the 2nd of December when again it was reinforced there was no other application?-- I certainly did not recommend that the position be offered to him, no.

D COMMISSIONER VIDER: Did you reconvene the panel to see what the other members of the selection panel-----?-- No, I didn't.

-----thought?-- No, I didn't. It was obvious to me from informal discussions with Pitre Anderson that he would have been quite happy for Lucky to take on that position. But there was no formal reconvening of the committee.

MR ATKINSON: The 2nd of December comes and goes. We have got no Director of Surgery. You continue as the Director of Medical Services until Dr Keating arrived in about April 2003. You advertise again in that period for Director of Surgery?-- Yes.

When was that?-- There was a second round of advertisements. I can't tell you the dates. It was in the documentation I read this morning.

I'd suggest to you there's an ad for a SMO but not one for Director of Surgery?-- Okay. Well, I advertised for a surgeon, yes.

A Senior Medical Officer?-- Senior Medical Officer is a grade that includes Senior Medical Officer nonspecialist and Senior Medical Officer specialist. I get the impression, if I may-----

COMMISSIONER: Yes?-- -----just go off in a tangent, that in some of the discussions which have occurred in front of the Commissioners that there has been a failure - it is my opinion - to appreciate that a Senior Medical Officer means different things in different contexts. I am a Senior Medical Officer. I am a specialist.

Doctor, if I can use a military analogy?-- Mmm.

A person may have the rank of lieutenant or captain, or whatever, in the navy but not be captain of a ship?-- Yes.

In this situation you're advertising for a person with a particular rank or seniority, but not for a particular position which was to be the Director Of Surgery. It seems to us that one of the difficulties with that is that the position of Director of Surgery necessarily implies that that person will be the chief clinician answerable in a practical sense to no-one else clinically for the operation of the surgical department at the hospital, and when Dr Patel came to Australia and was accredited by the Medical Board, it appears to have been on the footing that he would have the substantive position of a Senior Medical Officer where he would be under supervision, rather than the substantive position of Director of Surgery where he would be under no supervision. That's the difficulty that we have. It is correct, isn't it, as Mr Atkinson says, that whilst there had been two advertisements for the position of Director of Surgery, the advertisement which Dr Patel responded was an advertisement merely for the position of Senior Medical Officer?-- I guess there are three points in your comment or in your question. The military analogy is an interesting one. One of the reasons why the 18 months that I spent as the Acting Director of Medical Services was probably the worst 18 months of my life was because I felt very much as though I was a member of the senior executive of a military.

Yes?-- Except I was in the German army and when I was asking for lieutenants I was getting sergeants and when I was asking for 18 year olds I was getting 14 year olds. So the military analogy is that if you have a captain who falls in the field, you trump up anybody.

Yes?-- It's survival. So there's the point about the military. The point about the other aspects of the discussion is that there are really two different ways of seeing the role of Director of Surgery. I guess if you go to the traditional tertiary hospital and you have a highly respected gentleman with a lot of grey silvery hair who is the Director of Surgery, then what you'd find is that he would spend a minimum of time operating and a lot of time teaching and a lot of time attending meetings and really having clearly a leadership role.

Yes?-- If you go to the hospitals, if you go to Bundaberg, the Mackays, the Mouras, I could - the whole list of them throughout Australia where essentially you have got two full-time surgical staff and a number of visiting, the role of the Director may be the unlucky bunny who has to go to all of those meetings every month and the unlucky bunny who has to put names on a roster.

Yes?-- So that there is a Director of Surgery and there are Directors of Surgery, if you catch my drift.

Certainly?-- The other point, which may be I'm mistaken and

that's quite possible, it seems have been overlooked that Jay Patel did not respond to that ad. Dr Jay Patel was appointed on the basis of filling a locum position. This is a locum position. At the Bundaberg Base Hospital we have a long history of temporarily filling positions with locums. There have been a number of precedents where those locums have come from interstate, a lot of instances where those locums have come from America, from all over the globe. In my mind at least - and if the documentation or the paper trail does not reflect that then I'm at fault - but in my mind Dr Patel was employed, was engaged as a locum, temporary post. All right. So, job descriptions - unfortunately this is something else which I think Queensland Health needs to address and I think it's in my statement. There are certain rules for permanent staff. For reasons of pragmatism those rules haven't got the same degree of - you know, stringency for locum staff. I believe that there has been a clouding of this issue when it comes to Patel in this whole - you know, in the way that evidence has been presented. All right. If I employ a locum, I don't need someone to be a fellow of any college.

MR ATKINSON: Doctor, I will come to that. Let me take you through it?-- Please do.

You mention that difference between Senior Medical Officers or that understanding of them. I understand it's the case that specialists may be Senior Medical Officers?-- They are Senior Medical Officers, not "may be".

Then a Director will be somebody who is a Senior Medical Officer and will have extra administrative duties; yes?-- We have a Director at the Bundaberg Base Hospital who was a nonspecialist Director. In the six years that I have been there, we have had Directors of Anaesthetics who have been nonspecialist Directors of Anaesthetics.

They aren't members of the college?-- They aren't members of the Australian college.

Right. Right. See, the point here is that when you look at KN2, which is the position description for the person who is to be the Senior Medical Officer-----?-- Mmm.

-----and that's exhibited to your statement, it makes very clear, as the Commissioner pointed out, that the Senior Medical Officer in surgery reports directly to the Director of Surgery?-- Mmm-hmm.

Right. And it doesn't make clear what the position description did make clear for the Director of Surgery, namely that they have to be registrable as a specialist. So, the things that are important about the SMO in this context, and I understand there are broader generic issues, is that first of all they may not be a specialist and they may not need to seek specialisation or registration and, second of all, and very importantly I'd suggest to you, if you are the SMO rather than the Director of Surgery, and if it's been put to the Medical Board as, "Here's someone we're getting as an SMO", if

you are the Medical Board or anyone else looking at the process from outside you have this comfort that whoever that SMO is, they are going to be supervised by the director?-- I guess, with due respect to the Medical Board, they ought to get in the car and drive around the country and see what's going on.

COMMISSIONER: Doctor, that really isn't practical, is it?-- No, it isn't. But really, I mean, there's an ideal, isn't there? There is an ideal that every director should be an Australian trained Australian recognised specialist. That unfortunately has not been the case in Queensland for years at every hospital.

Well, that's one ideal. But I have to put to you that another ideal is that when the Medical Board processes an application for a position described as a position reporting to a Director of Surgery, they're entitled without getting their cars and driving to Bundaberg-----?-- Absolutely.

-----to assume the person appointed to that position will be under the guidance of a Director of Surgery, rather than being a loose cannon?-- Absolutely, and I think that is one of the - one of the - one of the reasons why I welcome this entire Inquiry.

D COMMISSIONER VIDER: One of the reasons we are sitting here today is because a person who by registration under special purpose registration was registered to the role of Senior Medical Officer-----?-- Mmm-hmm.

-----was appointed a Director of Surgery and, therefore, had no supervision?-- Mmm-hmm.

And we're all here today partly because there was no supervision and we have got very unfortunate patient outcomes that triggered this Inquiry?-- Absolutely. I think the corollary, if I may, is that we have had non-overseas specialists in positions as Clinical Directors without having adverse clinical outcomes.

COMMISSIONER: We accept that, doctor, but-----?-- It is a-----

-----there is a difference between the situation you describe and the situation the Medical Board has approved this individual to work under supervision and the individual is then almost immediately given a position where he works without supervision?-- Yes.

MR ATKINSON: Doctor, before we go to the SMO thing proper, I want to finish off Dr Jayasekera?-- Sure.

One of the things you said earlier was that you had understood that Dr Jayasekera was ambivalent about the job, you understand?-- That was the feeling I got from having formal discussions with him, yes.

See, when one reads the statement at paragraph 32, the second half of paragraph 32 it reads as if what you are saying is that Dr Lucky only told you about his interest to be somewhere else after he had resigned. You say, "The reasons Dr Jayasekera gave me for his resignation were two-fold." Do you accept that maybe Dr Jayasekera never told you about reasons he would like to be somewhere else until he had resigned on 28 December 2002?-- I can accept that, yes.

And perhaps this, too, that when he did that, that was part of him putting a positive spin on a bad situation?-- That is a possibility.

Because he was unhappy that he didn't have the job of Director of Surgery?-- That is a possible interpretation.

Can I show you this document? This is - sorry, on the audio visualiser. This is a document that was exhibited to Dr Anderson's statement?-- Mmm.

PEA13. You will see it answers your earlier question because it shows, or seems to show that Dr Lucky was still there in February 2003?-- Uh-huh.

But, doctor, it also shows that there is some level of animosity, don't you think? You wouldn't get a line of insults like that every day?

COMMISSIONER: Unless you were a Royal Commissioner.

MR ATKINSON: Yes, I was just thinking that. "Dictatorial, unresponsive, myopic and inflexible with no respect for specialists, their needs, or aspirations", and then it is signed by a bunch of impressive doctors. Do you accept what I have said? That's what the document shows?-- Can you just repeat what you said?

You will see in the first paragraph it talks about how the meeting, the Medical Staff Advisory Committee-----?-- Yes.

-----accepting the resignation of Dr Lucky?-- Yes.

And then it tees off, if you like, against management and says, effectively, the reason he is resigning is because "Management are dictatorial, unresponsive, myopic and inflexible", and they don't care about specialists?-- Yes.

All right. That's not easy to fit with the idea that Lucky left and was happy to leave?-- That language is not inconsistent with the language that Pitre Anderson uses frequently. I assume that this -that's been prepared by Pitre Anderson, as he is the proposer. What I suggest is that there was an unfortunate, even tragic degree of dysfunctionality between members of the senior staff. That's how I would interpret this.

But what you concede now, I understand, is that between September 2002 and 28 December 2002 you had no reason to think that Dr Lucky didn't want that job as Director of Surgery?-- My discussions with Lucky would have predated this. I think you mentioned the word "spin". I think someone is putting their own particular spin on a situation. This really doesn't agree with the impression that I got from speaking to Lucky in earlier private conversations.

And I accept that, doctor, but what I have suggested to you - and I think you agree with it, I just want to make it clear - is that those conversations only occurred after 28 December 2002?-- Yes.

Prior to that you might have offered the job to Lucky as the only man who applied who was a Fellow, but you didn't?-- I think I have already mentioned that Lucky was not my preferred applicant for the position as permanent director.

No, but your preference has gone. You have only got one left. You are there at the dance and there is only one fellow left to dance with?-- The way I read my choices is that I can either give it to someone or I can readvertise.

You didn't do either?-- Or I can buy some time by getting some locums.

All right. So what you did - if I take you to paragraph 14 of your statement. You put out this job for an SMO?-- Uh-huh.

You mentioned to the Commissioner earlier that people need to understand Dr Patel didn't apply for the SMO job, he applied for a locum job?-- Uh-huh.

But in paragraph 15, you talk there about Dr Bethell putting Dr Patel forward as the potentially suitable candidate for the position of SMO surgery?-- Uh-huh.

Yes?-- Yes.

So you accept that - put out the word that you wanted an SMO in surgery?-- I put out the word that I wanted someone who would be able to competently perform surgery in such a safe

way as was required by the population of Bundaberg. Whether that's a specialist, a non-specialist, whatever, I wanted someone who could perform safe surgery.

Right.

COMMISSIONER: And Dr Lucky could do that?-- He could.

And instead of Dr Lucky, we got Dr Patel?-- Unfortunately. Tragically.

Yes.

MR ATKINSON: But-----?-- Tragically.

-----we're still left with this mystery, doctor, if you don't mind me saying so, the position description, which is KN2, if you want to look at it, makes very clear that the SMO is to be accountable to this Director?-- Uh-huh.

But we don't have anyone in mind as the Director. It is just blank?-- Yes.

And let me cut to the chase, you know, without being rude, it looks as if you are getting this SMO in, you are running him through the Medical Board as an SMO, but looks like he is going to be the head of the surgical department because it is a pretty easy head count; he is it?-- I guess he is it for the period of the locum period. My experience with overseas surgeons previously at the Bundaberg Base Hospital was that we were able to get surgeons whose level of work was of a very, very high quality.

D COMMISSIONER VIDER: Doctor, but under his registration, he was not eligible for appointment to that position?-- He wasn't appointed that, as I understand it. As I understand it, that is a position description for a permanent employee.

And that was a position description that was presented to the Medical Board against which his Special Purpose Registration was granted?-- Okay. I accept that and that was in error.

MR ATKINSON: You mentioned, doctor, earlier that it was a temporary position?-- Uh-huh.

I must say, that causes some concern in retrospect, don't you think? This man, in the space of almost exactly two years, saw 1,451 patients, which means he is seeing - and, admittedly, he was a prolific worker - but he was seeing 700 patients a year?-- Yes.

The fact that initially he was only signed on for one year isn't much comfort if he was poor in his standards and if he was seeing 700 people. You agree with that?-- The whole circumstances are tragic.

But you mentioned earlier that it was a locum position and you were confident that someone might be got in? You know, is

that right, that you thought that someone of some substance-----?-- My previous experience with locum surgeons from overseas, particularly from the US, was that they were extremely good. When I first arrived at Bundaberg, or very, very soon after I arrived at Bundaberg, Pitre Anderson went off on a sabbatical of three months and he was replaced by a US-trained overseas doctor. Now, it would be interesting to check on the records to see if he had over that three-month period obtained Australian Fellowship credentials. I don't know.

But-----?-- My experience, if I was limited, was that surgeons trained and credentialed in the US were able to provide a high level of standard.

There is 260 million Americans and you would accept, I imagine, as Dr Thiele said, that that country produces the best and the worst of everything?-- I accept that now.

A domain of having met some American surgeons, and perhaps even seen some of their work, wasn't much of a protection to find out whether Dr Patel was good or bad?-- I accept that now.

COMMISSIONER: Doctor, I wonder if I might interrupt Mr Atkinson by making something very clear: there seem to be some people who think that I see the function of this Commission of Inquiry as being to find scapegoats. Can I make it clear that that is not my interest at all. My interest is to find out what went wrong with a view to making recommendations that will assist to ensure that it doesn't happen again, and if we can achieve that, I frankly don't care about any of the rest of it. Doctor, let me make it clear to you that in no sense are you in our sights. We're not looking at you as a scapegoat. Indeed, from everything we have heard over three months, the people of Bundaberg are lucky to have you and it would be compounding one tragedy with another if your future at the Bundaberg Base was to be disrupted in any way. But we need to work out what went wrong, as it seems to me, from what we've heard so far, you accept that Patel's appointment was a tragedy, and I don't think anyone would disagree with that. You accept that there was a candidate, Lucky, who may not have been the best person in the world for the job but could have done it competently and would have prevented the tragedy which occurred. Do you accept that much?-- I do accept that much.

We also have the fact, as I see it at the moment, that when Patel went before the Medical Board, it was on the understanding that he would be appointed to a position with the rank of SMO but an SMO who would be working under the direction of the Director of Surgery rather than an SMO who was also Director of Surgery?-- Mmm.

You accept that as well?-- I accept that.

Would you also accept that in all likelihood, if Patel's name had gone before the Medical Board as an appointee to the

position of Director of Surgery, the Medical Board might well have insisted on one or other or both of two things: one is supervision, that's one possibility; the other possibility is a closer look at his background and qualifications, and either of those could have prevented the tragedy as well?-- Yes.

So, as I see it at the moment, we've got a combination, a confluence of misadventures, but some of those misadventures include the fact that an available Australian-qualified surgeon was not given the position when he could have been and a foreign-trained surgeon was given the position in circumstances where the Medical Board was not given the full facts?-- Uh-huh.

Do you agree with that?-- Yes, I do.

MR ATKINSON: Doctor, as it turns out, you weren't just looking for one American surgeon, you went out looking for two in that period?-- As it turns out, we initially were looking for only one.

All right?-- And that was on the basis that we were going to get the applicant that we offered the position to and it was - it was the applicant who was successful in the first round of interviews. When Lucky pulled out, we had to increase the ante and we had to ask - we had to fill it with two locums.

All right, two SMOs?-- Two locums.

All right. Initially you get Dr Patel. I understand from reading Dr Gaffield's statement that Dr Gaffield applied for that position as well?-- That's correct.

But Dr Patel was more impressive?-- On paper, absolutely.

And then when you needed a second locum, as you say, you went back and got Dr Gaffield as well?-- Yes.

So you sent him a letter on the 9th of January 2003?-- Yes.

At that stage you have got these two surgeons coming in?-- Yes.

Patel's to start on the 1st of April 2003?-- Yes.

Dr Gaffield's to start on 28 April 2003?-- Yes.

It is clear that from your point of view Patel is the more senior one?-- Yes.

Older, more experienced and does more general surgery?-- That's correct.

Dr Gaffield, at best, complements Dr Patel because he does plastics, and he has been doing them for three years?-- Absolutely.

If either of them was to be the director, it would have to be

Dr Patel?-- In my mind, he was the natural choice.

Right.

COMMISSIONER: On paper?-- On paper.

Yes.

MR ATKINSON: Doctor, KN12 - so that's - sorry, in your major statement, the 12th exhibit is called Kees Nydam 12?-- Yep.

And that's an email dated 9 April 2003?-- Uh-huh.

Where you write to Georgie Rose and Val Coyle and say, "If we're not paying Jayant Patel the director's allowance"-----?-- We should.

-----"we should."?-- Yes.

So within eight days of him starting work, certainly the decision's been made that he should be the Director of Surgery?-- The Acting Director of Surgery.

If you look at the email, it doesn't say that word, "acting"?-- No.

But you think that's what he was?-- That's what my intention was.

COMMISSIONER: And, doctor, you would agree that regardless of what your intention was, I don't think once the word "acting" appears in connection with Dr Patel in the position of Director of Surgery?-- No - yes, I agree with that.

MR ATKINSON: More than that, doctor, the word "acting" suggests that he is a stopgap measure, that you are out there somewhere else looking for the real director?-- Yes.

But you are not aware of anyone seeking the real director in the course of 2003 or 2004?-- As a - as my understanding of process, you can appoint anybody as an acting director without going through a formal appointment. You cannot appoint anybody as a permanent director without going through an appointment's process.

My question, doctor, is different. If we accept Dr Patel was only acting up?-- Yep.

The corollary of that is someone is out there trying to find a substantive permanent director?-- I would hope so.

You don't have people acting up indefinitely?-- Well, I was acting for 18 months.

Sure.

COMMISSIONER: Yes.

MR ATKINSON: But the point is you are not aware of any attempts after 1st April 2003 to secure a new director?-- No, I am not.

It is as if he was there and everyone understood that he must be the director because there is no-one else on the horizon?-- Well, he was there on a 12 month contract.

Which he might have renewed or might not. As it happened he did?-- Mmm.

Can you comment on this: we heard evidence from a Dr Geoff de Lacy?-- Uh-huh.

Who said that - you know Dr de Lacy?-- I do.

You know he used to be the Director of QEII, the surgical department there?-- Yes, I do.

He has worked for maybe five years in rural Australia?-- Yes, I do.

He says that he comes into Bundaberg in July 2003?-- Mmm.

And approaches the hospital about doing VMO work?-- Uh-huh.

But he is told that recruiting a general surgeon isn't a priority at that time?-- I understand that's what he would - that's what he would have been told. I mean, I didn't tell him that but I understand that's what he would have been told.

I guess I am wondering this: if anyone was thinking maybe we need a new Director of Surgery, they might have approached or nibbled when Dr de Lacy came along and suggested to him, "Well, are you interested, given that you are a Fellow, given your experience as a director, would you like to be the director?"?-- My understanding is that you have got funding for four - for two full-time surgeons and a number of part-time positions. If all of your - if all of your funded positions are allocated, you are not in a position to offer anybody anything. You are certainly in a position to commence some kind of a dialogue but at that particular point you don't have anything to offer him.

I know in the past people like Dr Strahan have been the Director of Medicine but only given maybe two or three sessions a week to the hospital?-- Sure. It is - there are certainly lots and lots of precedents, and, as I understand, there is no objection to having a VMO as a director.

And wouldn't that have been an ideal situation, that you have someone like de Lacy, he is not chewing up the funds because he is not there all the time, but he has the expertise as a director and he can come in to supervise and to make sure there is some peer review for your two Americans?-- That would have been fantastic.

Do you know why that wasn't a course that was explored?-- I

don't. At that particular point, I understand I had already left the job.

COMMISSIONER: Well, that makes me wonder when you did leave the job and you were replaced by Dr Keating, did you make it clear to Dr Keating that so far as you were concerned, Dr Patel was merely acting in the position of Director of Surgery and that it remained a priority to find a permanent appointee for that position?-- At the time of handover, at the time of handover I understood that on paper Dr Patel certainly looked very, very impressive to me.

Yes?-- What I also understood was that even though he was there as a locum, as a temporary appointment for 12 months, it would be a tremendous strategy if, having proved himself during that 12 month period, we could try and entice him to stay longer. That was my strategy at the time. In retrospect, that was - I mean, that was a dumb strategy to have.

I am sure I can say that no-one would blame you for that because on paper you didn't know that he had misrepresented?-- No, I didn't.

Misstated his work history, and on paper he came across as a most experienced and impressive surgeon?-- That was how I was impressed.

Dr Nydam, I won't press you to answer this if you feel uncomfortable, but it sounds to me that the whole talk about Dr Patel being a locum is your way of rationalising a system of administration which just doesn't give you the resources and support and back-up to get the right person for the job, and there was a bit of - I don't use this in a pejorative sense, but it was a bit of a trick to call him a locum for the first 12 months in the hope that he would ultimately hold the position permanently?-- That would have been a strategy that was going on in my mind.

Yes. So even if it were literally or technically true to call him a locum, it is equally true to say that there was no intent to find a permanent Director of Surgery whilst Patel was at the hospital?-- That's right.

And that's why someone like Geoff de Lacy would have been told, "Thanks, but no thanks."?-- Yes.

D COMMISSIONER EDWARDS: Following up the Commissioner's point, is there a policy relative to the length of time a locum is appointed, or is a locum in perpetuity till the position is filled?-- I am not sure. One of the things that influenced me in my thinking was that we had appointed an overseas Senior Medical Officer, right, non-Australian credentialed, non-specialist, to the position of Director of Anaesthetics, Director of Intensive Care. This gentleman's name was Dr Martin Wakefield. He came with impressive credentials from over in South Africa but was not recognised as a specialist in this country. During the time that he

worked with us, he was able to make the necessary applications and obtain Australian qualifications and credentials. I understand he now works at the Prince Charles or the PA Hospital as a highly valued member of that staff. I guess I wasn't trying to be defensive about the - you know, about the locum SMO story. I guess what I was trying to impress on the Commission was that there was certainly, in my mind, lots of precedents where we had - where we had adopted the view of bring someone in as an SMO, encourage them to obtain Australian qualifications - I need to add that on several occasions I tried to get Jayant Patel to upgrade and apply for an Australian specialist qualification. At the time, it really didn't click why he would have avoided doing that, but now in retrospect it is absolutely clear. But I am just citing the example of SMO, Australian qualification, someone who is in the job and is a highly valued member of the medical clinical community, and I guess that's what I was hoping to reproduce with Jayant Patel.

But that wasn't the question I asked?-- I know. It was a comment.

I asked the question if you appoint a locum, don't you think there should be an appointment for a set time with potential, but what it seems to me - and I may be totally wrong - that he was appointed a locum infinitum?-- Well, the contracts are only a 12 year contract.

MR ATKINSON: 12 month.

COMMISSIONER: 12 month?-- Sorry.

D COMMISSIONER EDWARDS: For a locum - I am stressing the point a locum?-- Yes. That's a very, very unusually long period of locumhood.

I would think so?-- I really believe that we should look at that particular issue, and I don't know what your recommendations are going to be, because your recommendations have to hopefully match what is practical, but certainly it is wrong to have a locum for 12 months.

And-----

COMMISSIONER: Doctor, we had an example in Townsville a couple of weeks ago about a neurosurgeon coming from the United States as a locum, for I think it was two months, or something like that, and the Townsville Hospital was trying to lure him to that city, attract him with its climate and other advantages, and for his part he wasn't sure whether he wanted to move to Townsville. That's the sort of situation where I would think it is not only proper but desirable that locum positions be available for people interested in coming. But the notion of having Dr Patel arrive in Bundaberg on a 12 month contract and then be appointed within days to the locum Director of Surgery, particularly when the word "acting" or "locum" or "interim" is never attached to it?-- Yeah.

He was, so far as the entire world was concerned, the Director of Surgery at Bundaberg. It is, at least with the benefit of hindsight, an unsatisfactory way of-----?-- It is. If I could have permission just to explain another thing that was in my mind?

Please do?-- When we employ locums, the average rate for a locum is $1,500 per day. In a sense, Jayant Patel was a bit of a fool. Because he could have asked for that amount, and, the market as it was, he would have been given it.

Yes?-- I guess a part of going through my mind - and I guess I was seduced. This guy looks so fantastic on paper, that I felt embarrassed that we employ a guy with those sorts of credentials and we pay him less than what a locum second year - second year graduate earns working in most emergency departments, embarrassed, and if I had any little cherry I could give him to cover my embarrassment, then that was it.

Doctor, you would also agree, though, in theory at least, the reason that locums are paid a higher daily rate is because it is a temporary position and there is no guarantee that the job will be there in a month or three months' time?-- Yes.

Patel, in a sense, had the benefit of a secure 12 month contract with every chance of renewal without having to go through the hoops to prove his credentials to get the position of Director of Surgery?-- Yes.

That's what went wrong here?-- Yes, that was one of the major - but there was a lot of - there was a whole series of things.

Yes.

MR ATKINSON: I've put another document on the illuminator before you. You will see that it's an e-mail dated 20 December 2002 and it's from you?-- Mmm.

I'm only interested in the last paragraph where you say of Dr Patel, "Payment in the first instance will be as an SMO". Is it fair to infer from that that you expected that quite soon after he started he would receive the loading attributable to a director?-- I just need to read it because I haven't-----

Sure?-- Payment in the first instance would be as a senior medical officer, yes.

And my question is this: is it fair to infer from that that what you were thinking is that, "He will start as an SMO, but as soon as we get him here we'll make him the director and give him the loading attributable to a director."?-- No, no. What was in my thinking was that he would get here - or he would get there, after a period of time he would say, "Hey, this is okay. I like it here. I'm going to apply through the College to become an Australian recognised Fellow", and the payments would change.

All right?-- That's what was in the back of my head, something that he never did.

All right. Can I just suggest this: we heard evidence from Dr Strahan that the first day that Dr Patel arrived he was introduced as the Director of Surgery. That's something that could have happened?-- Yes.

You've said yourself that within eight days of him starting-----?-- Yes.

-----he was paid on the Director of Surgery's pay rate?-- Yes, yes.

It's pretty easy to see that no-one else was going to be the Director of Surgery?-- Mmm.

Can I just suggest this to you straight up: from at least December 2002, you had Dr Patel earmarked as the likely Director of Surgery?-- Yes.

And that doing the best you could with the funds, that wasn't something that might be done through the proper formal process, but it was done?-- Yes.

And similarly for that reason, although you've got your two American surgeons by 12 January 2003 when Dr Gaffield's accepted as well, and although Dr Patel's formal registration from the Medical Board doesn't come through completely until 1 April 2003, there's no thought given to going back to the Medical Board and saying, "He's not really an SMO because he's not going to be accountable to the director."?-- No, that didn't happen.

You mean to say you didn't go back to the Medical Board?-- I didn't go back to the Medical Board.

COMMISSIONER: Was that a deliberate choice or was it just oversight?-- It was oversight.

MR ATKINSON: And the result of all this is there isn't anyone supervising Dr Patel from 1 April 2003?-- That's correct.

And even when Dr Gaffield came, he certainly wasn't a supervisor?-- That's correct.

Doctor, you spoke a bit earlier about the process?-- Mmm.

Normally when you engage a Director of Surgery on a permanent basis, is this right: you get - one person comes up from Charlotte Street and someone comes across from the AMA and they sit on the selection panel?-- The process that I had been used to is that you convene an Appointments Committee. The Appointments Committee should be - ought to include a representative of the College-----

Right?-- -----it ought to include the Director of Medical Services, and it ought to include the District Manager. You can put any additional people on it that you wish. That's my understanding of the process, although I have never seen a - anything which is written. I haven't seen a written protocol. That was my understanding.

And as the acting DMS, you took the view that since Dr Patel was a locum Director of Surgery, if you like, you could appoint him without going through any formal panel like that?-- I took the view that because he was a locum, because I was appointing him as the acting, that I could do that without an Appointments Committee, that's correct.

Doctor, you mentioned earlier that you had encouraged Dr Patel to seek registration?-- Yes.

Can I - to be fair to you, I'll show you an e-mail that records that?-- All right.

COMMISSIONER: Just for the record, the last e-mail - the last document you were looking at forms part of Exhibit 50.

MR ATKINSON: In terms of quality control checks, one quality control check - one opportunity was the appointment process, and obviously there were various factors working to cause

aberrations there. The second was that if Dr Patel had applied for fellowship, then that would have precipitated more exact scrutiny of his qualifications?-- Yes.

And as you say, you went to some trouble to suggest that he do that?-- Yes.

You explained that it was a win-win situation?-- Yes.

Do you know whether hospital management ever followed that up, given that it was this win-win situation?-- I'm not aware of that.

Is there a process to make sure that - to follow people up? Is there some protocol about talking to doctors-----?-- Well, I know that James Gaffield did, and he got his Australian specialist qualification. Apart from encouraging him to do that, I'm not sure if there would be any other process.

COMMISSIONER: Dr Nydam, do you recall roughly when Dr Gaffield got his Australian specialist qualification?-- No, I don't.

I'm just wondering, if we pursue for the moment the theory that Dr Patel was just a locum, or just acting in the position of Director of Surgery, if you have that mindset, then surely when Dr Gaffield got his Australian qualification some thought would have been given to making Dr Gaffield the Director of Surgery?-- That would have been a good idea. I guess once again you've got the question of the skill sets.

Yes?-- We appointed Dr Gaffield with full knowledge that his major interest was in plastics. There was no secret that he was looking at the job in Bundaberg as a stepping stone into becoming a permanent Australian citizen with an Australian credential and maybe/maybe not moving on. It would seem reasonable that if you've got an interest in plastics - and plastics isn't a priority to be funded within the public sector - that anyone with a plastics credential would eventually move out into the private sector. I mean, does that answer the question?

I think it does, yes?-- He had a skill set that was fantastic, he had an Australian qualification, but he didn't really have the general surgical focus of his work.

I just see it as another example that the idea of Jayant Patel being a locum, who was only acting in the position of Director of Surgery, becomes more and more to look like a pretext rather than a genuine-----?-- If I look at it - if I look at the failure - in retrospect I would have offered the Director of Surgery to someone like Neil Robinson.

Yes?-- Even though he's an orthopaedic surgeon, everything has got advantages, everything's got disadvantages, but I think on balance, if I had my time all over again I would have at least offered the position to Neil Robinson.

Or even to a VMO?-- Or even to a VMO.

MR ATKINSON: What is the job of the Director of Surgery as opposed to a staff surgeon? What else is incorporated?-- Well, the job at Bundaberg is anything that the director wants to make of it, from the very, very minimum of putting names on an afterhours cover roster to attending the usual quality meetings once a month. As far as you want to go.

Doctor, you mention in that e-mail that, "If you become a specialist we can charge more."?-- That's correct.

Is that in the weighted separations or-----?-- No, no, that's got to do with - as I understand it, that's got to do with being able to recoup from patients seen in the outpatient clinic-----

When they use their Medicare number?-- When they use their Medicare number.

That's some of that cost shifting we spoke about?-- Yeah, yeah, which I don't understand.

No, okay. Can I tender that e-mail, Commissioner?

COMMISSIONER: Yes, certainly, if that can be handed up.

MR ATKINSON: Doctor, I wanted to turn to the-----

COMMISSIONER: Exhibit 274 will be the e-mail from Dr Nydam to Dr Patel of 25 February 2003.

ADMITTED AND MARKED "EXHIBIT 274"

MR ATKINSON: Doctor, I wanted to turn to the issue of credentialling as the third mark, if you like, when somebody might have pulled up Patel but it didn't happen?-- Yes.

You will see this e-mail in front of you. It's from Dr Patel to Dr Bethell?-- Yes.

And this is something that's consonant with evidence we've heard a number of times. If you asked Patel what he was good at in terms of general surgery, he didn't like to limit himself. He took the view he was good at everything?-- He had a very, very highly inflated view of his own ability.

Even allowing for some cultural stuff - I mean, when you see here in this e-mail he sets out what he's good at, he just pulls up short of vascular surgery?-- Mmm hmm.

But he's good at most things?-- Mmm hmm. Yes.

And that has to make you a little bit sceptical, I guess?-- I guess it goes back, you know, to the issue of we all hope that we are able to find generalists, even though they are a disappearing breed.

COMMISSIONER: And none of us assumes that a person is lying to us when they talk about their skills?-- It's in the eyes of the perceiver. It's in the eyes of the person who has the view.

MR ATKINSON: In paragraph 37, doctor, you mention that once Dr Patel commenced, there was no formal guidance or direction in respect of his scope of practice. Then you go on to say, "I assumed he would operate within the scope of his experience and prior practice", because he was a senior health professional?-- Yes.

There's a saying in Italy, trusting is good, not trusting is better?-- Mmm.

The whole purpose, isn't it, of the credentialling and privileging is to make sure that people can do what they think they can do?-- Yes.

All right. But that seems particularly important when you've got a fellow like Dr Patel. He's foreign, he's not going to be subject to the same peer review as someone at the PA is, he's got a catchment area of about 80,000 people, and despite what he says, he might be all hat and no cattle?-- Which he was.

All right. But in 2002 the credentialling and privileging process in Bundaberg Base Hospital was dormant, to use a word from Dr Keating?-- Mmm hmm.

People weren't doing it?-- Mmm hmm.

It seems in retrospect - and we're coming into this with all this hindsight, as the Commissioner says, but it seems like it's one of the most fundamental checks on the system?-- Yes.

General surgery covers things from mastectomies to oesophagectomies to bowel problems?-- Yes.

Everything around the abdomen. Most people might say they specialise in an area like endoscopies, but not everything, and if you have a good committee, the whole idea is that people be reviewed by their peers?-- Mmm hmm.

It's not a bureaucratic process, it's about people with clinical skills like yourself-----?-- Yes.

-----preferably close to the person being reviewed-----?-- Yes.

-----seeing what their skills show, and more importantly, I guess, doctors take a lot of stock of, "Is this someone who has done this operation many times before"-----?-- Mmm hmm.

-----and you look at that?-- Yes.

A neurosurgeon might say, for instance, of another neurosurgeon, "Thirty operations in two years, that sends off all kinds of alarm bells. That's not enough operations."?-- Yep.

COMMISSIONER: Doctor, not being very learned in Italian sayings, there's an Australian one that comes to mind, and that is if something looks too good to be true, it usually is?-- Mmm.

Did it ever cross your mind that if Jayant Patel was as skilled and as qualified and as experienced as he claimed to be, why would he leave the United States where a surgeon can make half a million US dollars a year plus to come to Bundaberg and get paid, I think, a base rate of 80,000 plus a package that I think was worth about 140,000, plus overtime that might have taken him close to 200,000 Australian dollars. Did that cross your mind?-- That crossed my mind quite early in the piece. One of the other errors of judgment which I made was that I took his explanation at face value. His explanation was that he had worked hard, he had earned a lot of money, and now it was time to give something back. Now, I've long taken the view that people who work in public health are either missionaries or idiots, and I thought that he was a missionary. That was an error of judgment.

That leads me to another question. I can't quote you his exact words, but I certainly had the impression from the evidence of Dr Brian Thiele, that with his contacts in the United States and elsewhere, it would have taken him two or three phone calls, maybe five or 10 minutes to find out the truth about Patel?-- Yes.

It never occurred to you to speak to Dr Thiele or anyone else-----?-- No, it didn't.

-----to see whether you could informally obtain verification of Patel's claims to be God's gift to surgery?-- No, it didn't.

D COMMISSIONER EDWARDS: Had you had any experience with Wavelength previously?-- Yes.

Were you satisfied-----?-- The previous experience that I had had with Wavelength was that they were a pretty superior recruitment agency, and I was particularly happy with past people that I had obtained through them.

I'm asking that, because in his letter to Dr Bethell on 13 December he talks about his training and experience, but in the submissions we've had, we really have not had a great deal of information that that training and experience was broad enough to get this position, and I think in retrospect everything is easy - I understand what you're saying - but I am gathering the feeling that Wavelength may not have got as

much information to be provided to the hospital as they could have?-- I think one of the problems in retrospect was that there were three bodies all hoping that the other person was doing the work. I was hoping that the checks would be done by Wavelength, Wavelength-----

They were being paid for that?-- -----was hoping that the checks were being done by the medical registration board. I was hoping, they were hoping that I would, and I think - yeah, there's a mismatch of what the expectations of each of the other party were. That's a part of the tragedy.

COMMISSIONER: You raise yet another point that's gone through my mind many times in the past three months, and that is why Queensland Health doesn't have its own recruitment operation rather than paying - whatever it was, 15 or so thousand dollars to a firm in Sydney that, at least on this occasion - and I don't mean any criticism in this, but on this occasion perhaps didn't scrutinise the candidate as closely as might have been desirable. Do you see some merit in a future approach which involves Queensland Health doing its own recruitment?-- Look, we had the same issue down in New South Wales, and I believe the same issues are generic in all of the states. Unfortunately it was assumed that in order to have a robust recruitment system, you had to have clinicians - or you had to have someone with clinical experience actually doing the interviewing and the gathering and everything else. Your issue about writing letters and all of the bureaucratic stuff - are you going to use someone within your own organisation on the shop floor? Are you going to send them overseas and - for recruitment? I guess in the past state health organisations have thought that it would be far better use of their resources to outsource that - the recruitment process.

I guess one of the tragedies-----?-- I don't know.

-----that flows from that is we've heard evidence from the Executive Director of the PA Hospital which was to the effect that they have no trouble with recruitment because they've got a lot of money, comparatively with other Queensland hospitals, they've got a great reputation, they're internationally known, they've got - amongst their staff they've not connections overseas and so on. It seems to me that the hospitals that are in the most trouble for recruiting staff also have the least resources to do so, and that a more equitable system would be one that Queensland Health recruits for the entire state and people are sent on the basis of need rather than capacity to pull strings?-- I don't know if it would - I think any idea should be on the table.

Yes?-- I guess my concern is if I was a German doctor and I wanted to go to Cairns because I heard that Cairns had some pretty attractive social and cultural opportunities, I would wish to contact Cairns rather than a central body who could send me to somewhere else.

Yes, Biloela or wherever?-- Yes.

MR ATKINSON: Commissioner, can I tender that e-mail?

COMMISSIONER: Yes, indeed. Doesn't that already form part of Exhibit 50?

MR ATKINSON: Not that one. The one before that, actually.

COMMISSIONER: I thought it did, but all right. Sorry, you're perfectly right. The e-mail from - it's an e-mail from Dr Patel to Dr Bethell, which was forwarded by Dr Bethell to Dr Nydam, dated 13 December 2002. That will be Exhibit 275.

ADMITTED AND MARKED "EXHIBIT 275"

MR ATKINSON: As a quality control measure, certainly before 2003, the idea of privileging was well accepted, not just in Queensland, but across the world?-- Yes.

And there was a Queensland Health policy both for - generally in Queensland and for the rural areas?-- Yes.

What happened - how come there wasn't any privileging going on at Bundaberg base prior to, say, April 2003?-- One of the few things that I hoped to affect in my time as the Acting Director of Medical Services was to improve on the credentialling process. I was concerned, because at that particular point the credentialling process involved using local people to credential their mates, and it concerned me that if you had a division - either a medical division or a surgical division or whatever - in the case of obstetrics and gynaecology, if you had two people, then effectively what you've got is you've got one mate credentialling his mate. That concerned me greatly. What I tried to establish was a larger pool, and that larger pool involved trying to establish a credentialling process that would involve all of those doctors in the Bundaberg area, as well as those at Hervey Bay, as well as those at Maryborough, so that there was a larger pool, so that there would be, you know, the possibility of some independence, some impartiality.

COMMISSIONER: Mr Atkinson, we might have to leave it there, for the reasons I mentioned earlier. We'll resume at 2 p.m.

MR ATKINSON: Thank you, Commissioner.

THE COMMISSION ADJOURNED AT 12.24 P.M. TILL 2 P.M.

THE COMMISSION RESUMED AT 2.09 P.M.

CORNELIUS MARTINUS JOHANNES NYDAM, CONTINUING
EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Atkinson?

MR ANDREWS: Thank you, Commissioner. Dr Nydam, prior to the luncheon break you were speaking about privileging?-- Yes.

And I suggested to you that effectively the privileging regime at Bundaberg Base had been dormant until about 1 April 2003?-- That's correct.

And if I could take you to this policy that's on the screen before you, this seems to encapsulate some of the ideas you mentioned. Doctor, sorry it has an effectively date of 1 January 2003?-- Mmm-hmm.

Could I ask you to scroll up? Initiator as Dr Darren Keating?-- Yes.

Does that mean that it's been backdated in a sense, because he wasn't there on 1 January 2003, was he?-- Look, I don't recall all of the dates, but I certainly can recall that this process was a process which I actually started.

Right. And what ws special about it, I guess, is that it has this Fraser Coast regime that you spoke about?-- Yes.

So that rather than having somebody credentialed by a mate or a rival, you can include Maryborough and Hervey Bay and have a bigger pool of experts?-- That was the concept.

Right. Now, you'd had quite a bit of experience with foreign trained doctors at the hospital?-- Yes.

And they were a mixed bag, it's fair to say?-- Yes, yes.

You had a particularly - a couple of particularly poignant encounters, one was with Dr Andy, I think, who had to leave very abruptly?-- Yes.

Like in that night?-- Yes.

Because he didn't have the proper visa for working?-- That's correct.

And you had another incident, if you like, just prior to Dr Patel's arrival with a Russian doctor, called Dr Anatoli?-- That's correct.

He maintained he was a paediatrician with qualifications from Russia?-- Yes. That case was a bit of a disaster.

You will die without knowing whether he really was a paediatrician?-- I'm not sure - that's a question?

You don't know whether people have questioned his qualifications?-- I questioned his qualifications myself.

Dr Lucky questioned his qualifications?-- Yes.

You still don't know whether he was a paediatrician?-- Well, he didn't claim to be a paediatrician, he claimed to be a paediatric surgeon. There is a difference.

Sorry. Well, can I mutate my question?-- Okay.

You didn't - still don't know whether he was a paediatric surgeon?-- I still don't know.

Right. All of that sounds very loudly for the benefits of credentialing and privileging?-- Absolutely.

Right. It's particularly important, I guess, in a country hospital because you don't have the same benefits of peer review that might pick up problems on a day-to-day basis in somewhere like the PA where you have 20 theatres?-- That's exactly correct.

D COMMISSIONER VIDER: Doctor, would you see in a place like Bundaberg there's an opportunity for the purpose of credentialing practitioners that you could have the private and public sector coming together?-- I think that would be an excellent idea.

MR ATKINSON: The thing that agitates for the credentialing here is that you were aware in the course of speaking with Wavelength that Dr Patel hadn't worked for a year?-- I was aware of that, but it was not something that I picked up on as being particularly important in view of the conversations we had on the telephone.

All right.

COMMISSIONER: You're referring particularly to the fact that you were led to believe accurately or otherwise that Dr Patel had made a lot of money?-- Yes.

Was essentially retired and now wanted to come to the New World and do some good works?-- Yes, yes.

MR ATKINSON: But the things you were hearing about how good Dr Patel was were coming from two sources, Dr Patel and the recruiting group who stood to make over $10,000 if he was accepted as the candidate?-- That's correct.

All right. Well, against that background do you know yourself why it was that the credentialing and privileging process wasn't applied to Dr Patel?-- Well, my understanding, and I mean it's obviously a bit of an issue, my understanding is

that the processes in terms of credentialing of locums is entirely different.

Well-----?-- We have locums working at the hospital right now who haven't ever been credentialed.

That means you have this bizarre situation, doesn't it, where - just let me finish - people like Dr Strahan, who are fellows in their college, and people like Dr Miach who are well regarded, they get credentialed in a fairly careful way?-- Yep.

But the fellow who comes in from America or India or Pakistan only for a year, no-one scrutinises him?-- I think that's a very good word.

Which one?-- It's bizarre.

All right. Can I show you these minutes from the credentialing committee. Maybe go to the next page - well, even on that first page you will see down the bottom, in particular, Dr Judith Williams?-- Mmm-hmm.

She was a paediatrician, wasn't she?-- That's correct.

But she had to put herself up for privileging?-- The usual rules are that everyone needs to be recredentialed every three years.

Right. And then can we go to the next page. And it wasn't - it seems to me from reading this page this wasn't a case of just rubber stamping things, for instance, with Dr Miach it was subject to evidence of the College of Physicians and an audit of the renal biopsy procedures?-- That's correct.

All right. So, it was applied with some vigour and yet, as you say, there was this bizarre factor that if you got a locum job for a year we would scrutinise them less than we would people from the colleges?-- Yes.

D COMMISSIONER VIDER: Doctor, since this has all happened, has that process changed, so that you now do scrutinise locum appointments as well?-- The last locum I'm aware of was Dr Martin Knapp who came up to work for a fortnight. My understanding is that he was not credentialed.

MR ATKINSON: I tender those minutes of the credentialing committee.

COMMISSIONER: You also tender previous document which was the credentialing policy?

MR ATKINSON: Sorry, Commissioner?

COMMISSIONER: There was a credentialing policy supposed to start from the 1st of January 2003.

MR ATKINSON: Yes.

COMMISSIONER: Is that already-----

MR ATKINSON: Actually I think that's come back without being tendered.

COMMISSIONER: Yes.

MR ATKINSON: I should tender that too.

D COMMISSIONER VIDER: Doctor, you could have an expedited review process for someone that might come in as a locum who is known to you or easily able to be checked, you know, as opposed to someone that might be an overseas trained doctor-----?-- Mmm.

-----coming in. If you have got a committee that meets once a month, for example, and you have got a locum coming for two months, you can't always wait, perhaps, but you could have an expedited review process without having to chair as a committee, and the Director of Medical Services or somebody could check it out. Otherwise you can't define their scope of practice while they are in your facility?-- Yes. Look, I have been trying to cogitate on this for some time and I would see this as being a tremendous advantage, given that the majority of our locums come from interstate.

Yes?-- That registration and credentialing is an Australasian process, rather than a State driven one, because then the idea of currency would be a lot easier to - be a lot easier to actually check and keep some kind of track of.

The registration part?-- The registration.

Credentialing would probably need to be looked at individually so that you could assess the frequency of practice, et cetera, for doing particular things, whatever. You can put the boundaries around people?-- I guess the colleges have really taken - have taken on credentialing and continued - you know, medical education, updates, really quite seriously, and if you look at the process in lots of instances, what you need to do is send some kind of a log book or some kind of evidence of your maintenance of professional skills to your college. So, it's really just the question of checking up to see if people, providing they have come from Australasia, in fact have currency within their college, and all of those - all of the details which were on the last - on the last thing-----

Yes?-- All that you do actually is that you resubmit what you have already submitted to your college.

COMMISSIONER: Exhibit 276 will be the Bundaberg Health Services District policy and procedure document entitled Credentialing and Clinical Privileges for Medical Officers. Exhibit 277 will be the Bundaberg Health Service District Credentialing and Clinical Privileges Committee minutes dated the 26th of November 2004.

ADMITTED AND MARKED "EXHIBIT 276 AND 277"

COMMISSIONER: Doctor, just going back briefly to the policy document, which although bearing Dr Keating's name you say you were either the author of or at least you instituted the preparation of?-- I instituted the preparation.

Yes?-- You know-----

It doesn't reflect the distinction you refer to in your evidence between permanent and locum appointments. On the face of it it should apply to all medical practitioners utilising the district health facility?-- On the face of it, I would recommend it applied to everybody before they stepped into the hospital.

Yes, on a hospital by hospital basis or you think that could be a broader basis?-- Well, that's the reason why I can see that there would be certain advantages in actually having it Australasian-wide because you have locum doing a fortnight here, three weeks there, fortnight here, and a tremendous amount of duplication. What you really need if there was some central - you know, database then it would be a question of just providing a certificate of good standing from your college.

MR ATKINSON: That was one of the advantages, I understand, doctor, of the Fraser Coast umbrella?-- Yes.

That a doctor could move between Maryborough, Hervey Bay and Bundaberg with the umbrella understanding that he or she had correct privileges that were transferable?-- Well, I guess that was one of the advantages. The other advantage is that - it's really the key - if, for example, you are credentialing a paediatrician, that you have a representative from the College of Paediatrics. Now, it would require a tremendous amount of man hours if a representative of the college was to flitter around and attend credentialing meetings at every hospital.

Sure.

COMMISSIONER: It doesn't have to be done with a face to face meeting, would it? You could bring in a represented college on the telephone?-- You could. You could. Telephone or telelink.

Yes.

D COMMISSIONER VIDER: My understanding is, doctor, the rigour that's now being sort is so that the reason for doing it for each individual hospital facility or little group of them is so that you can put it within the context of the service capability of a particular hospital?-- That's-----

So it may be you say to the general surgeon, "You cannot open a thorax here because the intensive care and the support services are not available"?-- That's correct.

Or, "You can't do whatever here because this, that and the other's not available", "You can't do that for a child here because there's no paediatric intensive care services"-----?-- Mmm.

-----available.

MR ATKINSON: The combination of looking at the surgeon's experience and the serviceability - the service capability framework in Bundaberg, for instance, about an issue like oesophagectomies might have had a difference on the outcomes?-- Absolutely.

You mentioned it wasn't the practice to credential locums?-- Mmm-hmm.

But the evidence, I understand, of Dr Keating will be that some effort was made to credential Dr Patel?-- Mmm-hmm.

But it wasn't possible to get a nominee from the College of Surgeons?-- Well, that is one of the problems that - you know, the people who are going to represent the college have to also look at the opportunity costs.

Right. I put an e-mail in front of you on the screen?-- Okay.

You know that one?-- Yes.

Were you aware of the problems obtaining a nominee from the college?-- I was not aware of this particular case, but I am certainly aware generically that it can be very, very hard to find college nominees.

Doctor, I don't mean to be offensive by this question, but there's been some suggestion from various of the witnesses that sometimes within Queensland Health people get obsessed by process?-- Yep.

Instead of the result?-- Yep.

And this seems to me to be something of an example for this reason, where there are good surgeons who are well qualified, and many of them are in Bundaberg where it seems to be rather blessed in proportion to other places, and they have good standing, regardless of whether or not they are nominated by the Royal College of Surgeons-----?-- Mmm.

-----to do privileging-----?-- Mmm-hmm.

-----there was no reason why the hospital couldn't avail itself of Sean Mullin or Pitre Anderson or Brian Thiele without waiting for the college?-- Not reason at all, no reason at all, but the college would have to nominate them.

You do it for the protection of your patients, not to make the-----?-- Okay.

-----college happy?-- Okay. I guess there is an advantage in using what is available locally. There is also an advantage of having some impartial independence.

You don't want a competitor or a mate?-- That's right.

But Sean Mullin or Brian Thiele couldn't be described as either of those things vis-à-vis Dr Patel?-- No.

So it's just a breakdown in the system really?-- It is.

People didn't think laterally?-- That's right.

Or flexibly enough?-- That's right.

Doctor, I was going through, you might recall, landmarks where maybe Dr Patel might have been picked up?-- Mmm-hmm.

The fourth one I wanted to look at is a suggestion amongst some doctors that Dr Patel impugned himself. The suggestion was that he did three things that meant he wasn't really amenable to scrutiny. The first was that he was more reluctant than other practitioners to transfer patients. The second was that although he had audit meetings, they tended to be more a lecture from Dr Patel rather than him inviting second opinions on his cases?-- Mmm-hmm.

And the third was that in his meetings with people like Dr Thiele, Dr De Lacey, he tended to have quick chats in the corridor and never to form any close relationships or working relationships with them or - in fact, even with Dr Gaffield?-- Mmm.

Looking at those three things then, the transfers, the audits and the relationships, do you recall evidence of that?-- The only really one that I have got a degree of direct evidence of, a direct involvement, are the clinical audits. The Thursday lunchtime was a time that was set aside for some kind of clinical teaching. That was every month that the clinical teaching took the form of an audit.

That's a scary thing, isn't it? Instead of it being one of these M and M meetings where there's a free-flowing discussion, you have got your alpha male teaching people?-- Yes, yes.

That's not good?-- Absolutely not.

That's not what the process should be?-- It is not good. I guess it would be interesting - those particular meetings were and continued to be open to anyone who wants to come. It would be interesting to know why the other surgeons didn't avail themselves of the opportunity of coming. So if you have only got an alpha male there, he's going to hold court.

COMMISSIONER: Doctor, when you were Director of Medical Services, was it your practice to attend such audit meetings?-- As many as I could.

What has been your experience with Dr Keating?-- I'm not aware that he attended as many as I did. I don't go to all of them, but if I was - if I was free I went to every meeting that I could. My impression is that Darren - Darren didn't do that. That's an impression.

One possibility is that if an audit meeting's being dominated by an alpha male with a loud bark, perhaps it's worth having an alpha male with a louder bark there?-- Absolutely.

MR ATKINSON: Or better still subvert the paradigm and say it's not about conflict, it's about discussion.

D COMMISSIONER VIDER: Doctor, would you think that there could be an evaluation of the committee process itself so that if it's not the best time in a lunch hour, which I know has gone on since time began, it may be that we need to review what is a more appropriate time, so that you can get people to go to the meetings and get them to say why it is they don't come if there are other than time factors that prevent them from coming?-- Mmm. It is highly desirable you get as many senior clinicians in one place for a - any kind of clinical audit, any sort of clinical meeting as is possible.

Yes?-- And that should be some sort of an objective that we should strive for, and if there are any sort of obstacles, those obstacles should be - well, addressed.

Are you aware that some places have their clinical meetings at 7 o'clock in the morning?-- I am aware.

They go for one hour and then they are in theatre by 8?-- I am aware of that.

MR ATKINSON: Would it be possible at Bundaberg to quarantine the M and M meetings so that people didn't have anything else to do except that during that time?-- You would have to try. There are a number of meetings and whilst I share half of the view that I feel comes out of this particular place about meetings, I think that sometimes they are important, and every possible combination, permeation has been tried. We have had meetings at 7 o'clock, we have had them at half past 5. It's more than simply organising a time, it's somehow they have to be sold to the senior clinicians as something that is important.

Right?-- And I think time is only one of the factors. I guess it comes back to, you know, formulating a real feeling of a team, and that seemed to be lacking.

Doctor, the other two things I mentioned, the first one was the reluctance to transfer. You didn't have any first-hand-----?-- I haven't had anything - yes, I haven't

had any first-hand-----

And the other, Dr Patel seemed to shy away from any kind of close rapport with other surgeons, like Patel - sorry, like Gaffield, De Lacey or Thiele?-- I haven't got any - any observations of that.

Something that seems to come out regularly in the evidence is also this - I will ask you to comment on it - that there is a complete dearth in all the records of this one thing with Patel, and that is letters to other experts, people in other fields asking for their advice-----?-- Mmm.

-----any discussions with the Director of Surgery at the RBH or oncologists or other people. Can you say whether in your experience he ever spoke to other people-----?-- Not from my experience.

-----other experts?-- No.

So, it's quite possible that in all these ways he was cocooning himself, but it wasn't really picked up by management?-- Mmm, yes.

That seems to be because perhaps the hospital in some sense was - had become a bit dysfunctional in terms of team work anyway?-- I think so, yes. And I guess he was also supremely confident, albeit ill-advisedly so.

D COMMISSIONER EDWARDS: Could it be also-----?-- It's his personality. I'm sorry.

Could it be - I am not defending him in any way - he just didn't know his counterparts in other hospitals as graduates tend to have when they come from a particular university or medical school?-- It could be that.

MR ATKINSON: Doctor-----

D COMMISSIONER EDWARDS: I'm not defending him, but I'm just asking what I think is a reasonable question to ask?-- I was disappointed when he didn't pursue credentialing through the college.

Right?-- As, in fact, you know, James Gaffield did. Because I was anticipating that that would be a natural progression.

And that would have, though, had an impact upon him?-- And that could have increased the networkings, socialisation. I mean, James Gaffield quite frequently flew down to attend scientific meetings in Sydney, in Melbourne, and made a concerted effort to try and network with all of his local counterparts. I'm not aware that Jayant Patel actually did that. I'm not aware of any instances.

COMMISSIONER: Doctor, it's already - there are indications of a very American-centric view of the world on behalf of Dr Patel, that having come from the States he was trained in

the best system and knew the best way to do things, and that really when he came to perform an oesophagectomy in Bundaberg he didn't need advice or assistance or guidance from anyone else. Would you agree with that?-- I think that he kind of displayed the worst of the ugly American, "Everything is bigger, everything is greater, where I came from, and I know it all."

MR ATKINSON: I won't take that any further.

COMMISSIONER: Thank you.

MR ATKINSON: Doctor, the fifth way where there might have been an opportunity for some quality control, of course, is in relation to complaints?-- Uh-huh.

I understand that you weren't aware of many complaints?-- No, I wasn't.

You were aware at least of four, I think: the first you were aware of is a complaint by a young doctor, David Risson?-- That's correct.

You knew him to be a hard working, well regarded, decent fellow?-- That's correct.

And he complained in the course of 2003 that he had had a clinical altercation with Dr Patel?-- That's right.

You didn't take that any further but you understood - you were a bit taken aback that someone like him had a stand up fight with Dr Patel?-- Where I took it as far as actually David wanted me to take it. You mentioned, you know, the role about an uncle and I guess I am quite happy to pitch in and act as a kind of uncle but it has to be with the permission of the person concerned.

Sure?-- I spent quite some time, if you like, engaged in a debrief with David. He asked for it not to go any further, so I left it at that.

All right. He has given some evidence himself. Was the case you are talking about a case where he transferred somebody and Dr Patel had wanted the person transferred for diagnostic purposes but Dr Risson thought that the person was to be transferred for diagnosis and treatment, and it was his doing that more complete thing that upset Dr Patel?-- Mmm.

That's the incident of which-----?-- That is the incident.

-----you speak?-- What I focussed on more in my dealings with - actually, with David was the communication, you know, part of it, rather than the clinical facts of the case.

Right?-- Obviously, you know, the alpha male got extremely angry and had thrown a paw at the cub, and that's what I was concentrating on.

A second incident you were aware of, of course, was the Bramich matter?-- Mmm.

And that comes up in about July 2004?-- Uh-huh.

You were supposed to be getting these submissions or something in writing from Doctors Carter and Patel?-- That's right.

And that never happened?-- I never got them.

You reached a conclusion anyway. I think you went to - well, tell us what you did?-- There was a lot of - there was a lot of discussion about that particular case. There was one of these clinical audits which was incredibly one-sided.

So a Thursday meeting?-- A Thursday meeting. It was actually a - it was actually a Thursday morning meeting, which is a radiology meeting, and there were other people there. And the case was discussed. My understanding - and, I guess, I erred by not independently checking the coroner's report but I understood that one of the causes of death was a haemopericardium. Now, that appears not to have been the case. But, yes, it was discussed. It should have been discussed a little bit, you know, more broadly.

And frankly perhaps?-- And frankly. There are - in terms of trauma audit, we, as you know, would send maybe one or two trauma cases after stabilisation to one of the major Brisbane hospitals. The Queensland Trauma Committee has a series of trauma auditing benchmarks, you know, if you will, and they quite regularly provide us with feedback, and the aim of that is to impartially tell us how we can improve things. And it would have been better to actually apply those benchmarks to this particular case. I have been with - to go with Martin Carter trying to get some local involvement in the Queensland Trauma Registry for some time because at the end of the day they have all the data sheets and all the processes to really perform a proper audit.

All right. So the way it ends, though, with the Bramich matter, is that you get this memorandum?-- Yep.

You don't get the written reports from Carter or Patel?-- Yes.

You go to a Thursday morning meeting, the matter is discussed, and that's the end of it, from your point of view?-- Well, from my point of view I had waited for quite some time. I mean, I am not exactly sure if we're talking weeks or what. The time-frame I can't recall, but I dropped it on the basis of my knowledge that there was now going to be an inquiry, which I think culminated in the Fitzgerald inquiry.

All right?-- And I thought it would be reasonable that that be included.

COMMISSIONER: And also a coronial inquest?-- Also a coronial inquest.

MR ATKINSON: A third complaint you are aware about concerned a young intern - and we haven't been mentioning her name here - I don't think it is necessary - but a young intern who complained that Dr Patel had intruded upon her boundaries, is I think a word you used?-- Yes.

And then a fourth complaint you were aware of concerned a patient called Linda Parsons, who complained more specifically

about Dr Boyd but certainly Dr Patel was the head surgeon?-- Yes.

All right. Doctor, in addition to those things, you were aware of some reasonably serious conflict over the term of Dr Patel's employment with Dr Miach?-- Uh-huh.

Ms Hoffman?-- I wasn't aware until the story eventually exploded on to the front pages of the problem with nurse Hoffman.

You were aware-----?-- But I was certainly aware that Peter Miach had mentioned to me a degree of disquiet concerning Dr Patel.

All right. In paragraph 60 of your statement you say, "There had certainly been some rumours of complaints but I formed the view that they were personality conflicts."?-- That was the view that I formed at the time.

But with Dr Miach, I mean, the disquiet you speak about, he wasn't unhappy about carparking or golf clubs; he was unhappy about clinical issues, is that right?-- Well, at one stage he was unhappy about carparks.

Okay?-- I am sorry, you asked the question.

Well, the point I am trying to make, and maybe I have made it badly, is that you say there were personality conflicts?-- Yes.

I have got two questions arising out of that, with whom and, second of all, were they about personal issues or were they about clinical issues?-- At a certain level, as an observer, it can be rather difficult - or I find it rather difficult to separate the two, and I guess on this occasion I found it rather difficult to separate the two.

And this is in relation to Dr Miach?-- Yes.

Were you aware of other conflicts?-- Between Dr Miach and somebody else?

No, Dr Patel and somebody else?-- There seemed to be a sense that certainly at certain committees the behaviour of Dr Patel led me to believe that he, you know, was trying to be or was able to give an impression of being a team player. Sadly, some of the other senior clinicians, either because of - what's the word I am looking for - inclination, aren't really great team players, and I think that there was this sense of, you know, he is a team player, we're not. So there is this argy-bargy going on. Because a lot of the others did not, for their own reasons, either know how or feel inclined to be a member of a team.

Well, there is a lot of them, aren't there?-- That was the dysfunctionality.

There were a lot of people finding it difficult to work with Patel. Dr Berens may have voiced complaints to you?-- He didn't, no.

Dr Smalberger?-- I was unaware of any - yes, but Dr Smalberger had complaints with Peter Miach as well.

But they were worth investigating? He is not a histrionic man, Dr Smalberger?-- No, he isn't. He is-----

A doer?-- -----a very, very extremely dedicated clinician.

And if he makes a complaint about somebody, at first blush, isn't this right, it is worth looking into?-- I think so.

All right. And there were other people. Dr Carter doesn't seem to have been particularly close to Dr Patel?-- I can't recall, apart from the odd comment, which I am not sure was, you know, delivered as flippant or you know what. I am not - I cannot recall any serious conversations where Dr Carter voiced concern about Dr Patel to me other than he is an alpha male. So it was kind of about personality type rather than actual clinical issues.

Doctor, would you have a look at this document on the screen before you?-- Yep.

It is just something I have done overnight trawling through the evidence about complaints we've heard about Dr Patel. And I just wanted to do this quickly, but it seems to me that you weren't aware of any of these, is that right?-- That's right.

I mean, the first one is only 10 days after he starts, inserts a PermCath wrongly?-- I was unaware of the PermCath.

It enters the carotid artery. And then in May, only a month later, you have got a meeting by Ms Goodman and Ms Hoffman about the oesophagectomy?-- Unaware of that up until when it actually broke in the media.

And then paragraph 4, you will see that you have got Dr Joyner going to speak to Dr Keating?-- Unaware of that.

Right. 5, you have got this complaint about him working on the wrong part of the ear?-- Unaware of that.

Complaint from an anaesthetist or intensivist in Brisbane, Dr Cooke?-- Unaware of that.

7 is that issue of Dr Smalberger who says that there was a spleen that was in good condition but Dr Patel said it was broken in two and he wanted to operate?-- The first time that I became aware of that was on this particular inquiry's transcript.

Right. Paragraph 8, you have got a fellow called Ian Fleming complaining about a sigmoid colectomy. Paragraph 9, questions from the renal people about septic technique?-- Unaware.

Paragraph 10, some issues about a bit of a bun fight between Dr Berens and Dr Patel?-- Unaware of it.

Issues of wound dehiscence have come up a number of times in this inquiry but that wasn't something that came to your attention?-- No.

You have got the Hoffman letter of complaint. Of course in November you have got a letter from a Jason Jenkins in Brisbane talking about a patient called Marilyn Daisy?-- Unaware of it.

And you have got Dr Keating and Mr Leck start to interview people identified on the 22 October 2004 letter. You weren't aware of that?-- No, I wasn't.

All right. And then there is a run of issues down to the bottom where you see Berens and Carter go to see Keating about Mr Kemps' oesophagectomy?-- Unaware of it.

And then you have a patient retrieval emergency physician called Stephen Rashford from Brisbane complaining about a young fellow we call P26?-- Unaware of the details.

All right. It seems a bit strange, doctor, that these things don't get widely canvassed. I mean, there is all these complaints going on in a 140 bed hospital?-- Yes.

And somebody relatively senior like yourself isn't cognisant of them?-- What - what I think I can't understand is that we have clinical meetings every month where these sorts of issues I would expect would have been brought up. I cannot recall in any of those meetings any of these things appearing on the minutes or on any of the discussion papers of any of those meetings and I think that is inexplicable.

Well-----?-- I don't know why.

COMMISSIONER: And scandalous?-- Sad.

Yes, yes?-- Sad.

Doctor, can we just spend a moment on that and look into why those things weren't raised in the appropriate way? One of the suggestions we hear is that overseas-trained doctors - and I am not speaking about Jayant Patel in particular, but overseas-trained doctors are really in a position where they can't make waves, they can't afford to because they are brought to Australia, in effect, bonded to work for only one employer, and they have got no option but to continue working in that position or to go back to where they came from. Do you think that's a possible reason why some of these issues weren't raised?-- I think that's a part. I think it is a minor part.

What would you see as the more likely or more important explanations?-- Look, I am involved with a training program

which is being developed within Queensland Health which is called HEAPS. HEAPS stands for human error and patient safety. Essentially it involves a couple of interactive teaching modules that is kind of based on why the airline industry is as safe as it is today.

Yes?-- And one of the issues is that it is safe today because pilots are now trained to be members of a team, pilots are trained to if they think there is something wrong, approach their colleagues impartially, and without attacking them, and say, "Listen, this is quite strange. Can you explain it to me?"

Yes?-- There seems to be - we are teaching our young doctors this but we're not actually teaching the older doctors this, and I guess that's because we've given up on them, which is sad, but we have. It is really important. Our senior clinicians were given opportunities, were given a forum, were given the tools, but they don't seem to have actually used it outside of the corridors or in the carparks. And that's not where these discussions ought to be taking place. I think they're afraid.

I actually wonder about that. I am a big believer in corridor and carpark discussions, only in this sense: that if something is raised at a meeting, it has got to be documented, it has got to be put on the minutes, people have to address it, and unless you are an alpha male, you are very reluctant to put yourself in that position?-- Mmm.

It may be a lot easier to go back to the uncle-like position, for a Dr Risson to come and see dear old Kees and have a chat and have a cup of coffee and say, "I have got these problems." Maybe we've got too formalised. Maybe having committees and forums and meetings is counterproductive in that sense?-- I think what has happened - and I don't believe that the Bundaberg Base Hospital is unique.

No?-- I think what has happened is that there was an old model and the old model was that the superintendent of the hospital was a highly charismatic person who was everybody's uncle.

Yes?-- Had a beer with everybody, slapped them on the back, "Gidday, how are you?" What's happened is the model seemed to have been that the medical administrator withdraws in the hope that the directors of clinical units step into the void, so that you have got a situation of real clinical governance being carried out by doctors who are clinically active. I think the model's great and the model probably works in a large hospital. But the model is very, very dependent on having a director of a clinical department who (a) has the inclination, and (b) has the skills, and (c) has the time.

Possibly (d) has the personality?-- And (d) has the personality.

You see, doctor, one of the things that I think is missing

from our system - and I will say candidly I agree entirely with your analysis - I think what's missing is the role of perhaps we can move away from uncles, which apart from everything else is slightly sexist, but we don't have the mentor, we don't have the figurehead, the leader, and one thing that I would like to see is to restore that position in a way that doesn't show a lack of respect for the importance of the functions performed by administrators, like Mr Leck and Dr Keating, but realises that their function is quite different, and that if you had a chairman or a chief clinician, or someone of that ilk who may be a VMO, may even be a retired practitioner, but someone that the young staff can speak to, share their troubles with, seek advice from and report problems to, that that would be a useful thing in every hospital?-- Mmm.

Do you agree?-- I do. With all due respect, in order to - for that to progress we have got to get rid of the them and us, the them and us being the clinicians, the bureaucrats.

Yes?-- And make a hybrid, because each role is important.

Yes.

D COMMISSIONER EDWARDS: It has been suggested to us in some of the discussions over the time that another reason is that they're fearful of starting a general inquiry. You can no longer within the system have a conversation about somebody without formal reporting and then investigation and so forth. That the system these days does not allow these informal complaints to be made, everything must almost become formal?-- I think that's a part of it. I think another part of it is a consequence of increasing subspecialties. With all due respect to all the parties concerned, as an example, I mean, Peter Miach is a fantastic renal physician. If anyone in my family had a problem with their kidneys, he's the man. I really don't know what his breadth of current application is outside of that area, nor should it be. So what you have got is you have got people who have got, you know, each their own pinnacle of excellence, having a discussion about cases, and there really - I don't think they said anything because they didn't have the confidence. They felt in their gut something is wrong but "What would I know? I am a subspecialist.", if you can catch my drift.

COMMISSIONER: Absolutely.

D COMMISSIONER EDWARDS: Yes, indeed?-- Maybe it was that lack of confidence that made them hesitant, but I think one of the sad things that we need to address is why was there hesitancy in not having information like this placed impartially before us at monthly meetings. That's why they were there.

COMMISSIONER: Doctor, yet another reason that's been suggested is what some people refer to as the culture of bullying in Queensland Health, that some other people refer to as the shoot the messenger culture, that as soon as you make a

complaint, you yourself become the target rather than the complainant. Do you have personal experience of that?-- I don't have any personal experience of any bullying, no.

You're aware of people feeling, rightly or wrongly, that if they do rock the boat they're going to get into trouble?-- Yes, I am.

Are you able to comment on whether that feeling's justified or unjustified?-- My sense is that a proportion of that is justified, a proportion of bullying is the 2005 equivalent of Mediterranean lower back pain. I think what is very, very difficult is to discern which is which. I think clearly if people are given the responsibility of managing and you don't like what they're telling you, an easy option is to put up your hand and say, "You're a bully." The real hard thing in terms of a system is to try and dissect out what is really bullying and what is legitimate management practice. I can't do that.

I agree with you that the word "bullying" is unhelpful, and one of the suggestions I've made with some witnesses is that what we need to focus on is what I'd call the collateral attack, the situation where you complain about one issue or you raise one issue, and then you suddenly find yourself under scrutiny, complaint or disciplinary regime over an entirely unrelated issue?-- Yep.

And I think that's what distinguishes it from the situation you're talking about where a superior says, "You did that job badly. You have to go back and do it again." That's the situation where there's no collateral attack, it's simply punishment or reprimand for undoing that is quite transparent?-- I think one comment which I would make, if I may, and that is when everyone is in a pressure cooker, the perceived and the felt level of bullying has to increase.

Yes?-- And maybe a part of the solution is to relieve the pressure.

MR ATKINSON: Doctor, you were wondering out loud about why people didn't speak more openly in those meetings. One of the possibilities is that they didn't feel supported. Can I take you to paragraph 42 of your statement?-- Sure.

You mention there that you were aware of a number of personal issues between Dr Patel and the other members of staff?-- Yes.

And we've discussed them. Then you say, "In the absence of objective evidence to the contrary, I believe these are arising mainly due to personality differences." Doctor, we had evidence from Mr Messenger that when he had concerns about Dr Patel, he made a phone call to a practitioner - a specialist in Bundaberg - and said, "Can you corroborate these", and the specialist said, "Yes, I can", in longer words. There was evidence from the Health Rights Commission when they were speaking to - needed to check on a cardiovascular work, they just rang around to a few different cardiologists and said, "What do you think of this treatment?" People were able to do things very swiftly?-- Sure.

The feeling we get - that seems to come through the evidence in Bundaberg is that if you want to complain to management, it isn't enough to put them on inquiry, it isn't enough to raise something like Dr Smalberger might have. You had to come along with lovely, complete, set-out evidence, and that seems to be supported by what you say here in the absence of objective evidence to the contrary. You decided that the issues you heard about were personality conflicts rather than a signal that there were clinical problems out there?-- Mmm.

It looks like the managers aren't proactive, they are passive, in the sense that until they get clear proof of a problem, they don't act. Is that a possible reason why people weren't open and frank in those meetings?-- It is possible.

And here's another possibility that I ask you to address, if you'd have a look at this document. The other possibility is that people thought that Dr Patel was protected?-- Mmm.

They thought that because he had made such a big dent in the elective surgery targets, because elective surgery was, on your view, something that Mr Leck was very concerned about - you'd agree with that?-- Yes.

A complaint wasn't going to be given much of a hearing. Do you think that's a possibility?-- I can only give my opinion.

We're interested?-- My opinion is based on the impressions which I get. My impressions that I get is that both Peter Leck and Dr Darren Keating were very, very receptive to any objective comments about anything. The notion that Patel was somehow protected, I haven't got any evidence for.

COMMISSIONER: I think-----?-- But then again I don't have any evidence for that previous list that you gave me either. But in so far as I walk the corridors, in so far as I attend meetings, my impression of both Peter Leck and of Darren Keating was that if you approached them and you had genuine concerns and you gave any amount of - any small amount of back-up to those concerns, they would be investigated.

Doctor, those are very helpful comments and I thank you for making them, and I mean that quite sincerely, but I think Mr Atkinson was really putting it in a slightly different way, that whether or not Mr Leck and Dr Keating were protecting Patel, Patel himself projected the image around the hospital that he was the favourite son of the administration?-- Now that I can concede to.

MR ATKINSON: You heard him say those things?-- No, but I can imagine him saying those things.

But to come back to the first point, you will see this memo on the screen before you, and it's late in the piece, 17 December 2004. It's a record of a phone call that Mr Leck makes to the audit people back in Brisbane, and he says in that highlighted section, "He stated that the district needed to handle this carefully as Mr Patel was of great benefit to the district."

Is that something that you had experience of, that feeling that perhaps issues concerning Dr Patel had to be considered with great sensitivity because he was valuable to the hospital?-- He was certainly regarded as being valuable. I have no evidence that he was treated any differently.

All right. Doctor, I have two last questions.

COMMISSIONER: I'm sorry, just on that last point, you wouldn't expect to read that, though, in relation to a junior intern, a member of the nursing staff or a member of the catering staff. Most people you would expect, if there was a complaint about them, that it would be dealt with on the merits rather than dealt with on the basis it has to be handled carefully because the person is of great benefit and they'd hate to lose his services. That's a fair comment, isn't it?-- Yes. Yes, it is a fair comment.

So in one sense that might be the evidence that was otherwise lacking?-- Sure, mmm.

Thank you.

MR ATKINSON: Doctor, these two questions - the first one is the airfare for Dr Patel to go home?-- Mmm hmm.

Were you involved in discussions with Mr Leck about that airfare?-- I wasn't involved with any direct discussions with Mr Leck. I was involved with a discussion in the corridor with Dr Patel. He had already gone down and organised his flight, and I saw him in the corridor and he said, "Am I able to claim this", and I said, "Yes, absolutely."

That was probably in late March, was it?-- Well, that was three days before he left.

Okay. And the last issue I wanted to touch upon, a couple of young doctors have explained that when they filled out death certificates, if they had any queries - or if you had any queries, there would be a discussion between you and them?-- That's correct.

Some of those doctors like Anthony Athanasiov, he seemed desperately junior in an operation like an oesophagectomy to be filling out the death certificate. He's the third pair of hands, he's never done one before, he's only read about one, he's a long way back, one suspects, in terms of viewing. Would you accept that in terms of the future, it doesn't seem very good practice to have the most junior doctors doing something as important as completing a death certificate?-- Absolutely.

COMMISSIONER: Indeed Dr Ashby, I think it was, indicated in her view it was - I can't remember her word - outrageous or contemptible, or something like that, for a senior surgeon to put on to a very junior doctor the onus of filling out a death certificate for an operation for which the surgeon was responsible. Would you share that view?-- Almost as

outrageous as it is to put on a junior doctor the responsibility of writing a medico-legal report, which we talked about earlier.

It's the same thing, isn't it?-- It's the same principle.

D COMMISSIONER EDWARDS: Is there a policy on this within hospitals?-- Not that I'm aware of.

So really it could be seen that there is no advice available to people being requested to sign a death certificate relative to their seniority in a hospital?-- No.

COMMISSIONER: Just on the subject of death certificates, you seem to have been a bit of a - again, the uncle that the young staff turned to for advice when they had problems, and so I wonder if I can likewise seek your advice. There does seem to be at least some confusion as to the interpretation of the Coroner's Act and the requirement that a matter be referred to a coroner in the event that a death occurs that is unexpected in the course of medical treatment. Having given that matter a lot of thought, it seems to me at least one arguable position is that death is almost always an unexpected outcome with elective surgery because, you wouldn't engage in elective surgery if you expected there to be a death. Is that an overstatement or an oversimplification?-- I think that's an overstatement.

Yes?-- I think people with the full understanding of informed consent - I mean, I can imagine a situation where I myself, with the full understanding of informed consent, would consent to an operation that had a 20 per cent chance of survival if the alternative was certain painful death.

Yes, of course. Of course?-- I think what happened was that the Coroner's Act was changed in 2003, and it changed, in particular, one of the items. One of the items was if anything was deemed to be a perioperative death, or if it was an anaesthetic death, then it was automatically notifiable.

Yes?-- Because of this very issue that you've raised, the Coroner - I guess there was an inquiry and they looked into it, and I guess they came to the conclusion that they were looking at too many cases unnecessarily, because the amendment in the Coroner's Act 2003 was if the death is unforeseen. Now, that's - in retrospect it's, you know, less work, but it leaves a larger hole.

And I think also, doctor, it leaves a bit of a loophole in this sense: let's say you're operating on an elderly patient with a delicate heart and anaesthetic death is therefore a foreseeable, even a likely outcome, but because the operation is lifesaving that risk is taken, the patient dies on the operating table and it's therefore not a reportable death. However, that logic, or that reasoning, would apply even if the patient died from something other than anaesthetic death. If the patient died from blood loss or if the patient died from falling off the operating table, it would still not be a

reportable death. So simply using the question of whether or not death was a foreseeable outcome of the procedure is not a very useful criterion in judging what should be reported and what shouldn't be?-- Well, I'm not privy to any of the review processes which was conducted prior to the change of the Coroner's Act, but I guess that there was a whole - there was a stack of vehement individuals involved. Maybe you should ask them.

Okay. Thank you, doctor.

MR BODDICE: Commissioner, could I just interrupt for one moment?

COMMISSIONER: Yes.

MR BODDICE: Ms Gallagher had asked that I keep her informed as to the likelihood of Dr Jayasekera.

COMMISSIONER: I think we can assume it won't happen this afternoon.

MR BODDICE: And she was going to come in especially for that, so could I let her know that?

COMMISSIONER: Yes, you can let her know that.

MR ATKINSON: Thank you. Doctor, you said you had that corridor chat with Dr Patel when you said, "Absolutely, you are entitled to a trip home."?-- That's correct.

What was your basis for saying that?-- The basis for my saying that was that in my mind - it's up for you guys to determine if that was right or wrong - he was a locum. The standard with any locum that we appoint is that we pay for them to come from where they come from and we pay for them to return home. I notice that there was a letter written by Georgie Rose which was the letter of offer that mentions an economy airfare if he was coming with his wife and a business airfare if he came alone, and there was absolutely no mention of a return airfare.

That's on the screen before you now?-- Is that the one?

"Travel from place of residence to Bundaberg"?-- If I would have seen that before it went out I would have corrected it, because this is not in keeping with what the usual practice was.

Right. But similarly when there was a locum letter on 2 February 2005, it didn't provide for travel home either, did it?-- No, that's what I'm saying.

There's two letters - there's three letters, I think?-- Yep.

But none of them say that he's entitled to a trip home?-- Mmm.

COMMISSIONER: And doctor, as the person immediately responsible for engaging or hiring Dr Patel, you didn't have any conversation with him where he was promised a trip back to the United States or anything like that?-- I didn't - well, I can't recall saying those exact words, but I can recall what my usual practice would be, and if I was asked that question then, I would promise him a trip home at the termination of his contract.

So far as you can recall there was no such discussion?-- I can't recall such a discussion.

MR ATKINSON: What happens in the corridor is Patel asks you if he's entitled?-- Yep.

You say off the cuff, "Absolutely."?-- Off the cuff, "Absolutely."

You haven't checked the records?-- I haven't checked the records.

And you don't speak to Mr Leck about it subsequently?-- No.

And you're very firm about that, that you haven't had a subsequent discussion with Mr Leck?-- Not that I can recall. If I did, I would have recommended that he pay the airfare.

One last issue. I know there's a perception amongst many doctors that lawyers call you in here and ask you to answer a series of silly questions. Is there anything you'd like to say to the Commission about the way forward for Bundaberg Base or the public health system?-- Gee, that's a massive question. I guess like anyone else - I mean, I have been trying to rack my brains to answer that particular question. I think that one of the reasons that the atmosphere amongst senior clinicians at the Bundaberg Base Hospital - private and public - was relatively dysfunctional was because the history, as I perceive it, was that prior to '99 - I don't remember exactly the dates - there was a feeling that the zones or the districts, or whatever it was, have a significant amount of autonomy. I think as a result of that autonomy what happened was that, in effect, as you went up the coast there was a whole lot of fiefdoms, right, where people with charismatic leadership held positions and they did what they bloody well wanted to do. My feeling, my sense, is that if you're faced with the role of a centralist health - you know, Health Department, that idea of having disparate groups all going off on their own tangent is a bit of a challenge, and my take is that health has undergone what I would call McDonaldisation. You go to a McDonald's food bar and every hamburger - you know exactly what it is. You never get a bad hamburger at a McDonald's, you never get a good hamburger, all right? I think what's happened within state institutions is that they've gone for the McDonald's principle, and the way of doing that is strong, centralist leadership. My sense when I was Acting Director of Medical Services was that, to use the medical model, I was an intern, the guys at the zonal level were the registrars, and the guys in head office were the

consultant, and that was a reaction to the fiefdoms to bring them back.

COMMISSIONER: Yes?-- My take, just as an aside, is that Peter Leck and that Darren Keating read their scripts perfectly, did not put one hair out of place in terms of that centralist philosophy. My fear is that as a result of this process some people may be tempted to go back to that old fiefdom model. If that's the temptation, beware, because you won't get a McDonald's hamburger, you'll get bloody good hamburgers and bloody lousy ones. I guess my other comment in terms of the - we were fooled, we were suckered by a bloke, for whatever reason, who weaved his way through our protective nets, and every effort must be made for that not to happen again. I get a little bit worried about the terminology of "bureaucrats". If there is any wastage within the system at all - and I think it will require a change in the constitution - then what needs to happen is to get rid of state health totally, because my vision is that there's - a lot of resources are chewed up working out how each can roger the opposite.

Yes, yes. Doctor, while we're talking about generalities, there's something I wanted to ask you about quite specifically. When we were talking together in Bundaberg about six weeks ago you said some very glowing things about Peter Leck, and I'd like you to have the opportunity to repeat those things publicly if you wish to do so?-- Well, you know, I have never had anything except very solid support from Peter Leck and from Darren Keating. I think what they were faced with having to sort of deal with is the backlash of having the old fiefdom, if you like, dismantled and having come in as the new kids on the block and having all of that antagonism. The antagonism between the private and Peter Leck and Darren Keating is palpable, and I set that down to the historical situation actually of dismantling the fiefdom and bringing in a centralist approach. The both of these gentlemen made errors. I made errors. Nobody's perfect. My take on the both of them is that they read their scripts perfectly. They were absolutely 100 per cent committed to the corporation. I think it would be tragic if the corporation that got so much - such a degree of loyalty from them, allows them to be the fall people.

Thank you for that.

MR ATKINSON: That's the evidence-in-chief.

D COMMISSIONER VIDER: Can I just make a comment? Doctor, you mentioned HEAPS before, the Human Error and Patient Safety group?-- Yes, I do.

And said that you have an interest in that?-- Yes.

You mentioned an analogy to the airline industry?-- Yes.

Can I say that we can all talk about how big the system is, whether it's state, federal, whatever it is?-- Yes.

But at the end of the day we all have our own workplace-----?-- Yes.

-----and our own institution in health care. If we go back to the airline industry, can I say that they seem to now be focused on what their role is, and that is to transport people, passengers, safely?-- Mmm hmm.

And that starts at very good understanding of the necessity of pre-flight checks?-- Yes.

So that everything is in place before you start off, all those bits are in line?-- Mmm hmm.

Can I suggest that that analogy is also part of HEAPS?-- Yes, it is.

And we've got to get all those processes in place?-- Yes.

And that takes away the bigness of the personalities and puts the emphasis on performance?-- Yes.

Because every one of us is meant to be there for the patient. Just as the airline pilot wants to get the passengers to their destination safely, we've got to care for the sick so that the expected outcome is achieved?-- Yes.

Now, we're service providers and that requires technology, but in this industry it also requires professional competence?-- Yes.

And that professional competence is wrapped up in a personality?-- Yes.

But we've got to understand it's the professional competence that gets the outcome?-- Yes.

And, you know, how big an individual ego is has got to be blended into the system?-- I think the - well, I happen to know that the philosophy of HEAPS is actually predicated on competence being an equal triangle between knowledge, skills and professional attitudes.

Yes?-- I think within health there has for too long, particularly in proceduralists, an importance - I think that the skills aspect has been lauded, and the attitudes and the communication that surrounds that have actually been downplayed. I think what we need to do is to develop those skills and we need to foster real teamwork, and that's a big challenge. I'd agree with every comment that you made.

COMMISSIONER: We might take a 10 minute break now, if that's convenient.

THE COMMISSION ADJOURNED AT 3.27 P.M.

THE COMMISSION RESUMED AT 3.48 P.M.

CORNELIUS MARTINUS JOHANNES NYDAM, CONTINUING:

COMMISSIONER: Doctor, am I right in thinking you are booked on a flight tonight?-- That's correct

What time do you need to leave?-- The flight leaves at a quarter to 7. So I don't know what the traffic's like.

Yes. We will bear that in mind anyway. Mr Boddice, any examination?

MR BODDICE: Just a few matters.

COMMISSIONER: Yes, certainly.

EXAMINATION-IN-CHIEF:

MR BODDICE: Dr Nydam, just on the last point, can I ask you some questions about HEAPS and it being based on the airline industry. Is one of the important criteria there the no blame culture?-- Absolutely.

Do you think that part of the problem at the moment is that even though the system says it's a no blame culture, that because people have grown up under the older system that there is a reluctance for people to deal with it in that way because there is a fear that somebody will have to answer for it?-- Yes.

And is that what you mean by the idea that with the younger practitioners, of course they are being taught in the new system and, therefore, they embrace that new system?-- Mmm.

But with the older practitioners, it's very hard to swing them back around from what they knew when they went through?-- Yes.

And you see that as a real issue that has to be addressed?-- I think it is one of the challenges, yes.

Doctor, you were asked some questions in relation to the airfare. Would you have a look at this document, which forms part of Exhibit 50, and it was actually put up on the screen before. If you accept that this is an upside-down e-mail?-- Yes.

Which was an e-mail that was tendered through the - Dr Bethell.

COMMISSIONER: Bethell.

MR BODDICE: From Wavelength, in this document that - we can make it a little bigger, I suppose - it appears to be and it is accepted by Dr Bethell that what it was was a note of a conversation that he had had with you-----?-- Mmm-hmm.

-----in relation to Dr Patel, and you will see that in there there is a reference under, "Relocation Expenses", "If he is coming for the year, we would normally pay return airfares economy for him and his spouse. If he comes on his own, I would be prepared to upgrade that to business class."?-- Mmm-hmm.

There are some questions about you didn't recall the conversation in respect of the matter. Could you have had such a conversation with Dr Bethell from Wavelength?-- I certainly could have.

And is that consistent with what you would have expected if you were discussing with Dr Bethell what would be the terms-----?-- That is consistent.

-----to be offered to Dr Patel? And would you expect that that conversation in the normal course would have been passed on to Dr Patel?-- I would expect that.

And is that consistent with what you said was your conversation with Dr Patel in the corridor this year when he said, "Am I entitled to reimbursement?", and you said, "Of course."?-- Yes.

Because that was your understanding-----?-- Yes.

-----of what the arrangement was. You were asked some questions in relation to Dr Jayasekera and the situation was this, was it, that when the position of Director of Surgery was first advertised in - I think it was about August of 2002, he was one of the applicants?-- That's correct.

And he was shortlisted with the applicant who was offered the position?-- That's correct.

And you said in evidence that you had informal discussions with Dr Jayasekera after that process?-- That's correct.

Were those discussions held shortly after that process or some time after the process?-- Some time after.

Were those discussions part of explaining to him - you said you had explained to him why he hadn't been successful?-- What I had told him was that if he wished to have feedback then he could formally request that. Informally I told him that his performance at interview did not really reflect well in terms of his - in terms of his capabilities and skills. He really, though, did not perform well at the process of interview.

Do you recall whether that conversation occurred before the position was readvertised?-- Yes, it would have.

So-----?-- The-----

Sorry?-- The usual process is that at the completion of interview the interviewing committee, if they can come up with a recommendation they put that forward, it's signed off. The successor - the successful applicant is told and any other applicants aren't formally informed of that process until the original offer has been formally accepted or rejected. Now, on this occasion, I can't remember exactly how long it took, but it was a matter of weeks while the candidate was vacillating about the pros and cons of the job. So up until that particular stage, I really couldn't - I really wasn't in the position where I could tell Lucky anything formally. I guess the usual thing is that if - you know, there's - there's been an interview and you haven't been fed back within a couple of days, then you don't have to be Einstein to work out, you know, that isn't you. So, yeah, there is - you know, those couple of weeks, if you like, where because of process - it's bad process - you really thought you'd can't dance around. There was communication, you know, between myself and Lucky, and I can't recall exact details of those-----

But that communication was before you readvertised the position?-- Yes, yes.

And was it in that communication that Dr Jayasekera conveyed to you that he wasn't disappointed that he didn't receive the position?

MR ATKINSON: Well, Commissioner, this is a question the doctor's already answered. My friend might like different evidence, but he's already said that the conversations happened after the 28th of December when he resigned, consistently with his statement.

COMMISSIONER: I think if on Mr Boddice's instructions that may have been a misunderstanding, then he should have an opportunity to clarify it.

MR BODDICE: That's so.

MR ATKINSON: As the Commission pleases.

MR BODDICE: Thank you, Commissioner. And the conversation that you rely where Dr Jayasekera told you he wasn't disappointed because he wanted to move back to Brisbane closer to his family-----?-- Mmm.

-----did that occur in this conversation about the fact that he hadn't got the job?-- I believe that it did.

Now, we're told that the readvertising closed in December 2002, so that conversation occurred on that basis before December 2002?-- That's correct.

And then when it was readvertised, Dr Jayasekera did not apply?-- That's correct.

And was that something that you took into account in terms of whether you would be offering the position to him, that he didn't reapply?-- Well, if he doesn't reapply I can't - I can't offer him a position.

COMMISSIONER: Doctor, it seems to me it's not as straightforward as that. He had applied for the position. As you say, the ordinary course would be that it's offered to the candidate who's at the top of the list?-- Yep.

If that candidate's knocked back, it's then offered to the selection committee's second preference?-- That is not my understanding of the process.

Well, isn't that why you don't tell the other people on the list that they have missed out until the first choice is-----?-- It leaves you - it leaves - it leaves that option open.

Exactly?-- Yes.

And the difficulty in the present case is that rather than pursuing that option, you - I don't mean any criticism of this - but you informally told him - told Lucky that he had missed out, that he hadn't performed as well as he might have done in the oral interview?-- Yes.

And presumably he was then given the impression that having applied once there wasn't much point in applying again?-- Mmm-hmm.

Is that a fair suggestion?-- That is a fair suggestion.

Whereas having been told, "Well, you're number 2 in the list. We're readvertising, and if you do apply again, there's a fair chance you will get it.", there's equally a fair chance he would have said, "Well"-----?-- Sure.

-----"to have a position of Director of Surgery, I'm prepared to forego the pleasure of living at Bracken Ridge"?-- Mmm.

Yes?-- Yes.

MR BODDICE: Thank you. Doctor, you were also asked some questions about Dr De Lacey?-- Mmm.

And when he came in July-----?-- Yes.

-----of 2003. In July 2003 there were two staff surgeon positions and there was some VMO positions?-- That's correct.

Were any of those positions vacant when Dr De Lacey came and approached the hospital?-- I can't recall exactly.

The staff surgeon positions were for a fixed contract, both of them?-- Both of them were for a fixed 12 month contract.

Which would expire in the March the following year?-- Mmm.

In round terms. The Director of Surgery, is that a separate position to the Staff Surgeon position?-- No. One of the two Staff Surgeons under normal circumstances would be the Director of Surgery.

So it's not a situation where there's three positions, two Staff Surgeons and a Director of Surgery?-- That's right.

There's two Staff Surgeons?-- Two Staff Surgeons.

One of them would take on the responsibility of Director of Surgery?-- Yes.

And do they get an extra allowance for that?-- They do.

And in round figures can you tell the Commission what that is?-- I think it's about - somewhere between 1 and 3,000. It's not much.

COMMISSIONER: But it's quite conceivable that a VMO could be appointed as a Director of Surgery?-- Certainly, yes.

And similarly, it's quite conceivable that someone other than a general surgeon such as, for example, an orthopaedic surgeon could be appointed as Director of Surgery?-- It's conceivable and is also not without precedent.

MR BODDICE: That allowance, is that part of some award, is it?-- Yes.

So it's fixed within an award as to what that amount would be-----?-- Yes.

-----for the Director of Surgery position. And the director of Surgery, you said, has, in effect, some administrative responsibilities in terms of rostering?-- Yes.

And going to meetings and things like that. And then apart from that they can, in effect, make the position what they wish?-- That's right.

Yes, thank you, Commissioner.

COMMISSIONER: Thank you. Mr Harper?

MR HARPER: Just a few questions.

CROSS-EXAMINATION:

MR HARPER: Doctor, I would like to talk to you about the investigation in relation to the death of Mr Bramich. You were aware at the time, were you, that a post-mortem was conducted by Dr Ashby?-- I was aware.

That was conducted the day after Mr Bramich died?-- I wasn't aware exactly when.

Okay. If I said to you that it was completed on the 29th of July, the day after he died, you couldn't then disagree with that?-- I accept that.

Are you aware that that post-mortem report by Dr Ashby revealed that the body of the sternum was fractured through in its upper to mid-third? You weren't?-- As I mention, I have not seen the autopsy report.

Okay. Were you made aware of that subsequently?-- You could actually deduce that from medical images. I don't know that you'd need to have an autopsy.

Okay. Are you aware that Dr Carter has indicated that that fractured sternum was not reported upon any of the radiographic studies?-- I was unaware of that.

Okay. So I take it, then - I might take you to paragraph 54 of your main statement where you talk about the meeting at which the death of Mr Bramich was discussed?-- Mmm-hmm.

I take it, then, that the issue about the failure to pick up the fractured sternum was not discussed at that meeting?-- No.

Okay. Can I ask in relation to your investigation, were you made aware that it was in response to the completion of a Sentinal Event Form?-- I wasn't.

You are aware of the Sentinal Event reporting process, though?-- I am.

Can I ask, then, you mentioned before that your investigation effectively fed into Dr FitzGerald being brought on board?-- Well, I-----

COMMISSIONER: I think the evidence was more that it was superseded by the FitzGerald investigation?-- Yes, yes.

MR HARPER: Okay. So you didn't complete a report?-- No, I didn't.

Okay. Thank you, doctor.

COMMISSIONER: Mr Allen?

CROSS-EXAMINATION:

MR ALLEN: Thank you, Commissioner. Doctor, my name is Allen. I'm appearing for the Queensland Nurses Union. You have explained that you only had a limited knowledge of four complaints regarding Dr Patel before matters broke in the media?-- That's correct.

And because of your position in the hospital, you weren't in a position to make any personal assessment as to Dr Patel's surgical performance whilst he was Director of Surgery at Bundaberg?-- That's correct.

However, on the 23rd of March 2005 you became aware of media reports concerning some proceedings in Parliament?-- Mmm-hmm.

And those media reports indicated that there were allegations, serious allegations, regarding Dr Patel's surgical competence?-- Yes.

Including allegations that he had been responsible for deaths of patients at the Bundaberg Base Hospital?-- Yes.

Including allegations that there was 100 per cent complication rate in relation to peritoneal dialysis placements?-- That was what was reported in the newspapers.

And that these allegations were being sourced from a nurse in the Intensive Care Unit at the hospital?-- I can't recall that the source went into that.

It was apparently a source from within the hospital?-- It was a source from within the hospital.

Okay. One of the hospital staff obviously. All right.

COMMISSIONER: One of the clinical staff it had to be?-- It had to be, yeah, yes.

You couldn't probably have guessed who that was?-- I didn't guess who that was.

MR ALLEN: It was in response to that publicity in the media that you penned your letter to the editor of the Bundaberg News Mail?-- Yes.

If you could just have a look on the screen at the letter as it was published in the News Mail on the 24th of March 2005. You will see that the first paragraph reads - excuse me, the second sentence reads, "I would have no hesitation of having this highly qualified surgeon operate on any member of my family or myself."?-- That's correct.

Now, there was - you don't suggest that that was meant to

convey to the readers that you would have confidence in Dr Patel performing appendectomies upon members of your family?-- That's correct.

And it was limited to that procedure?-- Well, it was limited to a certain level of operation.

Well-----?-- Now, I haven't put that there.

At all?-- That's what my intent was.

Well, you haven't expressed that intent in any way at all, I'd suggest?-- I haven't at all.

In fact, it would - can I suggest to you that you didn't intend to limit it in that way. The document speaks for itself?-- There has been a lot of water under the bridge. There has been a lot of influence in my subconscious of what's transpired subsequently. At the time that I wrote this letter, with the knowledge that I had, I would be happy for Dr Patel to perform a serious operation on my children, on me, on my wife. I had no reason to have any doubts.

So despite the allegations that were being published and, as yet, uninvestigated, you decided to go public with your opinion that you would not hesitate to have that doctor perform serious surgery on yourself or members of your family?-- That's what I have written.

And, indeed, the fifth paragraph of the letter makes reference to "provision of acute health care services"-----?-- Yes.

-----"where death will always be a frequent and unfortunate reality."?-- Yes.

You certainly weren't referring to minor operations such as appendectomies in that paragraph, were you?-- No, I wasn't.

Did you consider the possible effect upon the morale of staff, including the clinical staff member who had apparently communicated information which was reported in the media?-- Well, I didn't know who that person was.

Did you consider the possible effect upon that person of you as a senior doctor at the hospital coming out with a statement such as that?-- No, I did not.

Didn't, okay?-- I did not.

Now, on the 7th of April 2005 - I will tender the Letter to the Editor from the Bundaberg Newsmail, Commissioner.

COMMISSIONER: Dr Nydam, I take it that the letter expressed your honest views and opinions at the time?-- It did.

And for the reasons you have given in your evidence, those views and opinions have changed?-- Absolutely.

Yes. Exhibit 278 will be a copy of Dr Nydam's letter to the Bundaberg Newsmail of 24 March 2005.

ADMITTED AND MARKED "EXHIBIT 278"

MR ALLEN: On 7th of April 2005 at about 3 p.m. there was a staff forum at the Bundaberg Base Hospital attended by over 100 staff but also by the then Health Minister, Mr Nuttall, the then Director-General Mr Buckland, and the District Manager?-- Yes.

And you attended, amongst other staff?-- I did.

And can I suggest that Mr Nuttall spoke indicating that it was the third time he had been to Bundaberg in his capacity as a Health Minister, the other two being for positive reasons?-- I can't remember the exact conversation or text of his-----

You can't recall whether he made comment about having been to

Springsure and making positive comments about that hospital?-- I can't recall that.

Do you recall either Mr Nuttall or Mr Buckland telling all present at the meeting that because of the release of material in Parliament and Dr Patel's departure to the United States, that the outcome of the investigation by Dr FitzGerald would not be released?-- I do.

That it would be fruitless as Dr Patel had left the country?-- I do.

Do you recall some expressions of concern and dissent amongst the staff at that comment?-- I do recall there was one member of the nursing staff who asked a question about that.

Okay. Do you recall whether it was Mr Nuttall or Dr Buckland who said that the report would not be released?-- No.

Do you recall Mr Nuttall saying that the only way we could stop this rubbish and stop Mr Messenger was to vote him out at the next election?-- No.

COMMISSIONER: Are you confident that wasn't said?-- I cannot recall that that was said.

MR ALLEN: Did either Mr Nuttall or Dr Buckland say that no decent doctor would want to come to Bundaberg to work in these circumstances?-- I can't recall that.

Was it fair to say that the tone coming from the then Minister Mr Nuttall was critical of the staff because of the release of information in Parliament and the media?-- I can certainly recall with a great amount of clarity that the tone of his voice transferred exasperation.

And was that-----?-- That's what I recall.

Was that exasperation apparently with the fact that these matters had become public knowledge?-- I don't know. I just heard a tone of exasperation.

Did you get the impression that the Minister was being critical of staff at the Bundaberg Base Hospital because of the circumstances that had required his visit there?-- I got the impression that he was exasperated at the person asking the question.

And the question was?-- I can't remember, but it had something to do with does that mean the review - the body of the review will not be released to us. Something to that extent. I can't remember.

Okay, so a nurse questioned that?-- Mmm.

Sought clarity?-- Sought clarity.

"Does that mean it won't be released to us?"?-- Mmm.

And I suggest that the Director-General - the then Director-General said, "Well, how are we going to get him back from America now?"?-- I can't remember that.

Was the real - so the information you received from the meeting, from information given by the then Minister and then Director-General, was because of this matter going into the media and Dr Patel leaving the country, the report won't be released and that's the end of the matter?-- That's the impression I got.

And was it also the impression, given that it was staff who were being blamed for the fact that it had become public knowledge causing Dr Patel to leave?-- That could be implied.

Well, from what you saw, that was the impression gained by persons and caused them to be unhappy?-- If you visualise the room, I was sort of halfway - behind the corner. The acoustics of that room was incredibly hopeless. In fact, at one particular point I suggested that they both move a little bit more towards the centre of the room so we could all hear them, okay? I - I can clearly recall thinking that the response to a junior member of the nursing staff was inappropriate.

In what way?-- Inappropriate as it failed - well, inappropriate in that it lacked the sensitivity that I would have given such a question. I thought it was harsh, it was almost like a rebuttal. I can't remember exactly what was said because of where I was, but the tone and the body language was harsh, severe, was that of exasperation. It could well be that we're talking about a no-blame culture, and the question is, "Well, when are we going to know who is to blame?" The exasperation could have been, you know, "Why do you want someone to blame when we're trying to impress a no-blame culture?" I don't know.

Okay?-- All that I know is that I have a clear impression of a mood, of a body language, of a response that I can recall at the time was, "That's a bit harsh."

All right.

COMMISSIONER: Doctor, when you wrote your letter to the local newspaper on the 24th of March, given your knowledge of the situation as it then was, you thought at the time that Dr Patel had been badly done by with the release in Parliament of the details? Does that fairly encapsulate your state of mind at that moment in time?-- I try not to believe everything that's in the newspaper.

Yes?-- The primary purpose of a newspaper is that they supply you with comics.

Yes?-- I certainly don't respond to them. My concern - and I apologise if the person who subsequently we now know as the person who leaked that comment was adversely affected. My

thoughts at the time was there is a community out there. There is a community out there that we are supposed to care for. There is a whole lot of people with a whole lot of agendas. Why can't we get our act together as a team and care for a community. There are processes involved. We go to meetings where people are invited to bring their concerns. They don't. They cower with their tails behind their, you know, whatever. I was very, very upset - my primary concern is if this is the way we do business, then this is tragic. That was my primary concern.

And, doctor, with that state of mind, given that you were a lot closer to the situation than, for example, Dr Buckland or the Minister Mr Nuttall?-- Mmm.

It wouldn't surprise you that until the full facts became known subsequently, they felt equally exasperated at the way in which this matter had come out?-- Yeah, it is possible.

And that was the tone that they conveyed at the meeting that you referred to, one of exasperation that this matter had come out this way?-- Yes.

MR ALLEN: And the clear impression which you also gained from the comments made by the then Minister and then Director-General, was that there wouldn't be any further investigation to find out what the true facts were. Dr Patel had left the country and the matter was closed as far as they were concerned?-- That's the impression.

Thank you.

COMMISSIONER: Thank you, Mr Allen. Ms McMillan?

MS McMILLAN: Yes, thank you.

CROSS-EXAMINATION:

MS McMILLAN: Dr Nydam, as I mentioned to you, I appear for the Medical Board. My name is McMillan. Doctor, the Commission has heard evidence previously which suggests that Dr Patel coming from an American model of surgical care was more of a solo clinician than a team player, if I can use that expression. Would you accept that as a fair, perhaps, comment about him?-- I have never worked clinically in the United States.

Right?-- My knowledge of medicine in the United States is limited to what I read in the journals, which tells me that they practise medicine in the private sector at a very high level and in the public sector at a very, very low level, and information I glean from television.

I see. All right. Well, anyway, that's been evidence that's

been given, and from what you have also indicated, you have said today, as I understand, that Dr Patel was an alpha male, as you have termed it, which, as I understand, you talk about particular personality attributes?-- Mmm.

The combination, perhaps, of those makes it difficult for him to function as part of a multidisciplinary team, would it not?-- Yes.

If this is so, could you think of ways in which a senior overseas-trained clinician might be encouraged to adopt perhaps more the Australian team ethic, if I can put it that way?-- I think the question assumes that we don't have a similar problem amongst Australian graduates. We have our own fair share of alpha males, locally produced.

Perhaps we shouldn't be sexist. Perhaps there might be an alpha female as well-----?-- I think-----

-----or two?-- I think this is a real problem within the culture of western medicine.

COMMISSIONER: Doctor, just - I am sure everyone in this room understands what you are talking about, but just so that the record is perfectly clear, when you are talking about an alpha male, I understand you are referring to an expression often used with pack animals, such as dogs or wolves?-- Yes.

The alpha male is the dominant male within the group?-- Yes.

MS McMILLAN: Perhaps if we neutralise it, an alpha personality, perhaps, because there are obviously female practitioners as well, as you would accept. Female wolves, as Mr Atkinson says as well. That being the case-----

COMMISSIONER: He has more character than I have.

MS McMILLAN: He is never short of that, Mr Commissioner. That being the case, you are really saying it is a universal problem, I take it, rather than just being overseas-trained doctors, you are saying local doctors?-- That is my impression.

You have talked about young practitioners - this HEAPS program I think you described earlier - so that you are saying it is a difficulty you encounter at a more senior level, irrespective of whether they are overseas-trained or locally-trained doctors?-- What I am saying is if you read through the literature, in terms of medical education and curriculum planning, you know, going back for the last 10 or 15 years, the emphasis has been on trying to develop a product, if that's what you want to call a doctor, who has got more by way of communication skills, because you are going to need it to work within an interdisciplinary team, knows a little bit more about how to communicate in a non-threatening way. That's what the universities are trying to produce in response to a problem that is not only - which is not uniquely Australian, it is in Australia, it is in the UK, it is in the US.

Thank you. I will come back to that just in a moment. Another topic, doctor: Dr Lucky Jayasekera, in his affidavit he deals with the two incidents involving the Russian-trained paediatric surgeon. I use the term perhaps advisedly. How did you deal with that matter, doctor? His affidavit - you are aware of the contents of his affidavit?-- I am aware of it, yes, I am.

That he said he came and spoke to you on I think two occasions about that?-- This particular doctor came to us - what happened was that Sam Baker wanted to go overseas to attend a course over in America.

Yes?-- It was a course on some update of a procedure. As was usual, as the Director of Surgery, he organised his own replacement locum.

Uh-huh?-- His replacement locum arrived. I can't remember the time if he was there for - I think he was there for about three or four weeks. You may correct me. For the first two weeks-----

This is this Russian doctor we are talking about?-- This is the Russian doctor. For the first two weeks I didn't hear any problems.

I see?-- After that I started to get a filtering of problems. He came to me with the complaint that the nursing staff, the other medical staff weren't showing him the respect that he thought that he should be in receipt of. Nursing staff, junior medical staff said, "This guy is a bit funny. We don't know exactly what." Lucky and I had a conversation. I was particularly keen to get Lucky's cooperation in providing some degree of supervision. Lucky seemed not very, very keen to actually do that but I insisted it would be a pretty good idea.

Is this the first occasion he came to speak to you about the Russian doctor?-- This is about halfway through his locum period.

Right?-- I don't remember the exact - the exact incident that sparked Lucky's concerns but I had been hearing whispers.

Right. He came to see you again, did he not? Lucky, I will call him for the moment?-- I saw these doctors every day.

All right. But you advanced it, I take it, can I put it this way, more than just Dr Jayasekera perhaps informally supervising him, if you like?-- Yeah, the other-----

What was it that you did?-- The other problem which arose was that the last - the last of the weekends-----

Yes?-- -----that he was to be on duty, Lucky insisted on going down to Brisbane, which was his right. That caused me a tremendous amount of concern. I went through everyone I knew

in terms of my list of telephone numbers. In the first instance I contacted - I can't remember whether it was the Royal Brisbane, but the Director of Surgery to get some kind of a feel for what this chap actually - what his capabilities were. He was surprised that Sam Baker had agreed to take this guy on as a locum and said, "Well, really he should be supervised. He isn't even - isn't even in a formal training program."

Right?-- So that may be a bit of a concern. I asked him if it was possible for this particular weekend to send up a Senior Registrar who could cover him, and the answer was no. I rang around all the people to see who could cover him. Had a discussion with Brian Thiele. He was happy to cover him, in a sense, came to an arrangement with Martin Carter that we would let this guy operate on appendices. If there was anything else - if there was anything else larger than that, he would either have to run it through Martin Carter or myself.

Right?-- So we felt that we more or less contained the situation that way. I wasn't at all happy with it and I was certainly not impressed that this guy had come to us on the recommendation of Dr Baker.

Under what circumstances did that doctor leave the hospital?-- At the end of his - at the end of his period, I believe.

So did you deal with your concerns about his clinical competence, if I can put it that way, in any more formalised sense?-- He then, you know, rang me back on several occasions and told me how much he enjoyed working at Bundaberg and would we employ him, and I said no.

In terms of - I am talking about issues of competence. Did you, for instance, think of raising obviously quite considerable concerns about his degree of it with, say, a body such as the Medical Board?-- No, I didn't.

All right. Doctor, in relation to Dr Patel himself, is it correct to say that what we understand from your evidence is that in your communications with the Medical Board, you never had any intention of deceiving the Board about the appointment of Dr Patel?-- That was not my intention, never.

If the expectation of the Board was that Dr Patel, as a senior medical officer, would and should have been supervised, then do you accept that with Patel's appointment as an Acting Director of Surgery, the Board's expectation that he would be supervised was obviously not met?-- Yes.

All right. Now, doctor, do you accept that you didn't obviously advise the Medical Board that he had changed position, effectively, from the senior medical officer, which had been indicated was what he was being employed as, to immediately being the Acting Director of Surgery?-- I had no communication with the Medical Board.

Do you think that's something that should have occurred?-- I think in terms of process, it would have been an extremely good idea.

All right. Just excuse me a moment.

COMMISSIONER: Yes.

MS McMILLAN: Yes. Thank you, Mr Commissioner.

COMMISSIONER: Thank you, Ms McMillan. Mr Diehm?

CROSS-EXAMINATION:

MR DIEHM: Thank you, Commissioner. Dr Nydam, I am Geoffrey Diehm and I appear for Dr Keating. Just on that matter with respect to the Medical Board, just in case there is any uncertainty about your evidence, you described in your evidence earlier, in answer to questions from Mr Atkinson, that when you were appointing Dr Patel to the position of Director of Surgery, you thought you were really appointing him to an acting director's role. Is that right?-- That is correct.

You didn't, though, say anything to Dr Keating to tell him that from your point of view Dr Patel was only being appointed as acting director?-- No, I can't recall ever telling him that.

Thank you. In your statement at - and this is your substantive statement at paragraph 35, you talk about your email of 9 April 2003 to Georgie Rose, which, as we know, made a request for Dr Patel to be paid the Director's allowance. You then say, "All formal documentation proving payment of the director's allowance would have been undertaken by Dr Keating." Can you tell us what documentation you are speaking of?-- I guess what I am talking about is that I had appointed him as the acting. What I would have meant was to actually formalise that.

Yes. Are there any particular documents that you have in mind that would need to have been completed after your email to Georgie Rose requesting the increase in pay for Dr Patel?-- No, not as far as I am aware.

All right.

COMMISSIONER: Was there a process of a formal letter of appointment or some documentation to give a person the status of Director of Surgery?-- In order to - as I understand it, in order for someone to be permanently appointed as a Director of Surgery, they would have to have been interviewed, they would have had to have been, you know, the whole credentialing process. The situation, regrettably, is that it is not

uncommon for people to be in acting roles for months, for years, for a year and a half. That's regrettable. But my understanding is that whilst you are as an acting and as you are as a temporary, there is no process to actually appoint. You can't just all of a sudden take a guy and say, "Okay, I am appointing you." In terms of procedural fairness, I can't take a guy and say, "Look, I am going to make you the Director of Surgery", without giving everyone else a chance.

Yes, of course?-- So it is - it is a failing of the system, absolutely.

But even for the position of acting, I would have expected that there would be a letter from someone in authority, whether it is the District Manager or the Director of Medical Services, or whoever, that would say, "Dear Jayant Patel, you have been approved to act in the position of Director of Surgery until further notice", something to that effect. But you say there is no documentation, no paper trail like that?-- If I think in terms of the other classifications - I am talking about the AO, I am talking about the nursing classification, there is a movement form and that movement form has to have - has to have a starting date and has to have an ending date, and that can be three months. You know, that can be anything that you like. And it is a form which is promulgated through HR. And that's the only form which I am aware of.

Would there be a similar form for a director of a unit within the hospital?-- You could use the same form. I am not aware that you have to. I am not aware.

So the answer to Mr Diehm's question is as far as you know there was no paperwork formality?-- As far as I am aware, the only paper trail there is is email from me to Georgie Rose.

MR DIEHM: Yes. And whatever may be expected to usually be the case when a Director of Surgery or Director of other department was appointed, it is conceivable that you having sent that email, not having told anybody, as I understand to be the case, that Dr Patel was, in your view, only the Acting Director, that he could continue to work as the Director of Surgery without anything else being done?-- That's right.

Thank you.

COMMISSIONER: And that indeed was your expectation?-- Yes.

MR DIEHM: Now, you gave some evidence long ago this morning, doctor, about Dr Gaffield And your understanding that he had attained, since his arrival in Australia, his fellowship of the College of Surgeons. If I were to suggest to you that that happened in December 2004, does that fit with your understanding of when he achieved-----?-- Yes, could be.

Were you aware that Dr Gaffield had the intention - thus far not completely fulfilled, but had the intention at around that time on attaining his fellowship to actually cease employment at the hospital?-- I didn't hear from him that that was his intention. I don't believe that in fact was his intention. He has told me that one of the reasons he has resigned was because of the climate which was being generated as a result of this inquiry. I guess you make assumptions, you have hopes. My hope and my assumption was that at some particular point he would stay in the town, he would continue to have a role within the public and a role in the private. That was my hope.

COMMISSIONER: I think you told us earlier that given his interest is in the area of plastic and reconstructive surgery, that isn't a big priority in the public system?-- No.

And therefore you would have expected that in due course, once he had Australian qualifications, he would move into the private sector?-- I think there are certain aspects of the public sector which are very, very attractive to certain groups of health professionals. One of those is the contact with students. It's the students who keep you honest.

Yes?-- It's the students who challenge you. It's the students who probably teach you more than you teach them, and in a number of discussions he indicated that he quite enjoyed the students and quite enjoyed the kind of work. Sometimes cases coming through the Emergency Department are quite challenging, and sometimes they're a bit more of an interest than the routine sort of stuff that you would do electively. So he indicated that he'd be - in an earlier discussion that he would be quite keen to have this kind of a dual role.

Mr Diehm?

MR DIEHM: Thank you, Commissioner. Dr Nydam, you gave some evidence earlier this afternoon about conflict between clinicians at the Bundaberg Hospital, and it was in the context of you being asked questions about your understanding of things that you heard being said about Dr Patel being attributable to personality differences. Now, you mentioned that there were two positions in the hospital, one of them a senior physician and another more junior physician - who I'm deliberately not naming - who had their own conflicts. I want to ask you in a way that is depersonalised - that's why I didn't name the doctors that you mentioned before - has it been the case over the last several years that there have been conflicts between clinical service providers at the Bundaberg

Base Hospital that result in some feelings of disrespect and animosity between them at times?-- The answer to that question is yes.

And has that at times, in your experience, included Dr Patel?-- Yes.

But has it included quite a number of other practitioners as well?-- Yes.

Sometimes those things appear, do they, superficially, to be to do with clinical issues, in the sense that what is being reported as being the area of dispute is a dispute about clinical opinion on a particular matter?-- It's probably about a territory dispute. "This is my territory. No, it's not, this is my territory."

Can those territory disputes, though, sometimes take on the appearance of being a clinical dispute?-- Yes.

And other times be quite patently just a personality issue?-- Yes.

Now, of course there may be some times that they are genuine clinical disputes?-- Yes.

And one of the difficulties, of course, is being able to identify what this particular one is?-- Mmm.

And from your experience, having acted in the position of Director of Medical Services, is it the case that often times those disputes as identified as arising at the time are either dealt with by the practitioners themselves or perhaps with some intervention from line managers and are able to be resolved and people move on?-- Yes.

But sometimes not?-- Yes.

Doctor, you mentioned in your evidence this shift from the circumstances of the local medical practitioners who had a fiefdom, as it were, a control over the provision of medical services in their particular district, and I think in fairness you were saying that this was something that could have happened statewide, not necessarily isolated to Bundaberg, the shift from that model to the model of central control and the conflict that that caused. We perhaps heard some evidence about the effects of that along the way, but is what you're identifying that as a result of that change, the culture at the Bundaberg Hospital over the last few years has been considerably affected interpersonally between clinical staff?-- I believe so.

To move to another topic on-----

COMMISSIONER: Just before you do, Mr Diehm, I'm not sure whether this is a helpful or useful analogy, but it seems to me that the position that Dr Keating was put in when he came in, and particularly coming as a successor to Brian Thiele, it

would have been like taking over as captain of the Australian cricket team but being a non-playing captain and having to be on the sideline. It would have been impossible for anyone to attract the level of support and fellow feeling amongst the clinical staff that Dr Thiele had enjoyed during his time?-- I think that's an extremely good analogy. I think furthermore, it was a strategy that was contrived in order to shift the clinical governance away from the executive on to the clinical department heads.

Yes?-- That was a strategy that patently failed.

Yes. Thank you, Mr Diehm.

MR DIEHM: Thank you, Commissioner. A strategy of Queensland Health, you mean, in that sense?-- I think so, yes. Yes, that's how I understand it.

In other words, the system as it was conceived to operate from then into the future was not one for there to be a Director of Medical Services like Dr Thiele. They didn't want that kind of person running the show?-- That's right.

Doctor, with respect to the credentialling and privileging documents - processes, you've described how you were initiating that process which Dr Keating concluded after he succeeded into the position, and the policy that was drawn up as a result of your efforts. Now, the policy that was being worked upon and it was ultimately completed, in your understanding, was the policy that was consistent with Queensland Health policy?-- Yes.

Can I ask you to look at this document firstly? That's a four page document which I suggest to you is the credentials and clinical privileging policy of Queensland Health pertinent to the relevant time?-- Yes.

Can you go to the fourth page of the document? Is there there a heading that describes - or directs the reader to where they will find the information about the mechanics of how the system is to work?-- Are you referring to "Implementation process, e.g. instructions/guidelines. Refer to the document"?

Yes?-- Yes.

So the policy refers you to guidelines established for the very purpose of operating the credentials and clinical privileging processes?-- Yes.

Thank you. If you can - you may as well keep that document there and it can be tendered eventually with this one. Can you have a look at this document, please?

COMMISSIONER: Mr Diehm, both now and for future reference, there's no need to go through the process of formally proving documents like that unless you feel a need to. I'm not going to stop you, but if it will make it easier, you're welcome to

tender them without putting them to witnesses.

MR DIEHM: Thank you, Commissioner. Dr Nydam, the document that you now have in front of you, is that the published guidelines of Queensland Health for the relevant time period?-- It is headed, "Credentials and Clinical Privileges Guidelines for Medical Practitioners - July 2002".

Thank you. You will see that there are post-it notes then on two consecutive pages?-- Mmm hmm.

That set out some details with respect to the requirements in terms of the persons who are to make up the committees - or the committee for credentialling and privileging within hospitals?-- Yes.

Now, are those the guidelines that you had in mind as you were working towards developing a policy?-- Yes, they would have been.

Thank you. I tender both those documents.

COMMISSIONER: Thank you. Exhibit 279 will comprise the two documents, "Queensland Health Policy Statement on Credentials and Clinical Privileges for Medical Practitioners", and the Queensland Health document "Credentials and Clinical Privileges Guidelines for Medical Practitioners - July 2002". Those together are Exhibit 279.

ADMITTED AND MARKED "EXHIBIT 279"

MR DIEHM: Thank you, Commissioner. That's all I have. Thank you, doctor.

COMMISSIONER: Thank you, Mr Diehm. Mr Ashton?

MR ASHTON: I have no questions, thanks, Commissioner. Thank you, doctor.

COMMISSIONER: Mr Boddice?

MR BODDICE: Nothing in re-examination.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: Just a couple of questions.

RE-EXAMINATION:

MR ATKINSON: I'm sorry, doctor, Mr Boddice and I are playing a bit of a tug-of-war with you. I'm trying to understand that issue of when Dr Lucky raised his concerns about perhaps not wanting to live in Bundaberg at all. Can you look at paragraph 32 of your statement? Do you have that?-- Thirty-two? Yes, I do.

You will see half-way down the words, "On 28 December 2002"?-- Yes.

And then you explain that Dr Lucky resigned and he gave you reasons for his resignation?-- Yes.

Can you tell me, just crisply, was that the first time that he told you those reasons?-- No, he was a little bit cagey and he sort of let small little snippets out. I think he felt under some obligation to give the reasons that Pitre Anderson was trying to prompt him to give. I think he felt uncomfortable with that. I don't think he felt comfortable in giving anyone the true reasons, so he was dancing around it.

So he was cagey at least before he resigned?-- Yes.

All right. The Commissioner asked you questions about whether people might be offered the job when they didn't get it first time up. If you can look at the highlighted sections of this, this is an ad - you will see later on that it's signed at the bottom by you?-- Yes.

This is, I understand, a standard Queensland Health form if you want to readvertise. You will see just before the highlighted section it says, "There is no requirement to advertise any position. Recruitment activities should try to tap into the skilled staff within Queensland Health as a first option." Without readvertising with that closing date of 2 December 2002, you could have just picked out Lucky from the Queensland Health staff base, couldn't you?-- I could have, and I must say that that particular reading with that particular interpretation is something - and, I mean, I'm at fault, but that's news to me.

Could we scroll up, please, Mr Scott? Then you will see that it says - there's another highlighted section just below your signature. You accept that's your signature?-- Yes, I do.

And it's to the same purpose. You don't have to advertise if there's a suitable person on the staff. I tender that, Commissioner.

COMMISSIONER: The document headed "Request to Advertise a Position Form" dated 31 October 2002 will be Exhibit 280.

ADMITTED AND MARKED "EXHIBIT 280"

MR ATKINSON: Thank you, Commissioner. Dr Nydam, you were asked questions by my learned friend Mr Allen over here for the nurses, about the suggestion that during that meeting on 7 April attended by Buckland and Nuttall it was suggested that the FitzGerald report would not be released after all?-- That was my understanding.

And your recollection is that the Minister or the Director General may have said that in a tone of exasperation when asked a question by a junior nurse?-- Yes.

You agree with Mr Allen's suggestion that it might have been said that the reason it wouldn't be released was because he had been agitated in the media, the Patel issue, and he had gone overseas? Do you recall whether-----?-- Can you ask the question again? It's getting a bit late. I am a little bit tired.

Do you recall what reason was given for the nonrelease?-- There was no reason. I cannot recall any reason being given.

You spoke in terms of second guessing about the possibility that in a no blame culture you don't necessarily have to go back through the issues and find out whose fault any given accident was?-- Mmm, yes.

But do you accept in the context of the systemic qualities, safety issues we discussed this morning, that that would have been a mistake not to release the FitzGerald report about what went wrong?-- I think it would be a mistake not to do a very, very thorough investigation of root causes.

Not blaming isn't the same as not knowing?-- I agree.

It was a worthwhile thing to have that report?-- Yes.

Nothing further, Commissioner.

COMMISSIONER: Thank you. I'm sorry, doctor, do you mind just waiting a moment? I want to check something. Mr Ashton, I am sure you're conscious of what's in the transcript in Mr Leck's evidence at page 364 lines 30 to about 60. I know that you have chosen not to ask any question of this witness. Do you wish-----

MR ASHTON: I am just not sure.

COMMISSIONER: The passage to which I am referring is the passage in which Mr Leck gave evidence that Dr Nydam came and saw him on the 1st of April of this year and suggested that it was appropriate for Dr Patel to be paid for his travel back to the United States.

MR ASHTON: Thanks for bringing that to our attention, Commissioner. I had thought the witness said that he didn't remember that, but if he did - perhaps I should ask him. Sorry, Commissioner.

MR ATKINSON: I can clarify that. I do recall what the witness said. He said that he spoke to Dr Patel in the corridor, but he didn't speak to Mr Leck.

COMMISSIONER: I thought that was quite specific too. But-----

MR ASHTON: I'm sorry.

COMMISSIONER: The transcript will speak for itself.

MR ASHTON: May I ask the question?

COMMISSIONER: Yes, of course.

CROSS-EXAMINATION:

MR ASHTON: Thank you, Commissioner. I had misunderstood, I think. Doctor, you did say that you spoke to Dr Patel in the corridor?-- Mmm.

And I had thought that it was put to you - you were asked whether you told Mr Leck about your view of the contract entitlement. I thought you said you didn't remember that but if you did, if you did speak to him, that was the view you would have expressed?-- Well, I understood that that's exactly what was in my answer.

Yes?-- Had I been asked-----

Let's clarify-----

COMMISSIONER: Had you been asked?-- Had I been asked, I would have told him it was my understanding that he was due.

MR ASHTON: I see. Perhaps I misunderstood it. May it be the case that you did speak to Mr Leck?-- It certainly could have been the case.

Yes. And if you had you agree it may have been - if you had, that's what you would have said?-- That's what I would have said.

Yes. Thanks, Commissioner.

COMMISSIONER: Mr Boddice, anything arising?

MR BODDICE: No, thank you.

COMMISSIONER: Mr Atkinson?

FURTHER RE-EXAMINATION:

MR ATKINSON: Just to clarify that, it's possible that after that conversation with Dr Patel about whether or not he was entitled to be reimbursed, you're saying that it is possible that you then spoke to Mr Leck to say, "Mr Leck, he's entitled to be reimbursed."?-- I guess what I'm saying is that I have no recollection of talking to Peter. My memory is not that good about all of these events. I may well have. If I had been asked, I would have advised him that in my opinion he was due to be paid for that airfare.

Your evidence initially was that you gave some off-the-cuff advice to Dr Patel when asked?-- I certainly spoke to Dr Patel in the corridor and I said, yes, we should reimburse that.

You have no recollection of subsequently considering the issue in any more detail with Mr Leck or otherwise?-- No.

Isn't that something that you would recall?-- No.

Nothing further, Commissioner.

COMMISSIONER: Thank you. Doctor, your evidence has been in many ways a breath of fresh air, perhaps because of the frank and candid and rather colourful way in which you have given it. We are very grateful to you for your time, for your assistance, and for your comprehensive and thoughtful reflections, not only on the specific issues relating to Dr Patel in Bundaberg, but to the more general issues facing the Queensland Health system. I am sure we will find your evidence to be of enormous use to us when we come to write our report, and again we thank you for your attendance and for your evidence. You are formally excused from your attendance?-- Thank you.

WITNESS EXCUSED

MR ATKINSON: Commissioner, that's all we have for you today.

COMMISSIONER: Early night.

MR ATKINSON: On Monday it is proposed to commence with Dr FitzGerald and we are hoping to liaise with Ms Gallagher about possibly having a witness in the afternoon who the AMA seeks to be called.

COMMISSIONER: So you are planning to have the next two days off?

MR ATKINSON: With Dr FitzGerald being called-----

COMMISSIONER: No.

MR ATKINSON: Tomorrow and the next day, yes, I am.

COMMISSIONER: Yes, 9.30 on Monday.

MR ATKINSON: Yes, Commissioner.

COMMISSIONER: Do we know if that suits Dr FitzGerald?

MR BODDICE: That will be fine, Commissioner.

COMMISSIONER: 9.30 it is. What day are we going to-----

MR BODDICE: Tuesday morning at 8.30.

MR ATKINSON: That's the Skills Centre.

COMMISSIONER: We will adjourn now until 9.30 a.m. on Monday morning.

THE COURT ADJOURNED AT 4.59 P.M. TILL 9.30 A.M. MONDAY, 15 AUGUST 2005