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Transcript of Proceedings

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 15/08/200

..DAY 41

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THE COMMISSION RESUMED AT 9.33 A.M.

COMMISSIONER: Forgive me, everyone, by taking you by surprise. The lifts out the back aren't working. Mr Andrews?

MR ANDREWS: Commissioner, I recall Dr FitzGerald.

GERARD JOSEPH FITZGERALD, RECALLED:

COMMISSIONER: Mr Andrews, can you remind me where we're up to?

MR ANDREWS: Yes, Mr Boddice has finished his examination also and I think cross-examination is to commence.

MR BODDICE: That's my recollection, Commissioner.

MR ANDREWS: In case, Commissioner, there is someone in the room who hasn't been alerted, it is proposed 2 p.m. today to call Dr Woodruff.

COMMISSIONER: Yes.

MR ANDREWS: And Doctors FitzGerald and Woodruff are the only witnesses currently proposed for today.

COMMISSIONER: Thank you for that. Mr Mullins, does it suit you to go next?

MR MULLINS: Your Honour, I have had some discussions with Mr Allen and if the Commission doesn't object-----

COMMISSIONER: Not at all. Mr Allen?

CROSS-EXAMINATION:

MR ALLEN: Excuse me one minute, Commissioner.

COMMISSIONER: Of course, just while you are preparing yourself, Mr Allen. Dr FitzGerald, obviously it is about 10 days since you were here before. Is there anything over that time that you have reflected on and that you would like to add to or correct or supplement?-- Nothing that comes to mind at the moment, thanks, Commissioner.

No, thank you.

MR ALLEN: Doctor, John Allen for the Queensland Nurses'

Union. In relation to credentialing and privileging and the policies that applied generally during last year and perhaps back to 2003, we've recently had admitted into evidence a Queensland Health policy which, as I understand it, would apply Statewide?-- That's correct, yes.

And we have also seen in relation to the northern zone some particular suggestions to changes that were made after a case involving a Dr Isaac Maree?-- I am not aware of that particular incident.

All right. I am just wondering in relation to the credentialing and privileging policies that would have applied in Bundaberg in 2003, would one simply look at the Statewide Queensland Health policy or would there have been a policy which was particular to provincial or rural hospitals which applied Statewide, or even a policy which was particular to the central zone?-- I am not aware of any specific policy for the central zone. The Statewide policy aligns very well with the national policy which has been reached by the National State Quality Council, and there may well be local means of interpreting that policy or applying that policy in every zone, but I am not aware of any specific policy.

So the document which is GF16 to your large statement, that essentially seems to be an application of the policy that would have applied Statewide throughout Queensland?-- If I may - sorry, my 16 is minutes of the various meetings. Is that your recollection there?

GF16 seems to be the minutes in relation to credentialing?-- Yes.

Then if you go in about eight pages or so, there is a Bundaberg Health Service District Policy and Procedure document?-- Okay, so there is a specific - yes.

So that would have applied as at 1st of January 2003?-- I am just not sure of the dates of that.

The effective date is stated as being 1st of January 2003.

COMMISSIONER: Mr Allen, to be fair to Dr FitzGerald, I think we learnt last week that that effective date cannot be right because the document is attributed to Dr Keating and Dr Keating wasn't on board at the time.

MR ALLEN: Right.

COMMISSIONER: So it may be that that effective date is really retrospective. I think that was the effect of Friday's evidence from Dr Martin.

MR ALLEN: Thank you. So you are not able to help us as to whether or not there would have been a policy, in effect, in the first part of 2003 and, if so, from what time?-- No, I am not, I am sorry. I am not sure of the timing of those policies and when they were introduced.

But it is quite clear that there was a Statewide Queensland Health policy already in existence at the start of 2003?-- Again, I am not absolutely sure of the timing of these policies and when they were introduced but there certainly has been credentialing and privileges in place for a number of years.

A number of years, yes.

COMMISSIONER: Do you know whether there was any directive from corporate office requiring individual districts to apply credentialing and privileging policies on a statewide basis?-- I don't know specifically. I assume that as part of the implementation there would have been, but I can only assume that at the moment.

If Mr Allen doesn't mind me interrupting, we heard recently the suggestion that Dr Patel to some extent flew under the radar because he was regarded as merely a locum appointment in the position of Director of Surgery. To your knowledge, has there ever been a sort of exemption from credentialing and privileging requirements for a person appointed merely in a locum position?-- Not to my knowledge but I really don't know either way. I am not familiar with what instructions were issued at that time.

Certainly. I take it you would agree that if that were the case, it is a loophole that should be fixed up very quickly?-- Indeed. So I think before starting, anybody should be credentialed.

Yes. Thank you, Mr Allen.

MR ALLEN: But you are certainly not aware there was any exception to any process of credentialing and privileging which provided a loophole for locum appointments?-- I am not aware of that, no.

Your expectation would have been that someone being appointed to a position of Senior Medical Officer surgery for a period of 12 months should be subject to the credentialing process?-- That certainly would be my view.

And your audit of material indicated that in fact Dr Patel hadn't been put through any type of credentialing process?-- That was the information provided to me, yes.

Was there any explanation provided with that?-- The explanation, from memory, at the time was they had sought - the administration of the hospital had sought a nomination from the Royal Australian College of Surgeons and that that had not been forthcoming, they therefore felt the committee was not in a position to make a judgment about the surgeon expertise.

COMMISSIONER: Doctor, that strikes me as being unpersuasive, given that there were a number of surgeons resident in

Bundaberg and, for example, one of them, Dr Anderson, sat on the selection committee, another of them had himself been a previous Director of Medical Services at the base. Surely it shouldn't have been too difficult to persuade a member of the college to participate even if it didn't have the official imprimatur of the college?-- I would share that view and I am sure most of the other hospitals obtain that, although I would - in our investigations at the time we were provided with some exchange of correspondence between the college and other hospitals who had a similar problem. I think the college was concerned about - or it nominating people, therefore somehow being held accountable, but I think most of the credentials and clinical privileges committee would rely on one of the local surgeons to provide that.

Yes.

MR ALLEN: Who was it who provided that information as to why the process hadn't occurred with Dr Patel?-- It was either. Mr Leck or Dr Keating. I must admit, I am not sure who provided that exact information at the time.

Are you able to say whether it was common or not in 2003 through 2005 for persons to be employed as specialists, if I can use that term, in the sense as it applies to Dr Patel to be employed in hospitals without having gone through a credentialing process?-- I have no particular information on - as you would understand, my position is not a line management position, or my then position, Chief Health Officer, was not a line management position. So I certainly had no specific information that would help in that regard. But there were obviously this case, and from information provided informally from medical superintendents, they felt there were some other medical superintendents having similar difficulties dealing with people who are perceived as specialists in obtaining credentialing support from the college.

COMMISSIONER: I am going to apologise again for interrupting, Mr Allen, but I think this is tremendously important. As it seems to me, a distinction can be drawn between a person who is appointed to perform a specialist function but is under the supervision of a clinical director-----?-- Yes.

-----and a person like Patel who was appointed to be clinical head of surgery. Would you agree that credentialing and privileging is infinitely more important when you are appointing a person to be in a position where he or she has no control from a senior clinician within the same unit?-- Oh, I would have to agree, yes. I think it is critical if the person is not under clinical supervision, then it really needs an assessment by their peers as to their capability and scope of practice.

Thank you.

MR ALLEN: Has there been any type of review recently, as far as you know, to investigate whether there are staff employed

in positions such as surgeon who have not gone through a credentialing process?-- I am not aware of any specific widespread review. I know that most of the medical superintendents, of course, are very well aware of this and have been checking and ensuring that all of their specialists are appropriately credentialed, and we're just currently working on a number of initiatives around the safety and quality agenda to make sure that all happens.

Is that-----

D COMMISSIONER VIDER: Mr Allen, can I interrupt on that point? Just for clarification, doctor, when you are talking about the reviews that have gone on since this episode became public knowledge, we heard a lot of evidence that one of the difficulties was getting the college to nominate somebody to be on that credentialing process. But we've also heard that there are a number of appropriately and suitably qualified Australian surgeons in those towns?-- Yes.

Has there been any move in the review processes that have gone on that would let a locally-based Fellow of an accredited Australian college be the nominee of the college if the college was contacted and said, "We've got Dr Z Here. Will you be happy for him to represent the college view on the credentialing committee?", and then you have got someone there right on the spot?-- Mmm. I think the point, I suppose, I was making before is I think that's how most of the hospitals probably work anyway, is that they just obtain the local support from the local people.

Yes?-- I did have some conversations with the College of Surgeons last week at which it was very clearly indicated their support for these very important processes and they would be providing that sort of support in the future.

COMMISSIONER: And - I am sorry, Mr Allen, but as you are aware we're very interested in this subject. The other thing that strikes me about all of this is that it may not be critically necessary to have someone on the local scene. These things can be done by telephone or videolink?-- Yes.

The papers can be faxed down or sent over the internet. It seems to me much more important to ensure that people of the appropriate calibre are on the committee rather than ensuring that they're locals if there is no-one local who is willing or able to do it?-- I think that's correct. The other side, of course, in a place like Bundaberg, the sensible thing would be together have a joint public/private credentialing committee, so that - as I think I mentioned last time I was here, that the private sector, it is a requirement as part of their licensing for people to be credentialed before starting, so a joint - in a town such as Bundaberg, a joint committee would be the most sensible. I know there was some move - I am not sure of the status of it - to have a Wide Bay/Bundaberg credentialing and privileging committee. The point of the credentialing and privileging committee concept is that it is seen to be independent assessment by peers. There is always a

risk associated with such exercises in a relatively small environment, so broadening it is a more sensible way to go.

And just one other thing from me on that subject, from time to time during the evidence we've heard over the past three months people have been critical of the colleges as being monopolistic cartels that want to keep out the competition and so on. In your discussions - you mentioned the College of Surgeons, but in your discussions is there any room for suspicion that the colleges are deliberately uncooperative in this process because they want to protect their own turf?-- I am sure there is always room for suspicion but in my personal dealings with the colleges, I have always found them to be reasonably cooperative.

Thank you.

MR ALLEN: Does-----

D COMMISSIONER EDWARDS: May I ask, Dr FitzGerald, are there guidelines for the operations of credentialing and privileging committees set down by the colleges, or is it just that they work within their own feelings in a specific instance?-- There is a national document that's been prepared by the - I will get the name of the organisation incorrect, I am sure, but it is the run by Professor Bruce Barraclough, who is the Safety and Quality Committee - I am sorry if I have forgotten the name of the committee, but they set a national guidelines which have been published. And really they are the guidelines - those guidelines were very similar to those in Queensland. In fact, I understand, from some degree of - from some information forwarded to me, they were somewhat based on the Queensland guidelines.

You would be satisfied with those guidelines from your point of view?-- Yes, I think so. They outline very clearly the purpose and the intent of the credentialing and clinical privileges process.

COMMISSIONER: Possibly the only point that needs to be made in relation to them, though, is if you can't have 100 per cent compliance, it is better to have the best compliance you can in the circumstances. Rather than say to them, "Well, we can't comply with every requirement, therefore we're not going to have a credentialing and privileging process at all."?-- I think that's so and I think what happens often is people get a bit hung up with the process rather than the actual purpose, and the purpose, of course, is to ensure safe practice by - particularly by procedural specialists, and as long as there is a means of ensuring that's occurring, I am sure the details and guidelines can be informative.

In your experience - and you may not be able to answer this - but would it be unusual for such a committee to say in respect of a surgeon, "Well, you can do basic surgery but there are types of operations or procedures that you ought not to do and they should be referred to another hospital."?-- I wouldn't think it would be unusual. I would hope that's the intent of

the policy, to sort of ensure that surgeon - that the scope of practice at a particular hospital by a particular surgeon is appropriate to the hospital and to the surgeon's experience.

So-----?-- So-----

-----in this case when you went to Bundaberg, you immediately, or very quickly concluded that things like oesophagectomies and Whipples procedures shouldn't be happening there and that's precisely the sort of thing you would expect a credentialing and privileges committee to determine?-- Exactly, yes.

D COMMISSIONER VIDER: Dr FitzGerald, from discussions that you would have had, possibly even this year, with various hospitals, are you confident that they would have understood that for their privileges committee to define the scope of practice was an expectation?-- From the conversations I have had with the medical superintendents, Directors of Medical Services, I think most of them clearly understand the intent of the policy.

Yes?-- Yes.

Because within the ACHS guidelines, they also have a fair - fairly high expectation-----?-- Yes.

-----of the privileging and credentialing activity, and I think the observation has been made that since clinical audit committees and M&M committees have become much more active, that's helped a shift in attitude to move away from the individual, the person, to focus more on performance, and with a view to outcomes then to understand the importance of the defining scope of practice for some people so that it may put limitations, you know, on a practitioner that says, "In this environment, you can only do", or "you cannot do without supervision", or "you need to be supervised for the next 20"-----?-- Yes.

-----"then will be reviewed"?-- I think they're both elements of the checks and balances, aren't they. Obviously the credentialing and clinical privilege process, together with the service capability framework, is the policy intent, of saying that these are the sort of procedures we should do at, say, Bundaberg.

Mmm?-- Then, of course, the audit process to monitor-----

Yes?-- -----the outcome of those procedures and where concerns are raised, then, of course, to be able to feed that back to the credential process and maybe even to vary the scope of practice of individuals if they are not really achieving good outcomes in those patients.

Where an individual hospital or district may be having difficulty with the credentialing, would it be to the office of the Chief Health Officer that that information would come?-- The Chief Health Officer has a role, from my memory,

in the policy in being the Court of Appeal, I suppose, for practitioners who feel that she have been unfairly limited in their scope of practice. There has been other sections within the department that have managed the policy around credentialing and clinical privileges.

Thank you.

MR ALLEN: Does the current review by Queensland Health, if I could call it that - I know it is not a normal process of considering the credentialing and privileging process - include any consideration as to whether or not there would be some type of audit of the individual hospitals at a central level? That is, that the hospitals have to actually report back to Queensland Health whether staff have gone through such a process?-- There hasn't, to my knowledge, been to date but as of the last week or so, we have been looking at the whole safety and quality agenda and what actions need to be taken, and certainly what you have suggested is in fact one of the issues that we have on our paper to deal with, and the difficulty in the past has been to try and have some sort of database that could be relatively easily monitored. There is a database out there that supports this function but I understand it has some difficulties in terms of being able to accommodate the information at a statewide level. But as part of the safety and quality - tidying up the safety and quality processes now, one of the issues we are looking at is the issue you are talking about, which is to undertake a more formalised report of the credentialing and clinical privileges process.

If I could just ask you some questions about the process of the audit you undertook? You have explained the events in so far as the contact with your office in December 2004 and your commitment in late December '04, early '05, and you have indicated that on the 19th of January 2005, or thereabouts, you received a memo from Peter Leck including attachments, which is GF10 to your statement. I don't know if there is a difficulty with the copy you have received but there seems to be a little confusion, at least on my part, as to what material you received and when. Now, obviously the memo from Peter Leck was received on the 20th of January 2005. That's the first page of GF10?-- Yes. Can I help explain that?

Yes, please?-- I am afraid what GF10 represents is our bad bookkeeping. We accumulated a whole host of documents but we were unable to subsequently and retrospectively sift out what was there initially and what had come either as part of our discussions in Bundaberg or subsequent thereto.

I see?-- So I must - the whole of GF10 did not come with the initial submission. My memory of it is that it was largely the letter from Toni Hoffman, and I am not sure what else was attached to it but certainly a number of those items were hand delivered to us when we arrived at Bundaberg.

Okay, all right. Was there then a process after the initial material was received of therefore receiving some things in

person from staff at Bundaberg?-- Yes.

What about further material being forwarded from hospital management after the initial memo?-- Yes. What we asked, when we meet with a number of people when we travelled to Bundaberg, was any information that they thought was relevant and they could provide to us, we were happy to receive it. A number of people did give us bits of information or documents on the day, but in addition as we left on that day we did ask for some further information to be provided to us. We in fact took away with us, I think as I mentioned, the copies of records, the patient records for a number of those patients that had been identified as of concern, and we also sought from the hospital some of the information regarding the - their adverse event rates, ACHS adverse incident rates.

One of the documents in GF10 is a audit and operational review branch file note file number A15 and it records a conversation between an officer in the audit and operational review branch and Peter Leck on the 17th of December 2004?-- A15, is it?

Yes?-- Yes, yes, I have that.

And towards the end of the second page it seems that officer has a discussion with a Michael Schafer; who's Michael Schafer?-- Michael Schafer is normally the - I'm just not sure of the title, director of that - is the head of audit and operational review branch normally. He was I think, seconded elsewhere at the time which is why Rebecca McMahon was filling that role.

And it was agreed that the officer would CC this to Gerry Fitzgerald?-- That's right.

So I take it that's probably the file note?-- I don't recall seeing that file note at the time, the thing that I got CC'd was the note back to Peter Leck.

I see, the e-mail back to him?-- The e-mail back the Peter Leck, yes.

Do you recall this is part of the bundle of the material received? Do you recall whether you would have received that close to the event, that's in mid December 2004 or at a later time?-- No, I think there was a bundle of material that we obtained or was sent to us by the audit branch after I returned from leave in January, I think we - Sue Jenkins approached them or they approached us, I can't remember who, but to say what other documents did they have.

Okay, so was that before you went to Bundaberg?-- I really, I really don't know, I'm sorry, I can't remember whether we saw that before going to Bundaberg or not.

And on the first page where there's a Dot point 6 expressing Peter Leck's concern that the district needs to handle this carefully as Dr Patel's of great benefit to the district and they would hate to lose his services?-- Mmm-hmm.

Was that an attitude which was communicated to you at all by Peter Leck during the course of your discussions with him?-- Yes, it was. When I discussed with Peter, he - it, he, I think as I mentioned last time, that he really was unsure of what was happening in this event and he did indicate that he was receiving different information, he was receiving - people were expressing obviously concerns about Dr Patel, but he was also aware that he was treating a lot of people who'd been on the waiting lists for surgery, that from memory, he provided a lot of support to students and junior doctors and that there seemed to really be a difference of opinion about him in the hospital.

And when was that communicated to you by Mr Leck?-- I think when we had our discussion early in January.

Mmm-hmm?-- And also when we discussed the matter in Bundaberg.

Okay. And the discussions in January, they were partly in relation to the nature of any audit or investigation you would carry out?-- Yes, I think firstly the fact that there was a concern that he had - concerns that had been raised with him and would my office become involved in doing it, which indicated that perhaps we should in the circumstances and proceeded from there, I suppose, yes.

And we've seen e-mails that passed between yourself and Peter Leck on the 7th and 8th of February 2005 concerning the nature of what you'd be doing?-- Yes.

Did Peter Leck's concerns as to the possible loss of services of Dr Patel influence any decision as to the nature of the investigation or audit, whether it would be an investigation of Dr Patel or merely an audit of clinical services?-- Not in my mind in that what I was more concerned about at the time was because of the issue raised by Peter Leck, that Dr Patel was unaware of any of the complaints or significant details about the complaints, it then struck me that there was an issue of fair treatment and process, that if we were to pursue down what may have been considered an investigation of Dr Patel, then there was - he would fairly be entitled to have all of that information provided to him, and at that stage, I really did feel uncomfortable, we just didn't have enough information as to what was going on.

All right. And on the 11th of February 2005, yourself and Ms Jenkins met with Ms Barry and Ms Simpson from the Queensland Nurses Union?-- Yes, I can't - I'm sure that's the date but I know we did meet prior to going to Bundaberg.

And you indicated that the process was going to be an audit of all operations undertaken at Bundaberg from about 2003 onwards?-- Yes, a clinical audit, yes.

Yes. That it wasn't an investigation into Dr Patel, but that the chart of the patients he had operated on would be looked at along with patients operated on at Bundaberg by other surgeons?-- That's correct, yes.

And is it true that Ms Barry raised with you the allegation that Dr Patel had not been correctly recording outcomes in documentation?-- That was raised by a number of people, I can't remember whether it was raised in that particular conversation, but it was an issue constantly raised, yes.

And it was one which you were aware of at the time that you went up to Bundaberg to speak to clinical staff?-- Yes.

COMMISSIONER: Doctor, on that subject, as I understand it, the sort of clinical audit you were talking about was essentially paper based, I guess a bit like a tax department desk audit where you don't go and interview people or lock at

the outcomes of surgery on them and that sort of thing, you were essentially working from what's in the medical files; is that-----?-- Certainly that's true for the case-related information.

Yes?-- And in with the other aspect of this is actually to hear what people are saying.

Of course?-- And that part of it of course is not - is about interviewing and discussing, but not in a way which retrieves accurate detailed information but rather impressions, views, the overview of what they feel is happening. But the - certainly the records of the - we were reliant on the records of the cases as written rather than any sort of evidence about what happened in any individual case.

All right. And given the concerns which have been raised with you about the reliability of Dr Patel's records, I guess that would have presented to you a real problem in doing that sort of paper based clinical audit?-- Well, quite right, and I suppose we certainly had that in mind in terms of whether there was any potential for - well, for example, a number of the nurses from memory raised the issue that he would understate or tell the residents or Registrars not to record certain complications in the files-----

Yes?-- -----if they'd occurred or in the subsequent data that was collected, so I suppose what we were then looking for was the data to see what they showed us, and as I indicated when I was last here, that showed a number of areas where there was a really much higher complication rate despite any perception that he may have understated that.

Yes. And as I'm sure other people have looked at this have discovered, such as Dr Woodruff and also the various surgeons who have been looking after Patel's patients since his departure, you could glean from the files things that were inconsistent with what Patel himself had written, so he might write the patient is stable but then you've got the nursing notes with the patient's temperature, pulse rate, the amount of blood infused and those sort of things which conflict with Patel's version of what occurred?-- Well, indeed, so - and at the end of the day the outcome, particularly when it involved the death of patients, was very clear.

Yes?-- But I would make the observation that often with Dr Patel's notes, they were actually very good notes as a written record, but I suspect - but they certainly didn't seem to reflect the conversations or the information that we were receiving from other people.

Yes. Is that something - I don't know whether you've done many of these sort of clinical audit processes - is it a common problem?-- I haven't done a lot.

Yes?-- This was the first major one that we had done in the office, but it is a problem, because often we can write things as we see them or want to see them.

Yes?-- And it certainly is a problem in terms of relying on just the written record.

Yes?-- However, from dealing with individual cases from time to time, of course, our major concern is usually entirely the opposite, which is you've got no record of anything, you can't find exactly what happened because the notes have been inadequate.

Yes?-- I suppose the one observation we made of Dr Patel particularly around issues of consent, which is obviously a major significant issue, is if what had occurred was what was written, then it was an exquisite process in terms of obtaining consent.

Yes?-- I suspect he'd learnt lessons from previously.

Particularly in the United States.

D COMMISSIONER EDWARDS: One of the other matters that's been raised with us from time to time, both in discussions and in what we've heard that often the matter of writing the notes and summaries of ward rounds and operations was left to the junior RMO and so forth?-- Mmm.

And it seems that from pure lack of experience that sometimes they were inadequate in retrospect. I'm wondering if there is a policy - well, relative to the recording of ward rounds, recording of particular procedures that there should be a rigid protocol, much more rigid protocol relative to the notes that have been made?-- Mmm. I'm not aware of a policy in that regard, except, I suppose - well, I suppose there are policies obviously with the Medical Board and the profession in general about record keeping, but there's no policy which says that it should be recorded by the consultant. My observation - and may be Dr Woodruff could add further to this, he saw more of the charts - that Dr Patel did actually record a lot of notes himself. Often times, from experience in hospitals from some time ago, the recording of the operation - operative procedures et cetera was left to the Registrar, but it was of note that Dr Patel used to make his own notes.

MR ALLEN: Doctor, in GF10, in relation to the material that you were supplied with, and it may be my error, but I can't seem to find any material that would have been generated in early January 2005 as a result of matters of concern raised by doctors at the Royal Brisbane Hospital record regarding a 15 year old boy,P26?-- Yes, I don't know when we became aware of that particular case, I think it was referred to - I'm not sure if it's on Toni Hoffman's list.

Right?-- But I'm just trying to think when that information was made available to us.

And concerning a Mr Kemps, because both of those matters occurred shortly before Christmas-----?-- Mmm.

-----2004, so after the initial material had been forwarded?-- Yes.

But before you ended up commencing the audit?-- Of course. I'm not sure, I think we did obtain, we certainly did have some information on those two cases, I think they were raised at the day - on the day that we were up there, but I certainly don't recall when we got the information from Royal Brisbane or on those - either of those cases.

COMMISSIONER: I'll just remind the media that the first of those names Mr Allen mentioned, that of P26, is not to be used outside these proceedings.

MR ALLEN: Thank you, Commissioner.

Now, in evidence there is some correspondence that passed between, for example, Steve Rashford and Darren Keating and Peter Leck regarding that matter?-- Yes.

And concerns about the transfer of the patient. Did you receive that sometime before you were able to complete your audit?-- I think we did, yes.

Right?-- I'm just not sure of the timing of those, Steve Rashford used to send me any concerns that he had from time to time.

Okay. So you were certainly aware of those two cases, P26?-- Yes.

And Mr Kemps?-- Yes.

All right. Now, on the 14th and 15th of February, you were at Bundaberg and speaking to staff at the hospital, and on the 14th of February 2005, you spoke to Toni Hoffman along with Miss Jenkin?-- Miss Jenkins.

Miss Jenkins, excuse me. Miss Hoffman's recollection is that she told you of all of the general concerns she had regarding Dr Patel at that time and gave you specific examples and then elaborated as required in response to questions you asked of her?-- Yes.

And she recalls that towards the end of the meeting you asked her what she thought should happen with respect to Dr Patel?-- Yes.

And that she said that she wanted him stood down until the conclusion of an investigation?-- Yes.

Her recollection is that you then said words to the effect that, "It was better to have a surgeon rather than no surgeon at all.", and that you asked her to put forward a solution to the problem that would exist if the Director of Surgery was stood down?-- Yes.

Does that accord with your recollection?-- I do remember us having a discussion about that, it was really to try - and at that stage we were trying to work out what the balance of concerns were here.

Mmm-hmm?-- And as she was somebody who was well experienced in the hospital, we had a discussion about what would happen.

And did she suggest that Dr Gaffield might be able to perform Dr Patel's lists in the meantime?-- I don't particularly recall that, but that doesn't - I've no doubt that it could have - she could have said that, yes.

Miss Hoffman's recollection is that at the time you spoke to her, that you didn't have a copy of Miss Hoffman's letter of the 22nd of October 2004?-- I thought we had had it provided to us initially by Mr Leck.

And-----

COMMISSIONER: Mr Allen, I'm not sure whether that was intended to imply that Dr Fitzgerald didn't physically have it with him at the time or whether that the implication was that Dr Fitzgerald had never seen it, but just to clear that up, you'd certainly seen it before you met with Miss Hoffman?-- I'd certainly - yes, that's my memory, yes.

But you may not have physically had it with you?-- I may not have physically had it with us because of the number of people that wanted to interview us, Miss Jenkins and I conducted different interviews, we had some in common but different interviews and I think most of the material was - I mean, we had the material with us but the intent of the discussions was to really hear what they had to say rather than check information that had been provided.

Yes.

MR ALLEN: Miss Hoffman's recollection is that you didn't have with you physically her letter or statements of other nurses that had been forwarded with it; that might be the case?-- That may well be the case, yes.

And her recollection is that you indicated that you hadn't seen such material at that stage?-- Well, I'm pretty sure that I'd seen her letter but whether there was associated documentation from other nurses, I'm not sure whether that was provided to us at the time or what.

Right, that might explain?-- Yeah.

Now, Miss Hoffman had expressed a strong view in relation to her concerns regarding Dr Patel continuing to perform surgery?-- Mmm.

She quite clearly raised that with you?-- Yes, she did.

Did you get back to her at any stage after you'd returned to

Brisbane as to the progress of the audit and the-----?-- The time. The only contact I did have with her, I do recall she actually called me at one stage - and I can't remember when that was - expressing some concern about where it was all going, I think it was after it had been raised publicly though.

After?-- After it had been raised publicly, yes.

But certainly between the time you spoke to her on the 14th of February 2005 and when it became a matter of public knowledge?-- Yes.

There hadn't been any communications?-- There hadn't been any conversation, no.

When you went back to Brisbane, you mentioned that you spoke to Mr O'Dempsey and Mr Demy-Geroe?-- Yes, well certainly Mr O'Dempsey, I recall, from memory I think Michael was involved in that as well, yes.

And did that involve you informing them of any matters you'd been told about Dr Patel?-- Yes, what it involved or what the intent of the discussion was that concerns had been raised, that we hadn't really been able to sort them out to any great extent at that stage, but that they were significant concerns, and as a result of that, I think I was informed by Mr O'Dempsey that Dr Patel's renewal of his registration was due and had been applied for, so we agreed to put that on hold until such time as we had a chance to get some other information together.

And there was certainly no indication to you from anyone at the Medical Board at that time that they'd discovered any irregularities with Dr Patel's official application?-- No, no, I think from memory, Jim O'Dempsey had said that he'd also been contacted by the nursing union I think at that stage, so he had independent information raised in regard to this issue.

When did you first become aware of any suggestion that Dr Patel might have been restricted in practice overseas?-- It was, I can't remember the dates honestly, but I did hear some sort of rumour just before it was raised publicly, that information was raised publicly, and then subsequently received a telephone call from a journalist that gave further information.

Right. Okay.

COMMISSIONER: Are you able to say whether that - whether the rumour you heard came from journalistic sources or came from the Medical Board sources or somewhere else?-- Actually, it had come from somebody who had been in Bundaberg, it had come from one of the sources that had been in Bundaberg.

MR ALLEN: Sorry, someone who had been the Bundaberg?-- Well, the person, from memory, the person who told it to me was actually one of the senior officials of the department who'd

been up there and had said that he'd been informed that there was some problem with his registration in the United States.

And that was before there was any publicity of that effect in The Courier-Mail?-- Yes, yes.

Do you remember-----?-- It was only a day or two beforehand.

A day or two before?-- Yes.

And did the person indicate the source of that rumour or indicate their source for the rumour?-- I think it - I think it probably come from Dr Keating, I think that was the information that was provided to me.

Right. Did that occasion-----

COMMISSIONER: Doctor, I don't want to put you in a position of feeling that you're being disloyal to your departmental colleagues, but if that were the case, I think it would be useful if we had the name of the departmental official if you recall it?-- Yeah, it was the Director-General gave me a call after he returned from Bundaberg and said that he had certain information with regard to that and that he had told me that it was Dr Keating who had provided it to him.

Thank you.

MR ALLEN: The Director-General had visited Bundaberg along with the Minister on the 7th of April 2005?-- I don't know the dates, but I assume that's correct, yes.

So did you receive that information on or about the 7th of April?-- Yeah, well it was - I assumed it was that visit, it was within a day or so of that visit.

So not on the day, but-----?-- Oh, look, I really - it was a telephone call, I think, at one stage, and I don't recall when they actually travelled back, I'm sorry.

Okay. And was that - that was the first you'd heard about it, you hadn't heard about it from any other source?-- No, not at that stage.

And did you communicate that rumour to anyone at the Medical Board?-- Yes, I had a discussion with Jim O'Dempsey and asked - and suggested they may need to look into it.

Right. Was that very soon after receiving the information yourself?-- Within 24 hours, I think, yes.

COMMISSIONER: Doctor, when this was reported to you, was it, as it were, officially in your capacity as a member of the Medical Board or was it just sort of office gossip?-- I think it was reported to me in view of the fact that I'd done the audit up there.

Yes?-- So-----

It would seem to me, on the face of it, but obviously we'd have to hear what Dr Buckland has to say, but on the face of it, if the Director-General became aware of such information, it would seem to be essential that it be relayed to the Medical Board; would you agree with that?-- Yes. Well, it's perhaps not easy to tell whether which role he was inviting me to.

Yes?-- But obviously in either role had the communication with the Medical Board to explore this matter to try to find out some facts about it.

Yes.

D COMMISSIONER VIDER: Dr FitzGerald, when you went to Bundaberg, you talked before about the fact that one arm of audit is looking at the - through the records, but the other arm of that, of course, is interviewing staff-----?-- Yes.

-----and getting people's account of what went on. When you went to Bundaberg and had the opportunity to talk to the staff, were you able to form a view that there was some disparity, that the whole story wasn't coming together in identical fashion?-- Yes, very much so.

And that a block to good clinical outcomes was the communication problem, because if you've got the surgeon not talking to certain significant players, like, some of those nurses that he wasn't talking to?-- Mmm.

That doesn't lead for a united team effort for the best outcomes for the patients. The other thing then I'm asking you when you spoke then to members of the executive staff, were you able to come away with any, even preliminary thoughts in your mind that you were looking at a dysfunctional system?-- I think the answer to the last part of your question is yes. When we went up there, we were struck, I think, by the fact that there were camps in the place, and the first information in terms of our interviews and in these circumstances, I must admit, my experience is to try and hear it fresh.

Yes?-- You know, to not be too bogged down by what already has gone on and what history, I suppose, is the old medical practice of whenever you're confused, go back and talk to the patient, so we went back and talked to the staff and people from Toni Hoffman and others were very clear. Toni, I remember very vividly being very clear that she was - she didn't like this bloke and that there was a lot of clashes and a lot of difficulties with him but that was not her issue, her issue was that he was performing procedures that should not have occurred there and seemed to have a high complication rate. So I was very impressed with that and I was very impressed with the - a lot of the other staff were saying similar things, but there was very much a number of people who had differing views, strong and differing views. One of the groups that you often rely on to be the best judge of surgical

technique, of course, is the anaesthetists.

Yes?-- And the anaesthetists see a number of surgeons operate et cetera and see the bigger picture view. They were generally of the view that he's - he was certainly getting involved in things he shouldn't have been getting involved in and holding on to things - patients too long, but that they generally felt his basic surgery was probably all right. But there were a lot of issues around infection control and other things that people have raised with us which were clearly inappropriate and unacceptable and there was very much an adversarial interpersonal conflict going on, on top of all of that, so filtering through that sort of stuff to try and get to some facts was a rather difficult task.

Yes.

MR ALLEN: Doctor, when you spoke to Mr O'Dempsey soon after the 7th of April 2005, or soon after the information from Dr Buckland regarding the information from Dr Keating?-- Mmm.

Obviously that was before you spoke to the journalist, Mr Thomas, about that matter subsequently?-- Yes, that's right.

Do you recall what you were able to convey to Mr O'Dempsey? You didn't have too much information at that time?-- No, just that there was some issue concerning his - mainly in regard to his previous history and previous registration in the United States and that it had been - I think the only other bit of information, I think, that it had been obtained off the Internet.

Okay?-- And so I'd suggested to Jim O'Dempsey that he try and undertake some investigations and the next call was from the journalist and he not only mentioned Oregon but other practices he had practiced as well.

So you didn't hear back from Mr O'Dempsey in the meantime?-- I don't think so, no, no.

D COMMISSIONER EDWARDS: Doctor, in your role as a member of the Medical Board and Chief Medical Officer, it wouldn't be unusual for you to have those kind of discussions about reports that you hear about performances of medical practitioners in Queensland?-- No, not at all. As you would be aware, I'm sure that we hear rumours all the time about various things and I suppose the thing to do of course when you hear those rumours, just try and see first of all whether there is any facts underlying it. Often there isn't. In this situation there was.

MR ALLEN: So the next information you received by way of a more concrete fashion was from the journalist?-- That's right.

And did you then speak to Mr O'Dempsey again?-- Yes, he asked for a response to - the journalist asked for a response to the concerns that had been identified and I suggested that would best come from the Medical Board. So I rang Jim O'Dempsey and asked him to contact the journalist back.

When you spoke to Mr O'Dempsey then, did he indicate he has already investigated and-----?-- I think he did indicate that he had found issues of concern.

Did he detail them?-- I think he told me that there was a - that the certificate of good standing that we had on our file was incomplete and that - I think they had started doing - I'm not sure whether they had at that stage searched the Internet and found similar information off the registration systems in Oregon and New York.

Okay. If I could just - oh, and was that conversation with Mr O'Dempsey on the same day as when you spoke to Mr Thomas?-- Yes, it was immediately after Mr Thomas rang me. I offered to - he asked for a response and I suggested, "Ring the Medical Board and get that response from the Medical Board."

Exhibit 230, and you probably have a copy of it, hopefully, with you, the confidential audit report?-- Yes, I have a copy, yep.

Now, it obviously came into existence before the 24th of March 2004, I'd expect, because in paragraph 72 of this statement you say that you wrote to the Director-General on the 24th of March 2005 providing him with a copy of the report?-- Yes.

And GF14 is a covering memorandum saying, "The report of the clinical audit is now complete. I've attached a copy to the memorandum and there are issues which I need to bring to your attention"?-- Yep. Yes.

So was the document that would have been forwarded at that time the same document that's now Exhibit 230?-- Yes, it would have been.

So would it have been completed perhaps shortly before the 24th of March or thereabouts?-- Yes, to my memory it was - we passed it upstairs as soon as I had - had it completed.

Okay. And just in relation to - just a few questions about the contents. If you go to page 5 and you see there the table?-- Yes.

In the middle column where you refer to, in the third box, "The Director of this division", and then in the following three is the Divisional Director, they're all references to Dr Patel, are they?-- That's correct, yes, yes.

Okay. And then the next box down, "Some procedures and selection of patients are outside of the scope of Bundaberg Hospital"?-- Yep.

"And the opportunity for improvements identified is implement the Service Capability Framework"?-- Yes.

Now, that was a process that was under way, what, throughout the state?-- Yes, it was, yes.

But it hadn't been finalised at all in relation to Bundaberg?-- My memory is that we were actually - on the Bundaberg website at the time was a list of their service capabilities, so I think they had completed it but what was concerning us is that there were procedures there that actually exceeded the capacity for the level - for level 1 intensive care.

Level 1 intensive care, yes?-- Yes.

And that was quite clear from the investigation you'd made to that stage?-- Yes.

Okay. So how was that to be implemented? Was that supposed to be that Dr Keating would put his foot down and tell Dr Patel not to do surgery or did someone else speak to Dr Patel or?-- That would - I mean, the intention at that stage was that the administration of the hospital would take these issues and deal with them.

Right.

COMMISSIONER: That would mean Mr Leck and Dr Keating primarily?-- Yes.

MR ALLEN: Then the next problem noted is, "There's a lack of teamwork between operating theatre and ICU. Clinical issues sometimes complicated by personality issues." Did you identify any personality problems between staff in operating theatre and ICU apart from matters involving Dr Patel?-- Not - no items of substance. I mean, there was always clashes of personality and there seemed to be people there who had views about each other as you can imagine but certainly nothing of substance apart from concerns around Dr Patel.

Right. So, the answer to that was going to be "institute team building between and within disciplines"?-- Yes, there was certainly some divisions in the teams at that stage. The theatre nurses seemed to be supportive of Dr Patel. The - whereas the intensive care nurses of course were - had major concerns with him.

Well, the problem is with Dr Patel though. How was it going to have helped to have team building sessions?-- Well, I think the - I mean, that's obviously just part of the package but I - even removing Dr Patel out of the equation, there were still significant issues - there was - people had got into positions in regard to Dr Patel which meant that there had been a lot of ill feeling develop between various groups of people.

COMMISSIONER: Doctor, do I understand you to be saying that this wasn't a proposal to fix the Patel problem but to fix the fallout from the Patel problem in a sense?-- Well, to a large extent, yes. I mean, as I made the point I think publicly when I went up there, was that the - there were a number of things that had happened but there was the consequences of that and the consequences of that was really a fairly dysfunctional hospital as a result, where people were in their camps and had pros and anti views and there has been a lot of ill feeling and hurt people as a result and that really needed to be strongly supported to move forward.

MR ALLEN: You mentioned even removing Dr Patel from the equation. You didn't indicate in your report that he should be removed from the equation, did you?-- No, because we don't have the process to do that. The process to do that was really up to the Medical Board.

Because the last point on that page points out that, "The Divisional Director is keen to be involved in activities such as ACHS accreditations"?-- Yes.

On the face of it, that would suggest that he'd be continuing in his role?-- Yes.

D COMMISSIONER VIDER: Dr FitzGerald, can I go back a point. Are you saying that Queensland Health could not have removed Dr Patel?-- On the information that we had at the time, without further detailed investigation it would be rather difficult to have removed him on a disciplinary matter. I mean, we had issues of concern that had been raised but they needed further investigation before we could deal with it. The safety part was to stop him doing the major complicated procedures at the time.

Would it have been a consideration to have him stood down?-- It could have been a consideration, yes.

But that was not given at that time?-- It wasn't at that time, no.

COMMISSIONER: And, in fact, at the time we're talking about,

his contract was almost up. If someone had decided not to renew his contract, there wouldn't have been any natural justice or disciplinary issues involved, it simply would have been a matter of not offering him a new contract?-- That's right or, alternatively, his registration not being renewed on the basis of the concerns raised.

Yes.

D COMMISSIONER VIDER: Doctor, part of the dysfunctionality if you like of the hospital as it might have appeared to you at that time, could that be related to the particular management style that was permeating through the organisation? We've heard evidence, for example, that the executive were very busy because they went to a lot of meetings and they received a lot of reports and that was the particular style that was adopted by them. Consequently, they were not out and about?-- Mmm.

So a lot of the sorts of information, the attitudinal things, the daily problems that managers of departments won't necessarily write an e-mail about-----?-- Mmm.

-----but if you're there, they'll tell you about them?-- Mmm.

Now, we have heard evidence that it's Queensland Health's policy to devolve authority down to managers?-- Mmm.

And that can leave an executive member perhaps feeling that, with that approach then, they don't go and interfere. But I'm looking at it from a disconnected point of view. That the person who is the leader is never around or infrequently around-----?-- Mmm.

-----and, therefore, the opportunity to respond to a question, "How are things today?" is lost if you're never there today?-- We certainly weren't in a position, I think, to make any judgments about that but I think, like yourselves, is that we did get a lot of feedback that that was a concern to people, that they felt that it was difficult to approach the executive at times. But, I mean, as you've indicated, that's usually your source of the correct information, of actually walking around the hospital and talking to people. But I don't know, we weren't able to make any judgment about the management style at this stage.

COMMISSIONER: Doctor, it's certainly come to us from a variety of sources that the type of management structure or style that Deputy Commissioner Vider just described is favoured and, indeed, perhaps even encouraged under the corporate management of Queensland Health over a recent number of years. If that were the case, and I don't - again, we will hear from Dr Buckland and Professor Stable and others later, but if that were the case, would it be your view that for the future it would be better to go back to something closer to the historic model of the Medical Superintendent, who is actually seen on ward rounds and visits the functional parts of the hospital and is part of the hospital community rather than separated from the hospital community as it's been

suggested that executives are encouraged to do at the moment?-- Sure. I'm not sure I can comment on the culture of the organisation in that regard-----

Yes?-- -----but what I would say is that at a hospital level or at any organisational level, obviously management that is seen to be out there and talking to people is going to achieve its strategic accountabilities much more effectively than one that - than people who sit in their office and try to write the memos to respond. I would, however, say that I have noticed probably within the last 10 to 20 years more generally that the whole issue of accountability for people which has become appropriately sort of more acute in terms of the sense of the community, has I think had the unintended consequence of driving the sort of behaviours that you're alluding to.

Yes, yes?-- That people feel that if they're going to be accountable, then they have to try and drive that accountability and if they don't necessarily have the exquisite people skills to be able to get people on side and get people to cooperate, et cetera, then often they revert to a manner of behaviour which is probably seen as demanding and dictatorial, because they know that if they do not perform, and cannot make the organisation perform, then they'll be the ones who are in trouble.

Doctor, I think I understand what you're saying. In a risk adverse climate, it's much safer for a manager to send an e-mail and get a written response-----?-- Mmm.

-----rather than have a conversation in the corridor which can lead to all sorts of issues, including disputes, as to who said what to whom on what occasion, when they first found out?-- Yes.

I can understand exactly what you're saying in that regard but in terms of efficient hospital management, it does sound to me as if it would be much more effective if we could come up with a system where the likes of Dr Keating and Mr Leck are able to engage in casual conversation without a fear that what will - what is said will be used against them?-- I think that's very clearly so. I mean, all of us have been in the position where we have had a casual corridor conversation with somebody which to that individual is a fundamental conversation in their daily lives but to the passing manager-----

Yes?-- -----may be of limited consequence. And it is difficult to balance that flow of information, et cetera, with - with the style, but certainly the style and hopefully what we should be trying to achieve is a situation where people can feel comfortable about delivering what they need to deliver by engaging the team in the delivery of that rather than feeling they have to direct the team or instruct the team. That does require some very good people skills, yes.

The other manifestation of this problem as it seems to me, Doctor, is this increased reliance on committees and forums

and formal structures for discussion with minutes and records and agendas and so on and so forth. I'd be the last to disagree that that is necessary for some purposes but it strikes me that a lot of what we hear went on at various committees and so on could be done much more efficiently over a cup of coffee in a doctors' common room or, you know, even out in the garden on a fine winter's afternoon rather than sitting in a formal meeting where people are inclined to make speeches and the alpha males, as Dr Nydam calls them, tends to take over and so on. Is that your experience?-- That's my experience. I would, however, say that there's probably a necessity for both-----

Yes?-- -----in that I think it was once put to me that you can make the informal structures work better if you have a formal structure around which to use them.

Yes?-- I think if we do make sure that there are committees, they're intended for a purpose, that they're made to deliver that purpose but they are really a means of opening up communication channels which should occur around the informal channels rather than the formal channels.

Is that a convenient time, Mr Allen?

MR ALLEN: Yes, certainly.

COMMISSIONER: We might take a 10 or 15-minute break.

THE COMMISSION ADJOURNED AT 10.46 A.M.

THE COMMISSION RESUMED AT 11.12 A.M.

GERARD JOSEPH FITZGERALD, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Mr Allen, would you be able to excuse me for a moment just to mention some procedural things. It will be obvious to everyone here that we are pressed for time. We remain very keen, although we can't give any guarantees, that we will have our report by the 30th of September as the government has asked us to do. For that reason we need to consider the process for the making of submissions. Can I ask everyone at the Bar table just to think about these dates and perhaps let me know if you see any problems. We expect to conclude the evidence on Friday week the 26th of September-----

MR DIEHM: August.

COMMISSIONER: August, I'm sorry, Friday the 26th of August.

Whatever happens, there will be no sittings the following week. If we need to come back for any further evidence, it will presumably be in the week starting Monday the 5th of September but we're hopeful of avoiding it if possible.

Meanwhile we would like everyone to work towards having submissions finalised for us by Friday the 9th. In the week following that, the week of the 12th of September, people will have the opportunity if they wish to make oral addresses, although we're not going to encourage that. We think it's much more effective to put submissions in writing and, also, we will accept from parties who have leave to appear any submissions in reply by the 16th of September. That leaves us then only two weeks to finalise our report. I don't think we can be much more generous than that.

Can I also say in that context that I am proposing to depart somewhat from the usual practice of Commissions of Inquiry by not asking counsel assisting to provide a closing address or detailed submissions. In lieu of that, in order to ensure that no-one is disadvantaged, anyone who is under consideration for adverse findings will be given clear notice of that and that will been done privately so that people aren't the subject of discussion either in an open forum like this or in documents that are publicly available until they've had an opportunity to respond, and for anyone who is the subject of such notification, that date, the 16th of September, will be the date by which they can respond to any such allegations. Obviously notification will be given as soon as possible but with several of the critical witnesses yet to come for reasons which no-one can be held to blame, any such notification will have to wait until they get in the witness box, and if this adequately explain things, then there will be no need for clarification. That's how things will look but I would like you to think about it and let me know if you see any problems.

Also, under the time constraints under which we're operating, I would encourage counsel, parties with leave to appear, to be as succinct in their cross-examination of witnesses as possible. I am not going to fix time limits or try and impose arbitrary restrictions but I would urge your cooperation to confine things as closely as possible, consistent with your obvious duties to your clients. Does anyone want to say anything about that now or perhaps canvass it at a later time? Thank you. Mr Allen.

MR ALLEN: Thank you, Commissioner. Doctor, if I could just go back to exhibit 230, the confidential audit report. You have confirmed obviously it was prepared by the time of the memorandum to the Director-General dated 24 March 2005?-- Yes.

Are you able to recall whether the report had been prepared prior to matters being raised in Parliament on the 22nd of March and then receiving publicity on the 23rd of March 2005?-- Obviously there was work in progress from the time we left Bundaberg to the time the report was provided. I do recall, even in the vehicle on the way back, starting to put thoughts together at that stage, and Mr Jenkins commenced the process as soon as our return, starting to write up the essence of the report. What was the matter that held us up was really getting benchmarking data, as I mentioned the other day.

So it would be fair to say that as far as the report is concerned, it would have been in the form that we now see, or very close to it, prior to matters being raised in Parliament?-- I think essentially that's so, yes.

Now, in relation to pages 5 and 6 of the report where you identify staff opinion in relation to various matters, would it be fair to say that when there is any specific reference to Dr Patel, that they are positive comments identified?

COMMISSIONER: Mr Allen, the document speaks for itself.

MR ALLEN: And in relation to matters which could be considered to be critical of Dr Patel as voiced to you by staff, those comments are made or produced in a more general manner without reference to the divisional director?-- You may be right. That certainly wasn't a specific intent.

For example, on page 6 where you refer to the credentialing and clinical privileges process having not yet been fully implemented, there is no reference in the report to the fact that Dr Patel had not gone through any credentialing and privileging process?-- That's true.

Was there any other staff member identified who came into a similar category?-- No, there wasn't.

When you refer to the staff not always complying with policies and procedures for patient confidentiality, you have indicated that that was in reference to the indiscreet manner in which Dr Patel would talk about matters?-- Yes.

But it is not stated that Dr Patel would not comply with such policies and procedures?-- That's correct.

And the opportunity for improvement is simply identified as ensuring all staff are aware of their obligations?-- Yes.

There wasn't any deliberate decision not to make comments critical of Dr Patel?-- There was no deliberate decision.

But where there are positive things that could be said about him, such as creating efficiencies in OT, or being a good teacher, he is certainly identified as being the subject of such comments?-- That's a fair comment, yes.

It wasn't a deliberate decision to try and paint a positive picture of Dr Patel because of management concerns that he could be lost to the hospital?-- Not really, no. I mean, the - these were just points - counter points, I suppose, to the points of essence that were raised with us which was around the conduct of the major procedures, I suppose.

COMMISSIONER: Doctor, you did mention earlier that you were concerned about transparency and natural justice issues and matters of that nature. Was part of the reasoning behind the format of the report that you didn't want to say anything negative about Dr Patel until he had a chance to respond?-- We were certainly trying to avoid any - I suppose specific reference knowing full well that these documents do get out into the public arena, but I don't recall ever sitting down and seriously thinking, "Oh, we're going to paint it this way or paint it that way", to be honest.

Yes.

MR ALLEN: In relation to page 7 under the heading "discussion of staff feedback", that's supposed to be, what, a summary of the type of information you have ascertained by talking to staff?-- Yes.

And in the second paragraph it reads: "However, as well as raising concerns, some staff have made complimentary comments about the divisional director's commitment to teaching and mentoring junior medical staff."?-- That's correct.

"There has been a significant improvement in efficiency, specially in the operating theatre and meeting elective surgery targets with significant reductions in waiting times for surgery"?-- That's correct.

There is nothing in the discussion of staff feedback which actually identifies any particular concerns about Dr Patel?-- I am sure that's quite true but I think the issues of concern about Dr Patel are there in the report.

Well, in a discussion of staff feedback you made the point of pointing out those positive aspects in relation to Dr Patel. Why isn't there a discussion as to the matters of concern, any negative aspects regarding his practice?-- I am not sure I have an explanation as to why there isn't but certainly we were all very well aware of the concerns that had been raised by staff.

In the summary of the report, which starts at page 11, you

refer to a number of issues and concerns being raised with the reviewers, and, likewise, in addition, positive comments, and you go on to talk about those and then you summarise the concerns raised by staff into two main groups?-- Yes.

That is "procedures outside the scope of practice"?-- Yes.

And then 2, "lack of good working relationships between all staff and the general surgical service"?-- Yep.

The general surgical service, is that meant to refer to the whole type of scope of surgery being undertaken by Dr Patel?-- Well, general surgery as distinct from gynaecology, ENT, et cetera.

I see, okay. And what was the source for the comments that you include, "The Director of Surgery has high standards and this has led to some degree of conflict with staff"?-- I really can't recall. A number of people did say in the general discussions that they felt that their view of the concerns raised was that he - he wished to churn through patients and treat patients, et cetera, and some people had the view this was causing some conflict with some members who felt they were working too hard.

Okay. So the high standards was his eagerness to churn through patients on the list?-- Yes.

And that's what you were meaning to convey by that sentence?-- Yes.

I see. And then the last page, page 12, "recommendations both strategic and operational"?-- Yes.

There is no recommendation there that there be a more fuller clinical audit of Dr Patel's patients or anyone else?-- No, that's correct, yes.

There is no recommendation there that consideration be given to suspending him from practice?-- No, that's correct.

Or that someone be appointed to supervise his practice?-- That's correct.

Had you ascertained at that point that he was acting as a Director of Surgery without, obviously, any clinical supervision?-- We knew he was operating as the director - yes, I think we had, yes.

Was any consideration given as to whether that was appropriate, given that his initial registration and reregistration was as a Senior Medical Officer reporting to a Director of Surgery?-- At that stage it wasn't but obviously there was further work to be done.

That would have been an easy matter to ascertain, the terms of his initial registration?-- Yes.

You could have had that information within an hour, given your contacts with the Medical Board-----?-- That's correct.

-----in your capacity?-- That's correct.

Why wasn't that matter considered?-- I really don't have any explanation, except it just wasn't at the time.

Was it part of the aspect of the fact that the district didn't want to lose the services of Dr Patel so you weren't going to look too closely into it?-- That was not a matter that would have influenced me.

So that's the report then which is prepared prior to any matters breaking in the press. There is nothing in that report to voice any concerns that management had failed to act appropriately in the past as to complaints regarding Dr Patel?-- That's correct.

Why wasn't that a matter which was considered in the audit and reported upon?-- The issues of the management's performance around quality and safety in general were addressed in the covering letter to the Director-General suggesting that he needed to have a conversation with his managers in regard to the systems and structures that were in place.

All right. So that's the GF14, the memo to the Director-General?-- Yes.

In that you attach the copy of the report and then say, "There are issues which you need to bring to the Director-General's attention."?-- That's correct.

Why weren't those matters included in the report itself?-- Because it was a clinical audit, not a management audit. It was an audit of the clinical care of the patients.

You refer to the fact of the "Director of Surgery having a significantly higher surgical complication rate than the peer group."?-- Yes.

"Undertaking types of surgery beyond his capability"?-- Yes.

"And that of the hospital."?-- Yes.

And "concerns about his judgment." Then the second paragraph - excuse me, the fourth paragraph of the memo: "The audit report also identifies there has been a failure of systems at the hospital which has led to a delay in the resolution of these matters."?-- That's correct.

And that relates to the lack of credentialing and clinic privileging?-- Yes.

"And the executive management not responding in a timely or effective manner."?-- That's correct.

You are saying those matters weren't included in the

confidential audit report because they are management matters, not clinical ones?-- Yes. That's my view.

But the report goes into some detail in relation to matters which are beyond clinical. There is extensive reference to staff being supplied with the code of conduct, and if we look at strategic recommendation number 11, "implement appropriate processes to enable staff to access senior management."?-- Yes.

That's a specific recommendation in relation to management matters?-- I am sure you are correct. I suppose the thing in my mind, though, is about the performance of management as opposed to the relationship between management issues and the conduct of clinical services.

Well-----?-- I don't think there is any firm rule as to what's included and what's not.

No, but you were prepared to say that there should be appropriate processes implemented to enable staff to access senior management. Why didn't you point out that senior management hadn't in fact acted appropriately when staff had contacted them?-- I don't know that we were in a position to form that judgment.

Well, you were able to form it at the time you wrote the memorandum to the Director-General on the 24th of March 2005?-- Well, at least to say there were significant issues of concern.

Well, that the "executive management team at the hospital does not appear to have responded in a timely or effective manner to the concerns raised by staff, some of which were raised over 12 months ago."?-- Yes.

See, it seems that the report itself is somewhat bland and circumspect in painting the situation and that the real picture only comes into the covering memo for the Director-General?-- I can see your point but can I say, though, that the performance of management has to be dealt with in a different process, and obviously there is a major degree of investigation into what they did and what they didn't do which will need to occur following the raising of these issues of concern.

Had there been a change of tune between the time that you prepared the actual confidential audit report and then when you wrote the memorandum which is written a day after these matters received wide publicity in the press?-- It wasn't in my mind because we had those conversations on the way back in the car, which clearly the issues that had stuck out in my mind, apart from the clinical issues, which is the conduct of complicated surgery and the apparent - or suggestion of the high complication rate was the fact that these matters hadn't been dealt with and that there were some issues of the management structure and performance which would need to be attended to.

COMMISSIONER: Dr FitzGerald, is your point really this: that you weren't commissioned to audit the management and their managerial performance. So as far as you were concerned, rightly or wrongly, you thought the way to raise your concerns about that issue was in your covering letter to the Director-General, rather than in a report which was really supposed to be focussed on a different aspect?-- Indeed so, and the other aspect, of course, was in regard to Dr Patel itself, was that that became a matter for the Medical Board to deal with.

Yes, of course.

MR ALLEN: It is only, is it not, after the matter's received wide publicity in the press that there is any steps taken to have a fuller clinical audit of Dr Patel's patients?-- That happened, yes, in that order. I am sorry, I don't quite understand-----

Well, there is the review which is announced on the 9th of April 2005-----?-- Yes.

-----in relation to which you subsequently have input regarding terms of reference?-- Yes, that's right.

That wasn't something which was contemplated, it seems, at the time that you completed your audit report because there is no suggestion that such a further review should occur?-- There is not - there is no suggestion in that report, no, but ordinarily, in circumstances such as this, obviously conversations would occur about what the next steps were.

Well, there is nothing in your memo to the Director-General to suggest there is going to be a fuller clinical audit?-- That's true.

Can we perhaps infer from that that the fuller clinical audit only occurs because these matters receive extensive publicity in late March?-- I am not sure I can speculate on that. I mean, the events - we're probably speculating at the moment, then, of what may have happened if they weren't, and I am not sure that I can really give a sensible answer to that.

You subsequently - and this is obviously after the matter has received publicity - prepare a document which you describe as being an overview. That's GF26 to your statement?-- Yes.

And by that time, obviously, the - well, that document must be prepared after the 9th of April 2005 because it refers to the fact that the Minister has established a higher level review panel to undertake analysis?-- That's correct, yes. I think that document was prepared to - at the time that we visited Bundaberg to provide feedback to the staff.

Right. But when one looks at the overview itself and what's described as the key findings of the review, they're in a much different and stronger tone than the actual audit report them

self, aren't they, when describing the key findings?-- I suppose so, yes.

There is a much stronger tone in that there is a willingness to identify concerns in relation to Dr Patel in particular and that the checks and balances that should - that you have identified as such matters were not in place or did not function effectively.

COMMISSIONER: Mr Allen, the witness has already agreed it was a stronger tone. I don't want to cut you short but the documents speak for themselves. If, ultimately, you wish to advance some criticism of Dr FitzGerald because of the tone he used, you will have the opportunity to do so but I think you have made your point.

MR ALLEN: On the 13th of April 2005 you met with Dr Wakefield and Ms Jenkins and also nurses Toni Hoffman and others to give some feedback about your review?-- Yes, that's correct. Sorry, I was just trying to remember which date that was.

You indicate at that time that your report was finished but it would not be released publicly?-- That's correct.

Why was that?-- Because I suppose the principal thing with clinical audits is we are very reluctant to release them publicly because - I think we made this point the other day the last time I was here, it is about that clinical audits have the potential to identify both patients or sources of information so I would rather they are not produced publicly.

There was nothing in the audit review which could have possibly identified any patients, I would suggest?-- I think that's correct but I wasn't - I mean, I would like to have scrutinised or have independent scrutiny of that because you get too close to these reports and you are not quite sure whether they do identify anybody or not, but as a - just as a general principle, though, that was the point I was making, that we shouldn't release them.

But Blind Freddy could look at the report and see there was no identification of patients. You didn't need some type of review of that?-- But there were identification of people who had made complaints and comments they had made which would be identifiable in the hospital environment.

Comments from the sort of persons who were raising concerns such as Toni Hoffman?-- Yes.

You didn't really think that the staff would be upset or concerned if report was released?-- Well, I did at the time.

COMMISSIONER: Doctor, a point was made in this sort of context, that if you release names of complainants on one occasion, it discourages people from coming forward with their complaints privately in the future. Was that part of your thinking?-- Well, that's the core principle behind not making clinical audit reports public, is because it will discourage

people - apart from the identification, the embarrassment that may cause to individuals, but it does discourage people to be open and frank in their communications in the future.

MR ALLEN: But as far as any identification of staff opinion in your report, there was nothing in there which was actually expressed as being critical of Dr Patel?-- Well-----

Which staff were you trying to protect their confidentiality?

COMMISSIONER: I think the doctor has already said that he felt he was so close to it, he couldn't really pick whether people could be identified. His concern was in the hospital environment it would be possible to work out who had said what, whether it was positive or negative concerning Dr Patel?-- Yes, that's right.

MR ALLEN: Thank you, doctor?-- Thank you.

COMMISSIONER: Thank you. Mr Mullins, is there-----

MR MULLINS: I have just a very brief matter, Commissioner.

COMMISSIONER: Yes.

CROSS-EXAMINATION:

MR MULLINS: Doctor, you mentioned-----

COMMISSIONER: I should mention, Mr Mullins represents the patients of Bundaberg?-- Thank you.

MR MULLINS: Doctor, you mention that on 7 April 2005 you were advised by Mr Buckland that there was an issue relating to Dr Patel's qualifications?-- Yes. I am not sure of the date or the time but it was around about the time after he'd visited Bundaberg, which I think occurred on the 7th, wasn't it? Yes.

You can accept the visit occurred on the 7th of April 2005?-- Yes.

And you told us that he advised you on the same day?-- I understand it was soon after. I remember he called me at home and I don't know whether it was that night or the next night.

Now, you advised Mr Demy-Geroe then within 24 hours?-- Jim O'Dempsey.

Or, sorry, Jim O'Dempsey within 24 hours?-- I am not sure whether Michael Demy-Geroe was there.

Can you clarify did - what precisely was the information that you received?-- I had received that there was some concern -

information there was concerns with his registration in the United States, particularly in the State of Oregon.

Any further detail than that?-- Not that I remember, no. It was that there was some problem with his registration in the United States.

Did the information that Mr Buckland conveyed to you suggest that Dr Patel was in some way restricted from practising?-- Yes. Well, it was in that there was a problem in terms of his scope of practice or history in terms of his registration in the United States.

Now, the 7th of April, you can accept from me was a Thursday. On Friday the 8th of April, Mr Thomas wrote an article in The Courier-Mail which named you and indicated that you had conducted an investigation and gained evidence from interviews with doctors and nurses at the hospital. Can you recollect that article being published?-- No, not particularly, sorry.

I will show you a copy of another article then published on the 9th of April, which was the Saturday. Just the highlighted part, thank you. Can you read that on your screen?-- Yes, I can, yes. Did you want me to read it out?

Just read it to yourself, the highlighted part?-- Okay.

Do you recollect having a conversation with Mr Nuttall prior to 9 April 2005 where you advise Mr Nuttall that there were issues surrounding Dr Patel and they were serious?-- I had a number of conversations with Mr Nuttall. The first was the day I think it was raised in Parliament where he called and asked - and I went down to Parliament house to brief him on the conduct or the investigations of things that were found to date.

By this point in time did you know that there was a problem with Dr Patel's registration in Oregon?-- I am sorry, I am confused of the date of this.

This is Saturday 9 April 2005?-- I think at that stage I knew there were some problems but not the extent of it.

Did you convey that to Mr Nuttall?-- I don't think I did.

Can I just ask you to turn the page over? If you have got a blank page can you cover the handwriting on the other side? This is an article that was published on the 11th - Monday the 11th. Before we come to that, I suggest to you that on the 10th, which is the Sunday, you had a conversation with Hedley Thomas where you discussed these issues - when I say these issues - sorry, you had a discussion about the Dr Patel issues in general?-- I will have to accept your word for it. I had a couple of conversations with Mr Thomas but I am not quite sure of the times and dates.

Read the passage?-- Yep.

And see if you can recollect reading that, on Monday the 11th of April 2005 or at all?-- Well, it's all true, it's certainly things that we found, yes.

Did you personally ever advise any member of the press or the public that Dr Patel's registration in Oregon was problematic?-- No.

To your knowledge did a person from Queensland Health advise the public of that fact?-- No.

Is it the case that the - that fact first came to the attention of the public through the media?-- That's correct.

Well now, if that date was about 12 April 2005, I want to ask you this: you knew between about 8 or 9 April 2005 and 12 April 2005 that there was a problem with Dr Patel's registration?-- That there was a potential problem, what I didn't know was the details. I referred them to the Medical Board and didn't know the details at that stage.

And you and other members of Queensland Health were in regular contact with the media at the time?-- Yes.

Is it the case that you received an instruction from a superior at Queensland Health or some other person that you were not to disclose the information that there was a problem with Dr Patel's registration in Oregon?-- I don't ever recall receiving an instruction to that effect.

Were you ever advised that that issue was not to be discussed?-- The nature of the conversation the Director-General denies it was that he had heard that information and he wasn't able to confirm it at that stage and hence the referral to the Medical Board.

D COMMISSIONER VIDER: Doctor, given the statement there that indicates or you were quoted as saying that the surgery was too complex to be done at a regional hospital in your opinion, no doubt following the evidence provided to you in the audit?-- Mmm-hmm.

Would you have expected that the - that issue would have been identified and worked out by the local executive team and certainly that the Director of Medical Services could have had knowledge that would have concerned him as well and perhaps put restrictions or caps on the nature of the surgery done in that particular institution?-- Yes, I mean, I think, I expressed the other day that my official reaction to the conduct of this surgery was something of surprise, because I felt that this was surgery that should not be done at a hospital of that size, and I suppose I was somewhat surprised that the local senior medical staff would not have shared that surprise at that sort of complex surgery being performed.

Yes, because it's been established with us that regardless of

whether or not a particular clinical indicator was collected, like unplanned return to the operating theatre or unplanned admissions to the Intensive Care Unit?-- Mmm.

Reports were received on the Director of Nursing's desk, and I presume on the Medical Director's desk each morning that would have indicated that there were certain clinical activities happening to patients in Bundaberg that do relate to the clinical histories of these patients?-- That's correct, yes.

That should have been perhaps worthy of some formal inform after investigations to start with. I mean, simply go to the Intensive Care Unit, going to theatre and simply saying, "What happened?"?-- Well, I think that's correct. The obvious thing about the conduct of the surgery there in the first place.

Yes?-- I think is almost in fact speaking for itself.

Mmm?-- But the issues around complication rates et cetera are much more complicated and they do require detailed investigation.

They do, but those complications were very often being played out in Bundaberg?-- Yes, that's correct.

Those complications were either in the Intensive Care Unit or in the mortuary?-- That's right.

Or in the surgical ward very often?-- That's correct.

Or they were coming back through the outpatients department?-- So adverse incident monitoring would have - should have brought that to people's attention.

Yes?-- Yes.

MR MULLINS: Just a couple more questions. Can I just clarify then how this information was dealt with. You were advised on or about 7 April 2005 by Mr Buckland?-- Yes.

That there was a problem with the Oregon registration?

COMMISSIONER: No, I don't think that's what Dr Fitzgerald said at all. He didn't say that he was told that there was a problem with the Oregon registration?-- I was told that there was a problem with his registration. He was registered in Oregon, we knew that, yes.

COMMISSIONER: Yes.

MR MULLINS: All right. In any case-----?-- Yep.

-----you-----

COMMISSIONER: But all that Dr Buckland told you was that there was a problem with registration or that he'd heard there was a problem with registration?-- That he'd heard that there

was a problem with registration, yes.

He didn't go into any details of whether that was in Oregon or New York?-- I think if, from memory, the thing that stuck in my mind was that there was a concern about his Oregon registration was limited, his registration because I knew, I - well, we knew at that stage he had been registered in Oregon and there had been limitations in place in Oregon.

MR MULLINS: And then you sent that information across to Mr O'Dempsey?-- That's right.

And you left the disclosure of that to the public to Mr Buckland, presumably?-- Yes.

Thank you.

COMMISSIONER: Thank you. Mr - oh, did you wish to tender those newspaper extracts?

MR MULLINS: They form part of Mr Thomas' affidavit, I'm not sure.

MR ATKINSON: It's not in evidence yet, that statement, of course.

COMMISSIONER: Yes, no, that's fine. Mr Diehm - I'm sorry, Ms McMillan?

MS McMILLAN: I only have two matters and they just arise out of this morning's evidence, if I might, Commissioner?

COMMISSIONER: Yes.

CROSS-EXAMINATION:

MS McMILLAN: Is this correct, Dr Fitzgerald, from your evidence this morning is that you have a conversation with the journalist on the 7th and within 24 hours or so you first spoke to Mr O'Dempsey about that matter in relation to issues pertaining to Dr Patel's registration; is that correct?-- I'm not sure of the dates but it was, it was latish in the week that I had a conversation with Dr Buckland.

Mmm-hmm, with - well, that's Thursday the 7th?-- Yes.

8th was the Friday?-- The conversation with the journalist I think was early the next week.

So if I put it to you that Mr O'Dempsey next spoke to you on the 12th of April regarding the same issue and you advised that a journalist would contact the Board, you wouldn't have any difficulty with that, would you?-- No, that's correct.

Thank you, Mr Commissioner.

COMMISSIONER: Thank you Ms McMillan. Thank you, Mr Diehm.

CROSS-EXAMINATION:

MR DIEHM: Just continuing on with the same topic - my name's Jeffrey Diehm and I appear for Dr Keating, Dr FitzGerald?-- Mmm.

I ask these questions appreciating the source of your information came from Dr Buckland and not Dr Keating?-- Yes.

But was it the case that what Dr Buckland related to you was that Dr Keating had told him on the 7th of April, which we understand was a Thursday, that the evening before Dr Keating had conducted a search on the Internet and had discovered some problems with respect to Dr Patel's registration in the United States?-- Well, I don't recall the detail, all I know is that he indicated to me his source of information was Dr Keating.

Yes, he didn't say anything to you about how long before Dr Keating had learned of this information?-- No.

Or precisely what Dr Keating had told him?-- No, that's right.

COMMISSIONER: Or how Dr Keating came by it?-- No, that's right.

Yes.

MR DIEHM: Yes, thank you.

If Dr Buckland told Dr Keating on the 7th of April that he would pass that information on to the Medical Board, that would be consistent then with him speaking to you about the matter, wouldn't it?-- Yes, I'm not quite sure whether he actually suggested to me to pass it on but I assume - I assume he assumed I would.

Yes.

COMMISSIONER: Is that or was that at the time the usual conduit, if the Director-General wanted information conveyed to the Medical Board, wouldn't he send a letter or a formal note rather than simply mentioning it to you; were you chairman of the Medical Board at the time?-- No, no.

You were just one member of the Board?-- Yes. Ordinarily, if it's an official correspondence, then it should go through the official channels directly to the chief executive of the Board, but at - sometimes they're - if they need something sorted very quickly, then people will approach me and ask me

for my assistance to try and get information to the Board or get information from the Board on issues.

Certainly.

MR DIEHM: Doctor, I just want to go through some matters in chronological order for the moment-----?-- Mmm-hmm.

-----in terms of your dealings with Dr Keating. You've told us about your first visit to Bundaberg concerning these matters taking place, I think it was on the 14th of February-----?-- That's correct, yes.

-----of this year. And in terms of the process that you went through on that day, can I suggest to you that one of the first things you did was to meet with members of the executive individually and specifically that you met with Dr Keating?-- I think that's right.

And that in that meeting, you sought out some information from him, including questions that you posed about Dr Patel's manner, his attitude and his behaviour?-- That's correct.

That you also asked about issues concerning interaction between the ICU staff and other staff?-- Yes, that's correct.

You asked Dr Keating about Dr Patel's good and bad points?-- Probably, yes, I don't recall.

That's a question you asked lots of people, presumably?-- Yes, yes.

And that during that meeting, Dr Keating informed you, I suggest, that a matter of weeks before the position had been reached where an agreement, if you like, or a direction perhaps to Dr Patel, either an agreement with Dr Patel had been reached or a direction to Dr Patel had been given to the effect that he was not to perform any further oesophagectomies?-- Yes, that was the information we received on the day, yes.

And furthermore, that he was not to perform any further elective surgery that was of such a complexity as to be likely to require ICU support post-operatively?-- I really don't recall the details of that. The two issues were that the major conduct and major complex surgery would require ICU by implication, I don't recall the specifics of that instruction and also the other one was with the complex patients, seriously ill patients that should be referred to Brisbane.

Yes, all right, but in any event, Dr Keating informed you that steps had been taken to put those sorts of restrictions in place prior to your arrival in Bundaberg?-- That's correct, and that was reinforced by Dr Patel himself.

Thank you. Now, you then proceeded to spend the balance of the day carrying out the investigations by speaking to other staff members in the way that you've described for us in your

statement. But you returned to meet with Dr Keating again at the end of the day?-- From memory, yes.

And in effect, this was like a debriefing about what you had learned-----?-- Mmm-hmm.

-----to that stage, or preliminary views?-- I think that's correct. I can't remember whether there was a group - there was a group there or whether it was individually at the end of the day.

All right. Now, at that meeting, I suggest to you, you informed those present, whether it be Dr Keating and/or others, that one of the concerns you had was that there had been operations performed which were outside the scope of practice for the hospital?-- I'm sure that was discussed, yes.

Yes. That you thought that it would be appropriate for the hospital to determine its scope of surgery and to make that well known amongst staff?-- I'm sure that was - was a conversation about that, yes.

Of course, that was ultimately part of the ACHS process that was being implemented over that year as a result of Queensland Health policy anyway, wasn't it, for that?-- The ACHS? Oh, you mean the credentialing and privileges process?

Yes, the policy that you told us-----?-- Oh, the service capability?

The service capability, I'm sorry, yes?-- Yes, yes.

You also raised your concern about the fact that there had not been a credentialing and privileges process put in place with respect to Dr Patel or at least implemented for Dr Patel?-- In regard to Dr Patel, yes.

Yes?-- There was a credentialing and privileges process.

Yes?-- But it had not occurred with Dr Patel.

Now, you did understand, did you not, that that - it wasn't just Dr Patel who had not been through such a process, any surgeon, as it were, at the hospital would not have been through such a process either?-- Yes, I don't recall having a conversation of that - I do recall having the conversation around the fact that the College of Surgeons had not supported and that's why Dr Patel had not been credentialed.

Well, it would follow that any other surgeon would not have been through a process either?-- That's probably true, yes.

COMMISSIONER: Any other surgeon who had come recently such as Dr Gaffield, and I think Dr Anderson was still visiting at that time - perhaps I'm wrong.

MR DIEHM: Dr Gaffield was a staff surgeon.

COMMISSIONER: You're not talking about VMOs, for example?

MR DIEHM: I'm not specifically talking about them, Commissioner, though the position you understood it, Dr FitzGerald, that the credentialing and privileges process had been dormant at Bundaberg Hospital for a couple of years?-- We didn't obtain that information broadly, what we obtained the information that was provided to us was that they had not credentialed Dr Patel so we probably didn't specifically question the other individuals.

But nevertheless you understood that the reason it hadn't happened was the reason of the system problem in the sense that it was viewed that it was necessary to have a nominee from the College of Surgeons?-- That's correct.

And that that hadn't happened and that therefore the committee hadn't been able to do its work?-- That's correct.

And your advice at that stage was that what the executive at the Bundaberg Hospital should do would be to, as it were, put aside the policy and implement some other program practical solution to the problem?-- I'm not quite sure what that conversation was about, but it certainly - the conversation at that stage was about the complicated surgery. I'm sorry, I'm not quite sure what you mean by that?

MR DIEHM: I'm sorry, I'll be more specific, Dr FitzGerald?-- Yeah.

That what you advised the executive, was that if they couldn't get a nominee from the College of Surgeons, was to simply get somebody else who had not simply been nominated by the College of Surgeons?-- I see what you mean, I'm sure we would have done that, I'm not - it's a long time ago, I'm not quite sure of the details.

Sometimes the questions are a bit vague too?-- Yes.

You told Dr Keating at that stage that you were unsure if you would refer the issues concerning Dr Patel to the Medical Board but you would need to have some further investigations carried out?-- Yes. At that stage, I was really unsure of what - we'd had a very heavy day of information provided, and it became sort of clearer during, I suppose, as we started pulling together the information in our heads, if nothing else, that clearly the fundamental issue was the question of judgment, as to the judgment to undertake these sort of surgery at Bundaberg and that that by itself was worthy of further investigation.

D COMMISSIONER EDWARDS: This was a judgment by Dr Patel?-- By Patel, yes.

MR DIEHM: Doctor, you told, I suggest, those present, that something that you had identified was that there were some significant personality difficulties or issues amongst staff,

including Dr Patel?-- Yes.

And that was particularly the case with respect to the ICU?-- Yes, that had been raised by a number of people, yes.

You told them that you thought that the case concerning Mr Bramich had been the trigger for the complaint being formalised, as it were?-- I think that's true, yes.

And that you yourself had particular concerns regarding problems with the Employee Assistance Scheme for ICU staff arising out after that issue?-- Yes, I don't recall saying that, but I mean, it was an issue that was raised at the day that a number of staff said that they'd accessed the scheme and found it to be particularly unhelpful.

You told those present that you thought that one of the issues was that Dr Carter, who was the head of anaesthetics, tended to pour oil on both fires, that is, on the nurses and on Dr Patel?-- I really don't recall making those sort of conversations, I'm sorry, it was a long conversation. I do recall that some of the anaesthetists and Dr Carter had spoken about his concern that there were people - two sides in the camp, et cetera, but I'm not sure that we got to a judgment that would have mentioned him particularly as being doing something inappropriate, if that's what you're inferring?

I'm not inferring anything in particular, I'm merely relating to you-----?-- Yeah, I'm sorry, I don't recall making that conversation about Dr Carter.

Thank you. Doctor, you told them, assuming it was more than Dr Keating present at this meeting, that you intended to complete your report in about four to six weeks time?-- Yes.

But that you would prepare a draft initially and forward it to the executive to enable them to review the facts before you finalise the report?-- Well, that was our intent at the time, but unfortunately events took over that.

Yes. You also told them that you thought that there was a need to improve data collection and review?-- Yes.

Now, your next contact with Dr Keating, I suggest, was when you returned to Bundaberg in April?-- Yes.

You initially met with the executive in the presence of John Wakefield?-- John Wakefield and Susan Jenkins I think were both there.

You outlined four major areas of concern that you had following your further investigations which included the scope of hospital practice?-- Yes.

A higher complication rate which you thought required further investigation?-- Yes.

Failure and quality of safety systems?-- Yes.

And some problems with respect to morale?-- Yes.

You then outlined for the executive your intention with respect to the process for the day in terms of you having meetings with groups of people within the staff of the hospital?-- That's correct.

I suggest to you later in the day you spoke with Dr Keating alone and you told him that there was a problem in the sense that there was some senior medical staff who were very unhappy, in particular, Dr Miach and Dr Strahan?-- Yep.

You thought that there was going to be a need for a lot of bridge mending or building to be done by Dr Keating with staff, and indeed, you suggested some options as to how he might go about that?-- I must take your word for it, I remember there was a conversation with Dr Keating.

All right. Now, Dr Keating asked you - and in this private meeting - as to whether or not his position remained tenable?-- Yes, that's correct.

And you told him that that was unclear, but if it became that way, he should contact you and you would see what you could do to help him?-- Yes, that's correct.

Now, following on from some questions that Mr Allen asked you, at the time of your - the conclusion of your interviews and so on in Bundaberg in February - as I think you acknowledged last time you were here - you didn't form the view at that stage that Dr Patel should be dismissed or suspended from practice at Bundaberg Hospital?-- That's correct, yes.

You quite fairly obviously thought that it was appropriate that there were limitations on the scope of his practice-----?-- Yes.

-----which were to provide protection. And by the time you prepared your draft report, you still didn't have that view, that he should be either dismissed or stood down?-- That's correct.

And nor did you necessarily have the view that his contract should not be renewed, I suggest?-- I don't think I formed a particular view about his contract, except to say that there was not grounds for his dismissal in what we had found so far.

Yes. But you didn't make any recommendation, for instance, as you might have done-----?-- No, that's correct.

-----in your report that should his contract come up for renewal, that it not be renewed?-- No, that's correct, yes.

Just bear with me please. In paragraph 75 of your statement; can you turn that up?-- Yes. Yes.

You mention there that Dr Keating and Mr Leck had told you in

February that there were no patient complaints or adverse incidents about Dr Patel, and you then go on to detail some further information that you were provided on the 15th of April 2005 through Mr Bergin's office?-- Yes, that's right.

At the time that you met with Dr Keating and Mr Leck, you knew that there were, as it may be described, adverse incidents concerning Dr Patel?-- Yes, yes, that's right.

I'd suggest to you, Dr Fitzgerald, that the question that you asked of Dr Keating and Mr Leck was whether or not there were any claims that had been brought, that is, civil claims, that had been brought by patients arising out of Dr Patel's conduct?-- My memory of the question was had there been any complaints from patients? I mean, obviously there had been adverse events, but had there been any complaints from patients.

Yes?-- And we were informed again, from my memory, that no there hadn't, that the only complaint that they could recall was actually against Dr - the other American.

Dr Gaffield?-- Dr Gaffield-----

Well-----?-- -----at that stage.

-----I suggest to you that what they told you with respect to Dr Gaffield, or at least this is what Dr Keating told you, was that there had been in fact some claims against the hospital concerning Dr Gaffield's treatment?-- Yes, I don't recall whether it was claims or complaints - complaints the issue we were asking was in terms of balance having heard from the information from staff we were asking the question, "Well, what do the patients think?"

Well, with respect to the case - I'm sorry, I withdraw that. I suggest to you that what they told you or what you were told concerning patient complaints was that there had been some minor complaints but they have all been resolved?-- I don't recall that, all I know is what I recall was that we were told that there were no patient complaints.

Were you aware that there was in fact a claim, as it were, concerning the case of Mr Bramich?-- At that stage?

Yes?-- No, all I remember was that I think Mr Bramich's case was going to the Coroner anyway, so.

Now, with respect to the further information that you were provided, that, as I understand it, is part of or is contained in GF19 to your statement. Now, the first of those matters concerns a letter from P53?-- Yes.

Are you aware now or were you were then that the surgeon involved in the treatment of that patient was not Dr Patel?-- I certainly wasn't aware then and I probably am not aware until you've just mentioned it.

Because we can see that the fourth page of that exhibit is a letter or is a document that is purportedly authored by Dr Patel?-- Yes.

Which is some sort of review of the patient's case, but this patient, for instance, if there hasn't been evidence elsewhere but certainly the evidence of Dr Carter last week that the surgeon involved in that patient was not Dr Patel, but that's news to you?-- That's news to me, yes.

Thank you. Now, I want to ask you some questions about the draft report that you prepared; do you have that handy?-- Yes, somewhere.

Now, on page 4 of the document, you set out there for us some detail regarding data from the Client Services Unit of the Health Information Centre?-- Yes.

Now, that particular database is one that comes out of a system called HBICS; is that right?-- I think that's correct. It's the admission/discharge data sheet.

The database itself is not one which is able to be directly accessed by individual hospitals, is it?-- I really don't know. We obviously got our information directly from HBICS - from the Health Information Centre people. I'm sorry, I just don't know the access to that system personally by hospital-----

COMMISSIONER: Do you know whether your office could access it directly?-- I don't think they could - I could only assume they couldn't because Susan Jenkins actually had to contact the Health Information Centre to obtain the data.

And is that something that a medical superintendent or a manager or whatever of a hospital could equally do in seeking data like that from the centre?-- Yes, they could. Obviously they would probably have to approach the Health Information Centre but I'm not sure whether this system is otherwise widely available.

Thank you.

MR DIEHM: What I suggest to you the process with respect to that database is that it is the case that hospitals can request information from it. Sometimes those requests will be met, sometimes they won't, but you're not in a position to comment directly about that-----?-- No.

-----given what you've already said?-- All I remember is Mrs Jenkins had some difficulty getting the data but ultimately it was provided.

COMMISSIONER: And it would be fair to say you probably would have more pull in the system than a medical director or a - even a manager in a regional hospital?-- I would like to think so but I'm not so sure sometimes.

MR DIEHM: Did it take about six weeks for you or for your subordinate to get that information?-- There were two sources of data from memory that Susan was finding for me, one was from the Health Information Centre and the other was the Australian Council of Health Care Standards. I think it was the latter that took a longer time. The benchmarking data.

The benchmarking, yes, thank you. Now, is it the case that some of the information in the system described as transition 2 is drawn out of the HBICS system?-- I - that's what I understand but I must admit, I don't know too much yet about transition 2.

Thank you. Well, do you know this much, that it is transition 2 which is routinely accessible to hospitals without getting somebody's specific approval?-- I would have to accept your word from that.

Well, it will have to be evidence from somebody else, Doctor?-- Yes.

COMMISSIONER: Well, in a sense, Mr Diehm, in this sort of proceeding there probably doesn't. If you can tell us on your instructions that that's the case, unless someone else wants to challenge it, I'm sure we can accept your word or your client's word on your instructions.

MR DIEHM: Well, those certainly are my instructions Commissioner.

COMMISSIONER: Yes.

MR DIEHM: Now, one other type of database that you mentioned in your evidence last time you were with us was the measured quality data project?-- Yes.

Now, this was a specific project, was it, carried out over the last 12 months or about 12 months ago?-- Yes, it was. I think it was reported about 12 months ago, from my memory of it, so it would have undertaken the preceding one to two years I think that data would have been collected.

Is one of the things that was done in that project was to take the raw data from the likes of the CSU system in terms of adverse outcomes and put it through a process that risk adjusted that data?-- My memory of that report is that that did occur in certain areas where that could be done.

Yes?-- It was an attempt to try and get a balanced view of the - of the sort of - the outcomes, I suppose, the quality outcomes across the system.

And perhaps consistent with that, consistent with the term I used of risk adjusting the data, is that it would look at the incidents of adverse outcomes but attempt to adjust those statistics based on other considerations such as age of patients, comorbidities and so on?-- Yes, that's correct. I mean, that is the essential step that needs to be taken. The rough - the data as it comes off straight off the system is very raw data and is - will not be adjusted as you say, adjusted for risks of various patients. There are mechanisms of doing that, they are often very complicated mechanisms, but certainly intensive care wards, for example, have a means of assessing the risks of their patients and therefore adjusting the outcome data accordingly.

So that sort of data that comes out of the measured quality project as it were would be very useful for hospital managers?-- Yes, it would be.

That information is not available though, is it?-- I don't know. It was from my memory a one-off exercise. I'm not sure how much has happened subsequently.

You're not aware of the report or the outcome of it in documentary form becoming cabinet in confidence?-- I do

recall that it did become cabinet in confidence.

And a result of that is that the information isn't available-----?-- Isn't available publicly, that's correct.

COMMISSIONER: Do you know whose decision that was?-- No, I wasn't involved at all in those conversations.

Were you-----?-- I assume it was the Minister's.

We often read suggestions that as a system of avoiding freedom of information legislation, documents are sent to cabinet not because cabinet is interested in reading them but simply to run the trolley through the cabinet room so that they are then immune from disclosure. Have you had any experience of that in your time working for Queensland Health?-- In Queensland Health, I - I've never been involved in conversations where that was alluded to. Obviously that is common rumour that has been around in my experience in public life for 10 or 15 years and I have seen it happen before.

Certainly not confined to the present government or governments of the same political persuasion?-- Or to the health department, yes.

Or to the health department.

MR DIEHM: Doctor, with respect to the data out of the CSU, is it also the case, and you've mentioned before it is very raw data, that from an analysis point of view, one of its upper limitations is that it is not, to use a phrase, clinician validated?-- Oh, that's very true. I mean, because it's very raw data it really needs to be analysed in further detail before judgments can be made, not only for the risk of validating but also determine what's meaningful.

Yes?-- In that if we were to look at a particular incidence and look at a particular complication rate, we don't really know whether that's meaningful or not until we have the clinicians sit down and say that's the expected or unexpected outcome of that. I suppose the value of the data, of the analysing high level data is to identify issues that can be benefited by subsequent, further detailed examination.

And that's all you intended to do by referring to that data-----?-- Exactly, yes, yes.

Now, if I can take you to page 8 of your report, please. You there, in the first table that's reproduced, give us some statistics with respect to rates of unplanned re-admissions?-- That's right.

In terms of those figures, giving the number of patients involved in particular, is it right to say that there is no clear differentiation or distinction that can be made between the period between January and June 2003 versus the three later periods?-- That's right. I mean, without any complicated mathematics the variances would probably not be

significantly different over those periods.

So if Dr Patel didn't start at the Bundaberg Hospital until the 1st of April 2003, albeit that falling in the middle of the first of those periods, it makes it difficult to pick up from that data that there has been any significant change from the time of his operating out of Bundaberg on that criteria?-- That's correct.

No, going over the page to page 9, the figures there in that table which specifically relates to bile duct injury, you've got in brackets underneath the table "small numbers should be interpreted with some caution"?-- Yes.

Is that simply to reflect the proposition with these low numbers it is difficult to identify with certainty any significant trend with respect to this particular complication?-- Well, that's exactly right. I mean, if you look at - when we're talking about two - two cases with injury, that can be - can occur by chance.

Yes?-- So that's certainly the concern we were trying to express with the subtext note.

Incidentally, are you able to shed any light on the time period with which - within which the information concerning the last of those semesters would become available?-- I'm sorry, you mean when would you get the July to December figures?

Yes?-- I think those figures came from the hospital, so I would imagine they'd be relatively readily available.

Yes, they've become available - well, certainly available to you by February, weren't they?-- Yes, that's right.

COMMISSIONER: But that - it doesn't necessarily follow that Dr Keating or Mr Leck would have had them much - much earlier than that?-- Well, certainly not that last worrying figure, which was getting up to an eight per cent rate.

Yes.

MR DIEHM: Doctor, was it your understanding from your investigation carried out in Bundaberg that the problem with respect to the surveillance of data and the analysis of it was that the hospital wasn't accessing sufficient data to identify the problems that might have otherwise been identified?-- I'm not sure that's what was - concerned us most on the day but rather what they were doing with it. If - and bear in mind that on the day we didn't actually have this data-----

Yes?-- -----but in the report we did, and this data would have been available and I'd imagine if you look at the - the table at the top of page 9, which shows rates which in comparison with the table underneath are significantly higher than the national average or - for those sort of figures.

Yes?-- I think it was what concerned us was that the systems in place - the systems and structures in place appeared to be in place but they just didn't seem to be able to deal with this issue, whether that's because the issue was too complex or because they just didn't - didn't work.

Yes?-- It was too early for us to speculate and, ultimately, the responsibility of management to fix up I think. But certainly, they weren't working to the satisfaction of resolving these concerns.

Yes. With respect to the use of data for managing of complications and performance, we have heard some evidence late last week, Friday indeed, that what seemed to have happened within Queensland Health over the last few years has been a strategy to devolve responsibility for clinical management down to the Clinical Directors rather than perhaps where it lay exclusively before. Exclusively may put it too high but shifting it downwards from the Director of Medical Services to the Clinical Directors. Are you familiar with that?-- I see, do you mean within the hospitals?

Yes?-- Rather than central office to the hospitals?

That's right?-- I'm not particularly aware of any formal policy in that regard but I would suggest that it is a good idea to try and get devolved decision making down to the lowest possible levels.

Yes. One of the implications of that though - I'm not challenging you about whether it's a good idea or otherwise, one of the implications of that though is if you get a person dishonest as he appears to have been and with the competencies and perhaps the ego of Dr Patel and is that - that's the person you end up relying upon to be looking for the data and to be using the data in terms of the management of the surgical unit at Bundaberg Hospital; would you agree?-- I think that's quite correct, yes.

Because under that model of management, you would very much be expecting the Director of Surgery as well as the Directors of the other departments to be making decisions about what data they want to access and how they want to use it in terms of managing their own departments; would you agree?-- I think that's correct, yes.

You made your observations about the surprise that you had that Bundaberg Base Hospital was having operations such as oesophagectomies performed there and indeed I think you offered the view that you would have ordinarily expected a Director of Medical Services to be surprised at a suggestion that such an operation would be performed at a hospital the size of Bundaberg. Would you expect a Director of Medical Services confronted with that issue, for that person to liaise with and take the advice of members of their staff such as the Director of Surgery, the Director of Anaesthetics about the capability of the surgeon and the hospital to manage such a patient?-- Indeed so. In fact, it's subsequent to these

events that an instruction was issued that such surgery shouldn't be done which has resulted in major complaints from some of our big - bigger provincial hospitals, that they feel that they have made that judgment appropriately with the advice of the surgeons and the peers concerned. So, that is the normal way one would expect that to occur, that the Medical Superintendent should take advice from the college, relevant college, from the other experts in that field to see whether it would be appropriate to conduct that surgery at that location.

COMMISSIONER: But with a proper and functional credentialing privileging committee, that would happen automatically?-- That's correct, yes. That's the process one expects if that's to occur.

I meant to raise with you and you just reminded me of it when you were in Townsville last week, the Director of Medical Services there seemed a little bit disappointed that that decision had been applied to Townsville without consulting with him. Do I take it that such consultation will take place and any necessary revisions will be made?-- I already had a conversation with the Medical Superintendent up there about a mechanism where that could be dealt with but a - a contrary instruction to that effect would be issued in the next day or so.

Thank you.

MR DIEHM: Doctor, just so I can understand what you're describing has happened since these events, was it the case that there were other provincial hospitals in Queensland that like Bundaberg were performing operations such as oesophagectomies?-- Yes, it is. One of the exercises we asked after looking at this issue was for the data to be scrutinised to see who else was performing these operations. The vast majority of those operations were performed at the largest hospitals, the Princess Alexandra, the Royal Brisbane Hospital and, in the private sector, the Mater Private Hospital but there is over the last three years, the data we've collected, has been a small number of oesophagectomies performed at other provincial regional hospitals.

Are you able to say which ones?-- Not from memory. But-----

Can I ask you it this way: are any of them the same sort of size and capability as Bundaberg?-- From memory, places like - most of them I think were places like Rockhampton and Toowoomba, of that size, which is a much - which are much more substantial hospitals than Bundaberg but, I mean, if it's useful, I could recover that data and submit it.

COMMISSIONER: Perhaps counsel assisting can follow that up with you, thank you.

MR DIEHM: Thank you. Doctor, even without that more specific information, it's the case that Queensland Health has the view now and would have had the view earlier had it known that such

operations were being performed in those sorts of hospitals, that they shouldn't be?-- Look, I think so. Well, I think most of the senior clinicians would have the view that they - those sort of operations, being very complex operations, should be performed by people who are doing them all the time.

Yes.

COMMISSIONER: Doctor, I take it the only certainty where you draw the line is if you include Townsville, and if you include Townsville, whether you include Rockhampton, Toowoomba and Gold Coast and so on?-- That's correct.

But it's the major hospitals in any event that you think it should be confined to?-- I think the major hospitals which have the infrastructure to support it but then you need to have the surgeons who have the particular experience in that procedure.

And, as a number of witnesses suggested, a sufficient frequency of that operation to remain competent?-- Both for the surgeon and also the hospital.

Yes?-- Because of the - particularly around the intensive care infrastructure required to support it. It's not just the surgeon; it's the intensivists and the staff, et cetera, who need to be experienced in dealing with those patients as well.

Yes.

MR DIEHM: And that's the problem that has been identified with some of these other provincial hospitals performing such surgery, is that they're not doing them often enough and they don't have the capability to provide the support, post-operative support for the patients; is that right?-- That's correct, yes, yes.

But in each of those instances the Directors of Medical Services were permitting such operations to happen in those hospitals?-- Well, those operations were happening in the hospitals and I'm assuming the Medical Superintendents knew about.

Perhaps we can presume that, because you suggest that some of them complained since receiving the direction that they not have those operations performed at their hospitals?-- I think they got - the relevant surgeons raised their concerns very quickly.

Is it your understanding that those smaller hospitals, where they have been directed not to continue, were doing those operations where the Director of Medical Services was acting on advice from staff such as the Director of Surgery and Director of Anaesthetics, that it was in order for those operations to proceed at those hospitals?

COMMISSIONER: Or a formal credentialing process and

privileging process?-- Or that the credentialing process hadn't worked to that level of detail. Obviously the decisions - a surgeon constructs the operating list and wouldn't necessarily inform the Director of Medical Services of any particular operation that was on the list.

MR DIEHM: Yes, quite so. But even after the event, assuming the possibility that the Director of Medical Services did not know of any of those operations being performed in those hospitals, on learning of it afterwards, they were put out as it were that they were being told not to do them anymore?-- The particular complaints came from, well, obviously Townsville, which was concerned that they did have a surgeon who had the capability to undertake these procedures and the facilities and resources to support it.

Yes?-- And the other location from memory of course was the Mater, which does have highly qualified surgeons undertaking these procedures. The instructions that had gone out directed that they should be restricted to the Royal Brisbane and PA alone.

Doctor, perhaps to conclude on this topic, the fact that the performance of such a procedure might follow from a credentialing and privileging process that allow for such an operation to happen is no different in practice to the operation happening based on advice being given to the Director of Medical Services specific or outside of the credentialing and privileging process from senior clinicians within the hospital because in either case, in your view, it is wrong for such privileges to be extended?-- I think that's true. The judgment of - of those sort of procedures I think, whether they should be performed or not, even - even if the local surgeon felt that he had the capability to perform them, I think most of the senior surgeons in the college would strongly support the view that I have, which is that they should be performed in locations where they are done regularly.

COMMISSIONER: But, Doctor, to respond to Mr Diehm's question, surely the difference is that if it's simply the surgeon himself, like Patel, saying, "I should be allowed to do these operations", that's quite different from an independent body, whether or not it has formal approval or imprimatur from a College of Surgeons, that an independent body including independent members of the College of Surgeons saying, "Yes, we know this surgeon, we've examined his skills and we think he's up to doing this sort of operation and the facilities at the hospital are capable of supporting it"?-- Yes, that's the intent of the credentialing process, is to make those judgments and make them independently of the people concerned.

Yes.

MR DIEHM: And, Commissioner, I wasn't meaning to suggest that there obviously wasn't a difference in the matter you have just pointed out.

COMMISSIONER: Yes. I know. Mr Diehm, how much longer are you likely to be?

MR DIEHM: Not very long.

COMMISSIONER: Thank you.

MR DIEHM: I wouldn't like to express it in minutes, though. One of the bits of information that you received as a result of your investigation in Bundaberg albeit that you may not be too clear about when you necessarily received it was an audit of peritoneal catheter placements on six patients at the Bundaberg Hospital and you gave some evidence about it last time. Clearly, having been provided with that document and having had the opportunity to consider it by the time of the provision of your interim together with other information that you had, you still hadn't formed a view that Dr Patel should be suspended from practice or dismissed?-- That's correct, because that, basically, was a list of procedures, I think as I indicated last time I was here, where to me it just stuck out that he couldn't do it and he had been stopped doing it some time previously.

So it was no longer of a concern to you because he just simply wasn't doing those procedures anymore?-- That's right. Dr Miach had ensured that they were being done elsewhere.

D COMMISSIONER VIDER: Was it a concern to you, Doctor, that from the evidence that we've received, that wasn't necessarily an insight that Dr Patel had; it was Dr Miach who said, "I will not refer patients to you for the insertion of Tenckhoff catheters." It reflects, I suppose, the concern I've always had with Dr Patel, has been his judgment and decision making. I don't think anybody else expects a general surgeon in a regional location to be able to do every surgical procedure. And I think most regional general surgeons confronted with - if their past experience had been such that they had not undertaken this procedure, or felt not confident in it, would have immediately said, "I don't know how to do this", and would have worked with Dr Miach to ensure that those patients were looked after by somebody who could do that procedure or would undertake efforts and steps to learn the procedure properly.

MR DIEHM: You were asked some questions about this document last time, about what impression it would have left you with if you were a Director of Medical Services and you were given that document and what you might do with it. Firstly, if you were given that document at a time where that procedure was no longer being performed by the surgeon concerned and was not going to be performed by him into the future, you would regard it as a dead issue?-- Except for the element of judgment.

Yes?-- Which perhaps would warrant a conversation with the individual concerned to find out why.

Again-----?-- To find out why.

Assuming some things about what the document contains, which I needn't trouble you with, but it was put to you on the basis last time on receiving that document I understand there is a 100 per cent complication rate?-- Yes.

With respect to the performance of that procedure. If you were a Director of Medical Services, given that document at around a time when you learned there was to be investigation into the surgeon's competence, it wouldn't cause you to do anything special on the basis of that document, would it?-- Except perhaps to submit it to the investigators.

Thank you.

COMMISSIONER: Sorry, that implies that you are going to have an investigation?-- Yes, but I thought that was the scenario that you were-----

MR DIEHM: That was the scenario I put to the witness, yes.

COMMISSIONER: Would that document alone have been enough to cause you to feel the need for an investigation?-- I think - if I could imagine myself in the shoes of perhaps Dr Keating, presented with that I would want to talk to Dr Patel about why this occurred.

Yes?-- And perhaps to get Dr Miach and Dr Patel together to discuss this issue.

Your biggest concern would be that if he's doing one operation which he is obviously not capable of doing successfully, it may be he is doing others that you don't know about?-- That, and the exercise of his judgment as to why he would be choosing - why he would be boldly proceeding in a circumstance where clearly he was unable to do this procedure.

Yes, why when you have got four failures you go on with the fifth or the sixth?-- Exactly.

MR DIEHM: Doctor, if you were given that document and not given any explanation about it in context, would one of the things you would want to know, presumably, is some more information about the context?-- Exactly. That's why I think conversations would need to occur with the doctor concerned, which is Dr Patel in these circumstances.

Yes. But also with Dr Miach, I think you suggested as well?-- Of course.

Thank you, Commissioner.

COMMISSIONER: Mr Diehm, just before you sit down, Dr FitzGerald's covering note to the Director-General which accompanied the report - I think it is dated the 24th of March - it contains some things that might be thought to be critical

of your client - I am not saying that they are or should be viewed that way, I just wonder whether you wanted to enter on that issue at all?

MR DIEHM: Commissioner, I have considered that and can I-----

COMMISSIONER: Say no more.

MR DIEHM: Can I just say, so it is clear, I have taken the doctor's evidence to be that he wasn't forming any view about those matters and he was raising them for someone else's consideration.

COMMISSIONER: I think that's a fair interpretation of the evidence.

COMMISSIONER: Mr Ashton.

MR ASHTON: Thanks, Commissioner.

CROSS-EXAMINATION:

MR ASHTON: Doctor, I just want to - I think I can help you clear up the issue of just what material you received from. Mr Leck and I wonder if to undertake that exercise we mightn't just quickly check the sequence or chronology. The first contact I think you agreed was the telephone call by Mr Leck to Rebecca McMahon. That appears in your record. That's at-----?-- Of which there is the filenote?

Yes?-- Yes.

COMMISSIONER: Doctor, if it wasn't obvious to you, Mr Ashton is representing Mr Leck in these proceedings.

MR ASHTON: Forgive me, Commissioner. Forgive me, doctor?-- Thank you. Yes.

You see that's the first record?-- Yes.

Can I just incidentally suggest - and maybe you don't know, but that filenote is dated the 17th of December but the call appears to be made on the 16th. If you look at the next document, you will see Rebecca McMahon sends an email to Mr Leck on the 17th of December. "I refer to our telephone discussion yesterday"?-- Yes.

So it is perhaps the case - and it is probably in the material - it is perhaps the case that the memo was created on the 17th though the call was on the 16th?-- That could be correct, yes.

All right. Now, then on the 16th Mr Leck faxes the copy of the Hoffman letter to Rebecca McMahon. That appears in your

material, does it not?-- Yes.

And then on the 17th of December Ms McMahon emailed Mr Leck - that's the one we just looked at?-- Yes.

And cc'd it to you?-- That's correct.

That was your first direct contact on the issue?-- Yes.

Right.

COMMISSIONER: Do we know whether the facts of the Hoffman letter included the attachments?-- No.

That's a subject on which Dr FitzGerald expressed uncertainty earlier.

MR ASHTON: Yes, I can't answer that, on my instructions, what Ms McMahon sent to you but you are uncertain about that?-- Sorry?

The email was cc'd to you?-- Yes, it was just the email initially.

Thank you, doctor. I don't suggest otherwise. What I would like to suggest to you, though, is - and you might not know this but that Mr Leck telephoned your office then on the 17th of December to try to speak to you?-- Yes.

But was advised that you had the email, you were aware of the matter, you were going on leave and you would look after it. Can I put that to you?-- I don't know the date of that telephone conversation.

But you accept there was such?-- I understand there was a conversation that occurred at some stage. It didn't occur with me that I remember.

No?-- But it occurred with somebody in my office.

Yes?-- Who said that-----

If I put that to you that was on the 17th of December, you wouldn't disagree with that?-- No, I wouldn't. No reason to.

Thank you. Now, Mr Scott was sent an email from Mr Leck on the 13th of January and Mr Scott replied on the 20th - and I think those documents are in your material as well?-- Yes.

COMMISSIONER: I think that's Dr Scott, isn't it?

MR ASHTON: Sorry, Dr Scott, thanks, Commissioner. Yes, Dr Scott?-- Yes, I understand that.

And I think from your evidence you were unsure just when that material might have come to you, that is those two e-mails. Can I just take you to - bear with me - yes, appears at GF9. I think it is the first page of GF 9. That's Dr Scott's reply

on the 20th of January. Do you see that?-- Yes.

And you see it says, "Thanks John, have discussed matter with Gerry FitzGerald and progress is being made."?-- Yes, sorry, whereabouts?

That's the email of the 20th?-- I see, yes.

Does that suggest, do you think, that the content of Mr Leck's email to Dr Scott has been brought to your attention by Dr Scott?-- It does, yes.

Yes. Thank you. And that's on or about the 20th, I suppose, some time - since that's the date of his reply?-- The 20th-----

Of January?-- -----of January which was after my conversation with Peter Leck.

Yes?-- Yes.

All right. Now, it had been on the 17th of January that Mr Leck telephoned you. That's right, is it not?-- Yes, I think that's correct.

It was after your return from leave?-- Yes.

Then on the 19th of January Mr Leck sent you the material?-- That's right, material later.

Can I just ask you to have a look at this bundle. This comes from the hospital file, so it is not confused with the interleaving of material you received from other sources. I have copies, Commissioner. I've just parted with my own copy in which I underlined a couple of things, doctor. I am not sure if it has got to you or not.

COMMISSIONER: Mine doesn't seem to have any highlighting or underlining.

MR ASHTON: I merely underlined the attachment numbers so it probably doesn't matter, Commissioner.

COMMISSIONER: Right.

MR ASHTON: If you look at that, doctor, you will see that's Mr Leck's memo to you, isn't it, of the 17th?-- That's correct.

Of the 19th, I am sorry?-- 19th, yes.

And if I just take you quickly - I am conscious of not detaining you unnecessarily. You see in the third paragraph there is a reference to attachment 1?-- Yes.

That's Ms Hoffman. He says, "Ms Hoffman placed her concerns in writing."?-- Yes.

Attachment 1. And if you go quickly through the bundle you will see a document which is headed "Faxed message" and it has got attachment 1 on it. Do you see that? It is the third page of that bundle?-- The third page, I am sorry, yes.

See the words "attachment 1"?-- I see.

You see what follows is Toni Hoffman's letter?-- The letter from Toni Hoffman, yes.

If you go past that letter to the next document you will see attachment 2?-- Yes.

And attachment 2 in the body of the memo is described in the fourth paragraph as being a summary of discussions with medical staff?-- Yes.

So that's what those notes are, notes of the meetings that Mr Leck and Dr Keating had with the staff and there is a filenote, "Toni Hoffman attached adverse incident report"?-- Yes.

You see those things?-- Yes.

As you pass that document you get to attachment 3?-- There is some - oh, yes, attachment 3.

That's described-----?-- That's the email.

-----in the body of the memo at the very foot of the first page of the memo?-- Yes.

"Some assistance for Dr Mahoney in conducting the review was sought from audit and operational review branch. The branch indicated that as the matter was not one of official misconduct that your office would be best suited to assist." And that appears to be his exchange with-----?-- I understand.

-----Ms McMahon. And then lastly attachment 4, which is the very next document in the bundle - or commences with the very next document, and it is described at the top of the second page of the memo as being, "Several nurses had also provided correspondence raising their concerns."?-- Yes.

Attachment 4?-- Yes, in the material.

Now, would you accept then, doctor, that that constitutes the material that Mr Leck sent you?-- I would happily accept that.

Yes, thank you, doctor. It might be convenient to tender it in that form, Commissioner, although all this material is actually in Dr FitzGerald-----

COMMISSIONER: 281 will be the memorandum from Mr Leck, Dr FitzGerald dated the 19th of January 2005 with attachments 1 to 4.

ADMITTED AND MARKED "EXHIBIT 281"

MR ASHTON: Thanks, Commissioner. You were taken to some emails by my learned friend Mr Allen which then passed between you and Mr Leck in February?-- Yes.

They were particularly, you might remember, addressed to the issue of, well, how much should I be telling Dr Patel, what are the natural justice issues, that sort of thing?-- That's correct, that's correct.

There was - and this is immaterial - I won't bother taking you to them now - but there was other communication, too, with Mr Leck or his appointee in relation to his supply of patient information and other things you needed for your investigation?-- Yes, I understand.

Would you accept if I were to put it to you that he was - he was seeking guidance from you as to what you wanted him to do-----?-- Yes.

-----in preparation and that you were in charge of this investigation?-- Yes, that's correct.

Yes, thank you. And then you actually undertook the visit to Bundaberg on 14th and the 15th of February. A number of my learned friends have asked you about that and I won't detain people unnecessarily by going to it but I think there was just one matter I should mention to you. My learned friend Mr Allen raised some matters of Toni Hoffman's recollection about her meeting with you and put them to you. There was just one more, I think, that - it is appropriate to raise. She also said - and this appears at page 180 of the transcript - bear with me, doctor, if you would: she agreed with the proposition from the Commissioner - and I am sure it is also put to her by counsel assisting - that "Dr FitzGerald came to see you. His response was to say, 'Well, we can't do anything because nothing's been proved at this stage.'" Now, what do you say to that? Was that a conversation you had with Ms Hoffman?-- I don't remember the specifics of it but I think the statement would be true if it was said.

It might assist you at paragraph 63, I think, of your statement?-- Mmm.

Is where you deal with how you explained your purpose, as it were, to the staff you spoke to. Perhaps that would assist you to answer that question. Perhaps you already have?-- Yes, certainly - I mean, the intent of the day was to try and obtain information.

Yes?-- That might guide whatever next needed to be done. It was because of the procedural issues or process issues that we

discussed before about - it wasn't structured as an investigation as such but rather as an audit.

Yeah.

COMMISSIONER: And obviously Ms Hoffman's and, indeed, anyone else's recollection is more likely to be their interpretation of what you said rather than exact words, but the effect of what you said to her would have been nothing is going to happen until we've finished investigating?-- I think so, yes, because that was - I mean, certainly at that stage of the investigation that would be the appropriate thing to say.

Yes.

MR ASHTON: Now, doctor, I am just wondering if you can help me with an understanding of the point at which, if it is possible to define - perhaps it isn't - the point at which you really came to the view or a view about the enormity or urgency of this matter. Let me explain a little better - and, please, I intend no criticism. I am picking up on a matter that the Commissioner put to you in your evidence-in-chief. It appears at 3210 of the transcript. When he was really inviting you to comment on, "Well, if you didn't see things as urgent or serious at the time when, for example, you were at Bundaberg, would it be fair to expect Dr Keating and Mr Leck to have done so?" That was the thrust of it. And, really, just picking up on that, to get an understanding of when it came to your - when it was your judgment that this was enormous, this was serious, it was urgent.

COMMISSIONER: Mr Ashton, it is entirely a matter for you but I would have thought that the answer that stands there on the transcript is the best possible answer in the world, from your client's viewpoint. I cannot imagine why you would want to test it any further.

MR ASHTON: Thanks, Commissioner.

COMMISSIONER: But it is up to you.

MR ASHTON: Understood, Commissioner, thank you. Lastly, doctor, you had a luncheon meeting with the Commissioner, we have been told. Do you remember that?-- Yes.

When was that?-- I am sorry, I don't remember the date but it was before, obviously, the Commission started hearing.

Do you know how long before?-- A week or so.

Did you keep any records or notes?-- No.

Thank you. How did that meeting come about?-- I was-----

COMMISSIONER: Mr Ashton, is there an issue in the Terms of Reference as to how this is relevant?

MR ASHTON: Well, Commissioner, the subject matter of the

discussion - and I don't know what it was - may be very pertinent and that's what I am seeking to ascertain from the witness.

COMMISSIONER: You want a fishing expedition as to - what are you trying to achieve with this?

MR ASHTON: I want to understand what matters the witness discussed with you, Commissioner.

COMMISSIONER: For what purpose?

MR ASHTON: So that I can understand to what extent those matters might need addressing by me in submission, or in evidence, or in some other way.

COMMISSIONER: I can tell you now nothing that was said at that meeting needs to be addressed by you.

MR ASHTON: Well-----

COMMISSIONER: Do you have any other purpose in-----

MR ASHTON: No, thanks, Commissioner, if that's-----

COMMISSIONER: No, I am not going to stop you. If you think there is something relevant, you go ahead.

MR ASHTON: All right, thanks. I would just like to know the subject matter, thanks, doctor. Did you discuss your position, your role, your powers, responsibilities, et cetera, your job?-- I think there was some discussion around that. Most of the discussion was around about the future and how the health system could be managed in the future.

No, did you discuss Bundaberg?-- I am sure we discussed something of it but nothing in terms - nothing sticks in my memory about any specifics. I mean, Bundaberg was obviously the issue of the time.

What about Dr-----?-- For example, we would have used - in terms of talking, my memory was most of the discussion was about systems and structures. Obviously you would example Bundaberg in any of those discussions.

And what about Dr Patel?-- I don't recall us discussing Dr Patel in anything but examples of broader issues.

Issues thrown up-----?-- Yes.

-----by the Patel experience?-- That's right, yes.

And what about your investigation? Did you discuss that?-- I don't think we did at all, no.

What about the Hervey Bay orthopaedic report which is mentioned in your statement?-- I don't remember that being raised.

And the Queensland Health administrative responses to the Patel experience. You have given some evidence about them. Were they the subject of discussion?-- No.

Your position on the Medical Board, was that mentioned or a subject?-- Only by way of explanation that I was part of-----

Part of the - and what about overseas-trained doctor issues?-- Again, only by way of explanation, about systems and structures, improvements that need to be in place.

Yes. And credentialing and privileges?-- Again, only by way of dealing with the broader system issues. Nothing specific.

All right. Nothing further, thanks, Commissioner.

COMMISSIONER: Just stay there for a moment because you might want to follow this up. Dr FitzGerald, Mr Ashton asked you and you said that there was no discussion or you couldn't recall discussion about your report. I should put on the record my recollection, to give you an opportunity to agree or disagree, but I think following lunch we adjourned outside to tea or coffee and at that stage Mr Atkinson, who was with us, said something like, you know, "When you give evidence people might give you a rough time over the fact that your report"-----?-- That's true.

-----"wasn't as comprehensive as subsequent reports", and you replied to him with words to the effect that if people want to have a go at you, you will take it on the chin?-- Yeah, I think from my memory it was that perhaps I had been a bit gentle in the report.

Yes?-- And I think that was - your recollection of that discussion was the same as mine.

MR ASHTON: Yes. My question had actually been about your investigation but do you want to say anything further about that?-- Sorry, about the?

I think I asked you did you discuss the investigation. The Commissioner has mentioned the report?-- Which was the report of investigation.

Of course, the report prior to the investigation?-- Yeah.

Do you want to say anything further about that?-- No, I don't think there was anything else of substance.

I have nothing further, thank you.

COMMISSIONER: Mr Boddice?

MR BODDICE: Just a few matters.

RE-EXAMINATION:

MR BODDICE: Firstly, Dr FitzGerald, you referred to some credentialing document from the Australian Council for Safety and Quality in Health Care. Was that the-----?-- That's the one.

-----name of the organisation - dated July 2004. Would you have a look at this document?-- Yes.

Is that the document you were referring to?-- That's correct.

As the one that's the more Australian Standard one?-- That's correct.

But the Queensland Health one, in effect, dovetails in with that document, is that the case?-- Yes.

I tender that.

COMMISSIONER: Exhibit 282 will be document from the Australian Council for Safety Quality and Health Care, July 2004, entitled Standard for Credentialing and Defining the Scope of Clinical Practice.

ADMITTED AND MARKED "EXHIBIT 282"

MR BODDICE: Thank you. Just on credentialing, Dr FitzGerald, you said one of the things you have to be careful about is having a big enough pool?-- Of, sorry?

Of doctors to be able to call on when you are looking at the credentialing process?-- I see, yes.

And is one of the concerns there that you really can't have a mate - to use that colloquial term, a mate credentialing a mate, or, indeed, a foe, I suppose, credentialing a foe?-- That's correct.

Because of the risk associated with that process?-- There is from time to time concern expressed about commercial matters in small country towns between various surgeons or various procedures. So that's why having some sort of sense of independence from that local facility is valuable.

And do you know is that the reason why the involvement with the college is sought, to try and ensure there is that element of independence?-- I really don't know - I am not sure that I know the logic behind why the college was particularly approached but I would accept that the logic of having the college officially endorse the representatives does allow that sense of independence.

Doctor, you were asked some questions in relation to what information you had. If you could have a look at exhibit 281, which was the bundle that Mr Leck forwarded to you?-- This one here?

Have you got that there?-- Yes.

If you go to attachment 4, which of course will be some documents in. It is just handwritten "attachment 4". It is a letter dated 4th of January 2005?-- Yes, attachment 4, Michelle Hunter.

You were asked some questions did you have any information about the 15 year old boy and also Mr Kemps. Do you recall you were asked those questions?-- That's right, yes.

If you look at that letter for the 4th of January 2005 you will see that is in relation to the 15 year old boy?-- Yes.

And the following pages, if you look at those, that is information in relation to Mr Kemps?-- Yes, that's correct.

So does that help your recollection as to whether you had received that information before you went to Bundaberg?-- Well, I accept the documents that we had that information - we were obviously made aware when we went to Bundaberg of those cases as well, so I just wasn't aware before as to when I had first received that particular information.

And could I take you to your audit report. Do you have a copy of that?-- Yes.

You were asked some questions about page 5 which is the table of Observation of Comments and Opportunities for Improvements?-- Yes.

You were asked some questions about the item in Opportunities for Improvement, "implement the service capability framework"?-- Yes.

You gave some evidence - is the word "implement" the appropriate word, or is it a question of ensuring compliance with. The reason I asked you that, doctor, is you said, well, there was material on the website which showed that the service capability framework had been - had regard to it put into effect?-- Mmm, yes.

When you used the word "implement" are you concerned to ensure that it is being complied with, or are you asking that further parts of it needs to be put into effect?-- Yes, there is probably a word missing, like "implement fully", or "ensure the implementation of", or something like that, but that's what we were after because there was indeed some recognition of the service capability framework.

All right?-- But obviously the system concerned didn't get that down.

You said that one of the steps that you took was to receive some assurance that the competence procedure would not be undertaken in the future-----?-- That's correct.

-----by Dr Patel. Is that something that is in fact referred to in your report at page 11? You will see under the discussion second paragraph that, "The surgeon involved has agreed to undertake only those procedures within the scope of the surgical service and relevant support services."?-- That's correct, yes.

You were also asked some questions in relation to how the report is structured and whether things were done in a negative or a positive way?-- Yes.

Could I just ask you about some items - again on page 5.

COMMISSIONER: Mr Boddice, you are being very careful, as usual, but I don't think there is any need - as I said to Mr Allen, the report speaks for itself and if you were concerned as your witness Dr FitzGerald might be subject to criticism about the form of the report, I don't think you need further concern.

MR BODDICE: I won't take it any further on that basis, and those are the only questions, thank you.

COMMISSIONER: Mr Andrews?

RE-EXAMINATION:

MR ANDREWS: Dr FitzGerald, I am instructed that this morning you gave evidence that Dr Buckland may have raised with you a concern that Dr Patel's registration in Oregon or in the United States could be suspect?-- Yes.

And I understand that that was on about the 7th of April 2005?-- On or about. I am not sure exactly when it was.

It is likely that you'd have raised those matters with Mr O'Dempsey at the Medical Board on that or the next day?-- Yes, again, the timing I am not sure but around that time, yes.

We have the advantage of evidence from Mr Demy-Geroe of the Medical Board that he did an internet search on about the 8th of April 2005?-- Okay.

Friday the 8th of April. It's likely, is it not, that you'd have been - you'd have informed Mr O'Dempsey on about the 7th or 8th of April?-- I think that's probably likely, yes.

Now, Mr Hedley Thomas of The Courier-Mail has provided a

statement which suggests he contacted you at about 5 p.m. on Tuesday the 12th of April 2005. Now, do you recall a contact by Mr Thomas to you?-- I do recall that contact, yes.

Are you able to recall whether by the time Mr Thomas made contact, you'd had any feedback from Mr O'Dempsey or anyone else at the Medical Board informing you of the results of Mr Demy-Geroe's Internet search?-- I don't remember having received that feedback from the Medical Board prior to that time.

It seems that there was an ordinary meeting of the Medical Board held on the 12th of April 2005, and from its minutes, it appears that you were at such a meeting. The minutes will appear on the screen in a moment. That extract of the minutes fails to raise the - anything sensational about Dr Patel?-- Yes.

In respect of his Oregon registration or his New York disqualification?-- Mmm.

Do you recall whether at the Medical Board meeting of the 12th of April 2005 - it's correct that you attended?-- I'm pretty sure I was there that night, yes.

Was it brought to your attention during that meeting or prior to it that Dr Patel - that the inquiries relating to Dr Patel had revealed problems with his registration in the United States?-- I certainly recall because I asked Mr O'Dempsey if he'd called back Mr Thomas and he advised that he had and that that was the information that they had, that the Medical Board had was that the information that had been discovered by the journalist was substantially correct.

Can you - do you recall who the minute taker was?-- Of the - from the Medical Board?

Yes?-- It is usually - isn't that terrible, I've got a mental blank for a name - sorry, I've now got a mental blank for her name but it's lady who takes - I will remember it when I stop thinking.

Robyn Scholl?-- Robyn Scholl, yes, that's it.

Doctor, and so am I right in concluding that at this meeting, Dr Patel's registration problems were raised?-- I don't - I can't recall whether it was in the meeting, the substance of the meeting or as a side conversation with Mr O'Dempsey on the way in, but I'm pretty sure the matter was discussed in the public environment of the meeting, so.

And when Mr O'Dempsey raised it with you in a side conversation, he raised with you also the fact that he'd been contacted by - or he'd spoken with Hedley Thomas?-- Well, I'd - in fact, my memory is that I asked him had he returned the call to Hedley Thomas, which is what I'd promised the - Hedley Thomas, that I'd arrange for somebody to call - return the call.

Is that the first time that the results of the searches were raised between you and Mr O'Dempsey?-- To my recollection, yes.

Thank you?-- Sorry, it may have been earlier because I rang Mr O'Dempsey and said that - asked him to return the call to Mr Thomas, so it may have been in that conversation that he brought it to my attention.

COMMISSIONER: But that was on the same day?-- On the same day, that evening, yes.

MR ANDREWS: When you say on the same day in answer to the Commissioner's question, do you mean the same day as the Medical Board meeting or a different day, that is, the meeting of the 12th, is it?-- I think that was the date that I received the phone call from Mr Thomas.

Thank you?-- And responded by saying I would get the Medical Board to ring back and rang - immediately rang Jim O'Dempsey and it may have been in that conversation rather than a side conversation at the Board that that was raised.

Had the - do you know whether any plans had been made about whether or not to disclose the sensational registration information relating to Dr Patel?-- There were no plans in place that I knew of at that stage, no.

COMMISSIONER: But by the time that had been confirmed to you, Mr Thomas was already aware of it anyway?-- Indeed so, yes.

Yes.

MR ANDREWS: Is it-----

COMMISSIONER: And you didn't think he was going to hush it up?-- No.

MR ANDREWS: Doctor, what are the prospects that the Medical Board would have hushed this matter up?-- I don't think the Medical Board would have hushed the matter up. The - although the minutes don't record it, I'm sure this matter was discussed at the Board and I'm sure that the Board was briefed on the discovery on that night.

COMMISSIONER: Doctor, were you a member of the Board at the time of the Berg case from Townsville, the psychiatrist who-----?-- I'm sorry, I don't know when he was registered initially.

My recollection - I'm sorry, there's been so much evidence over the past three months?-- Yes.

So I thought it was 2001?-- I've been on the Medical Board since 2003.

I see.

MR ANDREWS: And I was wondering whether it was 2002, so-----

COMMISSIONER: Yes. I thought he was registered in 2001 and

deregistered in 2002, but I may be wrong. Mr Allen has a knowing look. Do you remember better than that?

MR ALLEN: It was before 2003.

MS McMILLAN: I think it was 2000 onward because there were issues about whether - when his contract terminated.

COMMISSIONER: Yes.

MS McMILLAN: He wasn't re-appointed and there was evidence that he left the jurisdiction, I think that was early 2002 was my recollection of the evidence.

COMMISSIONER: Yes. It's fascinating, we as lawyers love criticising witnesses who can't remember details of conversations and here we're speculating about something which we only heard last week.

MR ANDREWS: Doctor, after your visit on the 14th and 15th of February 2005 to Bundaberg, you will have been preparing your report, at least in draft?-- Yes.

Did you give any feedback to either Mr Leck or Dr Keating before the preparation of your final report to alert them to the patterns which you'd observed of higher than appropriate numbers of complications?-- Not formally, but I do remember running into Mr Leck at a conference on the Sunshine Coast and mentioning to him at that stage that in my view there was some significant problems that needed to be addressed, but that I was being held up by getting the benchmarking done.

Can you say when that conversation was? Before the 24th of March?-- I think so, it was a zonal conference. I can check my diary for the dates and provide that if it's useful.

Thank you, I'd appreciate that?-- Thank you.

And did you give Mr Leck anymore detail than that fairly cryptic comment?-- No, not at that stage.

I see. You didn't alert him as to whether or not one of his surgeons was a matter of concern for you; Dr Patel, for instance?-- Oh, I think he already knew that, I remember I knew - I'm sure that was the tenure of the conversation.

I have nothing further.

COMMISSIONER: Mr Ashton, is there anything arising out of that last exchange?

MR ASHTON: Yes, thanks Commissioner.

CROSS-EXAMINATION:

MR ASHTON: Doctor, let me get this straight: you weren't suggesting, for example, that you told Mr Leck that Dr Patel should be stood down or dismissed or anything of that sort?-- No, no.

No. Did you - did I understand you to say that - and please don't let me put words into your mouth, I might have got this wrong - did you tell him you were waiting for benchmarking information?-- Yes, I think they - well, that was what we were doing at that time.

Yes, so does it really amount to, you said you weren't suggesting any immediate action, you were indicating that your report wasn't yet finished, you wanted more material and you did so you would have your concerns simply addressed?-- Yes.

Yes, thanks Commissioner.

COMMISSIONER: Thank you. Doctor, I know it's been a long morning-----

MS McMILLAN: Mr Commissioner - sorry.

COMMISSIONER: Sorry, yes.

MS McMILLAN: My instructing solicitors tells me she knows exactly the details of Dr Berg. 4th of January 2000, he was registered until the 3rd of January 2001, but I don't know whether it takes it anywhere.

COMMISSIONER: No. Thank you so much for your time, doctor?-- Thank you, Commissioner.

And we really do appreciate the candour and frankness and openness with which you've given your evidence. It will be enormously valuable in preparing our report and you may go with our thanks?-- Thank you Commissioner, thank you.

WITNESS EXCUSED

COMMISSIONER: I see Dr Woodruff's in the back of the courtroom. We were planning to resume at 2 o'clock, weren't we? But that doesn't give anyone time to even have a sandwich. So why don't we start again at 2.30? Would that suit Dr Woodruff? Yes? 2.30 it is.

THE COMMISSION ADJOURNED AT 1.27 TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.32 P.M.

MR DEVLIN: Commissioner, may I address one matter briefly?

COMMISSIONER: Yes, Mr Devlin.

MR DEVLIN: About what arose about this morning's proceeding? I've just put on the screen a particular document about which Dr FitzGerald was asked this morning. Implicit in some of the questions this morning, without wishing to be critical of anyone, there seems to be some issue being agitated about the actions of the Medical Board of Queensland in and about the 8th to the 12th of April 2005 as to whether it wished to go public with certain claims.

I draw your attention to this minute which was supplied by the Medical Board to this Inquiry. In particular, to paragraph:

> "The executive officer briefed the Board in relation to issues surrounding Dr Patel...complaints received."

The suggestion implicit in a question this morning was that the Board would not have gone public with information that Patel may have failed to reveal certain issues when he applied for registration. The sequence is this: as already deposed to by Mr Geroe and not challenged with him by anybody, he was ordered to do a report-----

COMMISSIONER: Mr Devlin, there was no such implication as far as I know. Dr FitzGerald was asked whether the Board intended to cover it up and he said not, but by the time that it had been documented, Hedley Thomas from The Courier-Mail already had the facts, so there was the - the issue didn't arise, I think it ends there, doesn't it?

MR DEVLIN: Well, the only issue the Commission may be interested in, and if you're not interested in it then I won't press it, is whether the issue of Dr Patel having told untruths was raised at the meeting at the 12th of April, and I'm quite happy to produce statutory or affidavit evidence that that matter was canvassed in detail, hence the discussion of the conflict of interest.

COMMISSIONER: Yes, and Dr FitzGerald again has confirmed that those matters were canvassed and that there has been no challenge to that.

MR DEVLIN: Thank you.

COMMISSIONER: Thank you. Mr Boddice, can I also raise with you, I had a slightly cryptic message from Mr Andrews that you - or not personally but on behalf of various people have a concern about the way photography and filming has been going on.

MR BODDICE: No, no. What happened was that in terms of the

Skills Development Centre tomorrow.

COMMISSIONER: Oh, I see, yes.

MR BODDICE: It was raised by some members of the press as to whether the press would also be coming along for the visit.

COMMISSIONER: Yes.

MR BODDICE: And what I had - I can indicate that Queensland Health has no objections to the press being present because there's no patients obviously involved in such matter.

COMMISSIONER: Yes.

MR BODDICE: But one of the matters I had raised is that sometimes it can restrict the process of going around obviously with cameras following.

COMMISSIONER: Yes.

MR BODDICE: And that perhaps a solution was that the press be able to come and take some photographs initially in relation to it and then the visit could simply proceed thereafter.

COMMISSIONER: Well, look, I have no difficulty. I thought we'd proceed a bit like the situation in Bundaberg, where we'd provide a photo opportunity for anyone who wants it on arrival or on departure but otherwise we wouldn't encourage the media to follow us around just because that would, as you say, be counterproductive to the purposes of the exercise and possibly embarrass some of the staff.

MR BODDICE: We're happy to do it on that basis.

COMMISSIONER: Thank you.

MR BODDICE: And we've arranged for parking and I'll just be able to sort that out-----

COMMISSIONER: Yes, I've got a note about those details. Thank you. Mr Andrews?

MR ANDREWS: Dr Woodruff, would you take the oath please?

PETER WILLIAM HAROLD WOODRUFF, SWORN AND EXAMINED:

MR BODDICE: Commissioners, I seek leave to appear on behalf of Dr Woodruff.

COMMISSIONER: Such leave is granted.

MR ANDREWS: Dr Woodruff, would you identify this statement which appears to be signed by you and dated the 15th of August

2005, it's a copy?-- Yes, I identify that as my statement.

Thank you, I tender it.

COMMISSIONER: Yes, the statement of Dr Woodruff will be Exhibit 283.

ADMITTED AND MARKED "EXHIBIT 283"

MR ANDREWS: Doctor, the facts recited in it, are they true to best of your knowledge?-- Yes.

And your opinions, where they appear, and you express quite a number of them in Annexure PWHW4, they're honestly held opinions?-- Yes.

Doctor, your experience includes, among other things, that you are a Fellow of the Royal Australasian College of Surgeons; the Royal College of Surgeons of Edinburgh and of the American College of Surgeons; you were a member of the Council of the Royal Australasian College of Surgeons for about eight years until 2005?-- Yes.

Serving for five years as the Vice President and Honorary Treasurer?-- Correct, three and two.

I see. And you currently are the President-elect of the Australian and New Zealand Society of Vascular Surgeons?-- Yes.

You were the President of the Australian Association of Surgeons from 1997 to 1998?-- Yes.

And you are a member of the Board of the Australian Council of Health Care Standards, the principal accrediting authority for health institutions in Australia?-- Yes.

You're a Wing Commander in the Royal Australian Air Force Specialist Reserve?-- Yes.

And that you've included that among your qualifications because it gives you an insight into how audits are done in the Air Force?-- Yes, that's correct.

You've had considerable experience practicing surgery in isolated areas as the sole surgeon, including in Orkney, Shetland and Bougainville?-- Yes.

COMMISSIONER: Doctor, you also mention in your statement you were in Mount Isa for a period of about 18 months, some of that as a locum. I imagine that in those days, we're talking the late 60s or early 70s?-- 1967-68.

The surgical resources there would have been fairly limited at

the time?-- That's correct.

MR ANDREWS: Doctor, Exhibit 102 includes the review of clinical services of the Bundaberg Base Hospital. You were, you say, primarily responsible for section 3.2 of that report?-- That's correct.

You studied 221 patient files, according to paragraph 12 of your statement. You say that, "In accordance with the terms of reference, those files concerned patients who had died, been transferred to another institution or had an outcome the subject of a complaint." I have to hand a copy of the Terms of Reference signed by the Director-General then, Dr Buckland. They do not particularly describe those categories. If you look at the monitor, they should appear in a moment. It's on page - the second page of the document. That makes it difficult to appreciate - yes, the Terms of Reference, they don't - firstly, I suppose, are they the Terms of Reference of which you speak?-- I believe so, I haven't seen the document in its entirety, the one that's on the screen at the moment.

I suppose you haven't seen it for some time in any event?-- No, that's correct.

You will see that nothing within it obliges the review of the clinical cases to be confined to deaths, transfers to another institution or outcomes the subject of a complaint. Rather, it seems to be an identified adverse outcome or where issues related to clinical practice have been raised. Who identified the 221 relevant patient files for you?-- I believe it was Dr Mattiussi in collaboration with the other members of the team considering that that was an appropriate extent of the task at hand.

And do you disagree with that proposition?-- No.

You examined the case chart of each patient which meant reading any files that related to the patient?-- Correct.

Now, for instance, we've had the advantage when discussing a particular patient, a Mr Desmond Bramich, we've had the advantage of a number of letters of concern relating to the treatment of that patient that were forwarded by clinical staff; would you have been briefed with such matters as letters of concern?-- No, the complaints and letters of concern were purely to identify the subject matter of my study or of our study.

You say that, "A full investigation of the care of any particular patient might also involve, where possible, interviews with relevant members of the health care team and the patients concerned." But I gather you were obliged to confine yourself to the charts, the documents?-- I spent one week interviewing personnel in Bundaberg with the other members of the team who spent a more extended period of time there, but I was part of the Bundaberg interviews for a week.

Is it - am I right to conclude you didn't have the advantage

of speaking with any of the patients?-- That's correct.

And is it right to say that it can be advantageous to speak with the patients?-- Oh, certainly, undoubtedly.

In a perfect world, in doing the perfect review, you'd have spoken to the patients as well?-- Correct.

You say that there may be patients in respect of whom there was an adverse outcome who've fallen outside the scope of the review; do you mean there may be others apart from the 221 to which you were referred?-- I'm certain that there are.

COMMISSIONER: Doctor, you've been, I take it, generally aware of the evidence that we've heard from Dr O'Loughlin from the Royal Brisbane Hospital and Dr de Lacey from Bundaberg, that would confirm the view that there may well be adverse outcomes that are not covered in your audit sample?-- Correct. I would like to add, if it's appropriate, that I'm very grateful to the Commission for allowing me to have access to 144 electronic summaries of Dr de Lacey's and that just a week or so ago, that was of considerable interest and of those 144, 16 patients in his group form 16 patients of the 221 in my group. And of those 16, there is a very good agreement in our findings, particularly in 14, there was a slight difference of opinion of a minor nature in the other two.

So that - to that extent at least, you can endorse the evidence that we've heard from Dr de Lacy?-- In those 16 cases I can.

Yes. And that's a fair representative sample to suggest that his strike rate is pretty good?-- Well, Commissioner, this inquiry raises the selection of data. I mean, I believe looking at deaths skews the data in one way. Looking at the walking wounded, as it were, skews it in another way. And between Dr de Lacy and myself, we've looked at perhaps 400 of the 1200 patients he operated on. I think there is another bulk of data there that, if surveyed, might give us another opinion.

Yes.

MR ANDREWS: Doctor, I did law because I couldn't count but my calculation of Dr de Lacy's 144, you say that 16 of his are in your group of 221. As I calculate it, that means that there were about 349 patients reviewed between the two of you?

COMMISSIONER: And on top of that, another 50-odd, wasn't it, by Dr O'Loughlin.

MR ANDREWS: Yes, that's the case.

D COMMISSIONER VIDER: Forty-two.

COMMISSIONER: Forty-two.

WITNESS: Sorry, I'm even slower with my maths than you, sir. You left me there.

MR ANDREWS: Perhaps you could do law too. Doctor, you looked - this particular report of yours seems to concentrate on the 88 - on 88 deaths within your sample group of 221 and you've broken those up into categories. In particular, you've isolated and called perioperative deaths the group of patients who died within 30 days of surgery; am I correct?-- That's correct.

And within that group who died within 30 days of surgery you have put to one side those patients who were suffering a terminal illness in any event; am I correct?-- That's correct.

And you would do that on the logical basis that those patients might - whether their care was reasonable or poor, might have died in any event within those 30 days?-- No, the terminal patients - it becomes rather complex. Could we refer to the individual tables because they have subtle differences?

Well then, I'll proceed in a - in the logical way in which your own statement proceeds and come to those tables as you describe them in your statement.

COMMISSIONER: Just so I understand where we are going here though, Doctor, you don't put a patient into the terminal

category merely because that patient has an illness which is likely to prove fatal eventually. So Mr Kemps, for example, is a cancer patient and may have had 12 or 24 or 36 months to live but he wasn't-----?-- No.

-----on death's door?-- No.

MR ANDREWS: Now, 34 patients, it seems - of the 88 who died, 34 of them died within one month of surgery?-- That's correct.

And deaths within a month of surgery are taken as an accepted yardstick of surgical performance?-- That's correct.

Is it the case that if a surgeon has more than a peer group's number of deaths within 30 days, it's cause for alarm?-- That's correct. There is a reasonable distribution and if one goes to the mortality audits that are available, there's a very good one from - known as the surgical audit - the Scottish Audit of Surgical Mortality and I visited their figures over the last three years in relation to performance in Dundee and the number of an individual surgeon acquired in that series ranged from five to 34 per annum with a mean of 17 per year. But, once again, it underlined the difficulty of comparing data from one place with the next because in Dundee they have a palliative care unit and a great number of the cases that we are referring to in the 88 from Bundaberg would not have been attributed to an individual surgeon. That just underlines the difficulties in comparing data from one institution with the next.

You must be very careful to ensure you're comparing like with like?-- Exactly.

And if one has a palliative care unit at a hospital, you'd expect there to be many more deaths because the dying are sent to such a hospital for pain relief and quality of life in their last days?-- Correct.

COMMISSIONER: But you've really excluded those factors here by saying, "Well, these patients were in extremis, therefore, we take them out of the equation and look at the death rate amongst patients who could reasonably have been expected to live at least for some months or years"?-- Yes, correct. I mean, would it serve to illustrate these categories, just to give the Commission some idea?

Yes.

MR ANDREWS: Yes, please?-- Could we perhaps look at what I consider - well, on the first table that comes up there, label-----

You're referring to perioperative deaths?-- Perioperative deaths.

Some in this room don't have the advantage of your monitors.

COMMISSIONER: Oh, they won't be able to see the details.

MR ANDREWS: No?-- These are the deaths occurring within 30 days, and it's there further subdivided those 34 into terminal patients that are considered number 23 and, Commissioner, I misled you, Mr Kemps' name does appear in that list of terminal patients. But that group can be further split into those I considered to be in extremis and there were 13 of those. And if we look at those, one can gain an idea of the use of that terminology. For instance, the first one on the screen suffered a ruptured abdominal aortic aneurism. The second one was a victim of a motor vehicle accident sustaining a head injury and was transferred from Biggenden to the Royal Brisbane Hospital via Bundaberg. And so, a short spell in Bundaberg, perhaps for a CAT scan, seems hardly justification for linking that patient's subsequent demise on the 25th of the 4th, '03 in the Royal Brisbane Hospital with Dr Patel. Then the next one, the third one on your list, is another patient with a ruptured abdominal aortic aneurism. I would question the method of resuscitation and the occurrence of troublesome juxta suture line bleeding, questions a suture technique, but it is a condition which carries a 75 per cent mortality. So, once again, arriving in that parlous state could seem an in extremis category.

That last patient,P200?-- Mmm-hmm.

If I'm correct in recalling that, you do in fact attribute Dr Patel's intervention to the adverse outcome in that patient?

COMMISSIONER: I think that's in attachment 4, the revised views as it were?-- Yes. If you look at the bottom right-hand corner of the screen, I've included my survey information and if I open that window, I've said that Dr Patel maybe contributed to an adverse outcome in the case ofP200. I think that's relying on my experience as a vascular surgeon. I believe excessive crystalloid resuscitation often produces exsanguination and an intraperitoneal rupture, which is what they found at operation and, secondly, that suture line bleeding is indicative of - usually indicative of suturing to diseased aorta and the solution to that problem is to replace the proximal clamp at a higher level that enables you then to suture a healthy aorta. But that is a challenge to an experienced vascular surgeon in a senior vascular unit. But I think the performance perhaps might have improved upon at the Royal Brisbane or the PA.

Within your written statement as opposed to your - or the document on screen, it's at table E that P200's name now appears; is that correct?-- That's correct.

On page - it seems to be page 13 although I see that your page number isn't consecutive. Yes, table E?-- Well, I don't have P200's name on that I believe.

COMMISSIONER: On my copy it's - well, it's in after alphabetical order immediately above Fleming-----?-- My

apologies, I'm looking at the second page of the list. Yes, my apologies, I was one page ahead, Commissioner.

MR ANDREWS: Now, despite the fact that P200 was one of the 23 terminal patients who's presented in extremis you nevertheless have concluded as a result of your experience that Dr Patel's efforts have either contributed or may have contributed to the adverse outcome?-- That's correct.

Which of it is the case in P200's, that he may have contributed to the outcome or that he did?-- May have. And I believe, as I just outlined, for rather subtle reasons, in particular of a vascular nature. I think perhaps that's being a little harsh on a regional surgeon to attribute that form of demise to surgical adverse outcome.

And is that why you put him in the may have category?-- Mmm, correct.

The balance of those 13 who came to the hospital in extremis, you exclude, do you, from the persons whose demise has been caused by Dr Patel?-- I do. I think if we turn to table B3 I have no doubt in - as a result of my observation or perusal of the notes that Dr Patel contributed to the adverse outcome of the six patients listed in table B3.

Well, I have seven on my table B3?-- Subsequent to-----

You've removed P220, have you?-- I've recategorised P220 to table B2 following the instruction to read Dr Strahan's statement in relation to this patient and I did that over the weekend and I believe that I was rather harsh in attributing P220's demise to Dr Patel. I believe there were other people involved who had major contributing roles.

It's your opinion, is it, Doctor, that you've uncovered instances where patients' adverse outcomes, indeed deaths, have been contributed to by clinical staff other than Dr Patel?-- Correct. And they - the most significant of those are in the "not terminal patients suffering as a result of the activity of other surgeons", and their names appear in table C2. The terminal patients, there are four in table B2, where other medicos were involved, not necessarily in iatrogenic fashion but they were complicated more than by Dr Patel's management.

When you use the expression "iatrogenic" - I-A-T-R-O-G-E-N-I-C - can you explain to me what you mean?-- It refers to a medically caused mishap or injury. It's-----

Does it necessarily mean caused by lack of reasonable care?-- I believe - I believe so, yes.

Thank you?-- There may be iatrogenic injuries if I can correct myself, that they're medically caused injuries that could arise even with reasonable care but they are injuries specifically attributable to the medical management.

COMMISSIONER: Doctor, in case you're concerned, we're not really interested in what would be classed as negligence in the context of a medicolegal matter. We'll really much more concerned from your assessment as a vascular surgeon, the treatment was suboptimal if I can put it that way?-- Okay. Well, there is no question that the patients in B3, C2 and C3, the treatment was unquestionably suboptimal.

MR ANDREWS: And so, wherever you say a patient has died as a result of iatrogenic process, you mean that the treatment provided to that patient was of a standard lower than you would expect to be provided by reasonable clinicians in Bundaberg?-- The event - even with the most careful care and attention, medical disasters occur. Iatrogenic disasters occur in the best of hands from time to time so I think it is dangerous to categorise for iatrogenic injuries occurring in a range of practitioners is indicative of substandard treatment in Bundaberg. Are you referring more specifically to the iatrogenic problems of Dr Patel?

Those of Dr Patel and you've, within your statement at paragraph 230 subparagraph (e), spoken of four who died by reason of iatrogenic process by colleagues and you've put them into table C2. I'm assuming thatP217, P243, P257, and P326 are patients who've died as a result of processes by persons other than Dr Patel?-- Correct. Can I just expand on that?

Yes.

COMMISSIONER: Yes?-- If we take the first one, P217, admitted with gallstone pancreatitis having had a gall bladder removed not in Bundaberg, I believe at the Royal Brisbane and Women's Hospital, but there was a little uncertainty about that in the review of the notes. Because of that history she was transferred promptly to the Royal Brisbane Hospital without surgical treatment in Bundaberg. I consider that a non-morbid or appropriate transfer. And she died in the Royal Brisbane Hospital or from - I'm not absolutely clear where she did die but she was transferred to the Royal Brisbane Hospital in April and died out of Bundaberg on the 1st of May. And, therefore, her surgical history is attributable to the previous cholecystectomy, the retained calculus and whatever steps were taken to remove that retained calculus at the Royal Brisbane Hospital and not in any way directly attributable to Dr Patel. And if we go to the second one-----

Perhaps before you leave that, and I'm interested in whether you've made a conclusion that the process by those at the Royal Brisbane Hospital was suboptimal?-- I'm not in a position to comment because I haven't studied - and this is why I'm a little vague about what actually happened at the Royal Brisbane, I haven't had access to the case notes from the Royal Brisbane Hospital.

Thank you. You were going to move on to the next patient.

D COMMISSIONER EDWARDS: But pancreatitis would not be an uncommon complication of gall bladder disease?-- Correct. I-----

D COMMISSIONER VIDER: Doctor, did you say that - this lady had had a previous cholecystectomy?-- Correct.

Had that been done by Dr Patel?-- No.

So she had nothing to do with that-----?-- No, he had no surgical intervention with this lady.

At all?-- Correct.

So her transfer to the Royal Brisbane Hospital was appropriate?-- Yes. They're my file notes that I've projected now and if I access the - if I refer briefly to those, the original cholecystectomy was performed in January 2002 before Dr Patel came to Bundaberg and the ultrasound of the abdomen was on the 7th of March '03 showing the calculus in the common bile ducts with palpitation of the biliary tree and the patient was admitted to the Royal Brisbane Hospital on the 3rd of April with gallstone pancreatitis - my apologies, admitted to Bundaberg on the 3rd of April with gallstone pancreatitis and transferred to the Royal Brisbane Hospital on the night of that admission.

Thank you.

MR ANDREWS: Doctor, of the four patients mentioned in table C2, are any of them patients whose perioperative death was caused by a doctor from Bundaberg Base Hospital - I beg your pardon, was following an iatrogenic process of a doctor from the Bundaberg Base Hospital?-- If we move to the next patient on the list, admitted to Bundaberg Hospital on the 30th of October 2004 with peritonitis and overwhelming sepsis as a consequence of a rectal polypectomy performed by a colleague at the Mater Private Hospital two days previously and Dr Patel's comments are a very informative assessment of the dire state that that patient is in or was in at the time of her admission. Dr Patel did operate on the patient. The patient, following that operation, was transferred to the Wesley Hospital and was looked after by two of my colleagues down there and I've spoken to them about the case and despite their efforts, the patient died there on the 22nd of December '04 and, perhaps, I think it's of use to the Commission to actually draw their attention to one or two of the letters that surround that transfer and admission to the Wesley Hospital. There's a letter from Mr Russell Stitz and I project that now. In that letter he says that, "As we discussed on the phone there were never any particular problems with her abdomen and pelvis after her transfer to the Intensive Care Unit at the Wesley", and I think that my appraisal of the situation is that Dr Patel was confronted with an extremely morbid situation 48 hours after the rectum had been perforated. He did an appropriate operation and transferred the patient to further appropriate care but the

patient never really got over the initial iatrogenic. So, once again, I think it's inappropriate to attribute that particular demise to Dr Patel directly, although it is one of the 88 that his name is associated with.

Thank you. Doctor, would you look, please, at perhaps table B2 and tell me what is the distinction between those patients in B2 who you say died with other doctors involved and those patients in C2 who seem to have died as a result of a process by doctors other than Dr Patel?-- If we take the first patient on the list in B2, Frances-----

-----P164?-- -----P164 who died from peritonitis following steroid therapy. The patient was admitted to or transferred from Bundaberg to the Royal Brisbane Hospital with a viral pneumonia and treated with massive doses of steroid, and developed an acute complication, steroid therapy. Shortly upon return to Bundaberg, having got over the respiratory problem, developed a non - well, a steroid-induced peritonitis, and, in fact, looking at the details of her case it is edifying. Dr Patel comments on the 1st of May, "66 year old female admitted from the 18th of March through to the 19th of April for respiratory infection. Treated with steroids on Prednisone. Developed an acute abdominal pain with coffee ground emesis this morning. She arrived via ambulance with hypertension, her blood pressure was 60, a tachycardia of 130 and dehydration. The BP responded well to hydration. The patient was observed to be awake and alert. Her abdomen was distended with difficulty" - in other words, he elicits the signs of peritonitis - "particularly in the epigastrium. There were no bowel sounds." He then lists his plan of treatment and proceeds with an operation, which he performed on the 1st of May, and he notes that surgery of pyoperitoneum and inflamed bladder there was - he describes the technique and notes that there was free purulent fluid on entering the peritoneum via midline laparotomy. He could find no evidence of fistula. The gastrointestinal tract, stomach showed nothing other than mild diverticulosis and the nasogastric tube was noted to be in situ. The appendix was normal. There was no pus evident around the appendix and the other adnexia and uterus were considered normal. And he has described a powerful case of steroid induced peritonitis and this is summarised elsewhere in the chart. My apologies, that's the death certificate. But the progress note's consistent with the diagnosis that we have just outlined.

Doctor, is it your opinion that a doctor at the Bundaberg Base Hospital other than Dr Patel was a significant contributor to this outcome?-- Well, the person - not at Bundaberg, but the person who was responsible for the steroid therapy - it is a steroid-induced demise. It is a complication of steroid therapy and that's why I have said it is not an iatrogenic injury, it is a death where other than Patel have had a significant contributing role.

And so there are four deaths in the perioperative period where you feel that doctors other than Patel had a significant contributing role which was not caused by an iatrogenic process and you found four other deaths where it was caused by an iatrogenic process of persons other than Dr Patel?-- Correct.

And is that the difference between B2 and C2?-- Correct.

Okay. Doctor, I am seeking to locate one of your tables in which you discuss the deaths in the perioperative period of non-terminal patients. Am I right in thinking that?

COMMISSIONER: The C3.

MR ANDREWS: That that is a particularly significant group because one does not expect non-terminal patients to die in that period?-- Correct.

Have you identified four whose deaths you feel Dr Patel adversely affected?-- Correct.

Now, I see the first of those named in C3 is Desmond Bramich. Are there other persons in addition to Dr Patel who may have adversely affected Mr Bramich?-- I believe so.

But do you conclude also that Dr Patel's treatment adversely affected this patient?-- Yes.

Thank you. Would you explain the basis of your opinion?-- Can we refer briefly to the notes that appear besides Mr Bramich's name? He was admitted under Dr Gaffield on the 25th of the 7th following blunt chest trauma. A CT Scan revealed contusions of both lungs and fractured ribs and we subsequently learnt that he fractured his sternum. He was clinically well for two days but deteriorated noticeably at one o'clock - 1 p.m. on the 27th and at that time his BP fell to 50 millimetres and his haemoglobin to 77 grams per litre. He was noted to be in acute respiratory distress, and looking at the case notes in detail at that time, I think is very informative. And if I can draw the attention of the Commission to the note of the 28th of July, the patient was admitted by the surgical team. The retrieval team from the Royal Brisbane Hospital were present or contacted. There was an acute onset of symptoms at 12 o'clock on the 27th. At that time the patient complained of worsening pain and the drain was noted not to be draining, and blood was noted to be issuing around the drain. And these are features of a blocked underwater seal drain consistent with the subsequent autopsy findings. The management of the injury that Mr Bramich had is conservative, it is not surgical. It should be managed by functioning underwater seal drainage, and the fact that the drains stopped working and were left in a non-working state at least while three litres of blood accumulated in the chest was the injury that produced his demise, and I think it is a team failure to fail to appreciate that underwater seal drains are not functioning. I don't believe you can attribute that to any single individual. So I believe that there is undoubted vicarious responsibility for the person in charge of the case, but I think that it is a rightful anticipation that others would have noticed, and rather than tick the drainage was okay, that the drains were in fact not working - or the drain at that time was not working. It was appreciated that the fluid was accumulating and a second drain was put in, and this didn't produce sufficient improvement, and at that time Dr Patel attempted to drain the pericardium on the basis that

that might be the explanation of the patient's calamitous deterioration. I don't believe that that was a clinically significant event. It was shown by the pathologist not to have produced any damage to the myocardium and, in fact, the patient wasn't suffering a pericardial tamponade. The problem was the 3,000 grams of blood in the right chest, the displaced media sternum, which, in effect, choked him, particularly as his remaining lung tissue was contused by the original injury. I have spoken with two of Brisbane's leading thoracic surgeons and they believe that there was no indication for surgery in that patient other than replacement of the blocked drains.

What then about Dr Patel's conduct do you say contributed to the death of Mr Bramich?-- Well, he was the principal clinician caring for the patient at the time and he had the vicarious responsibility of ensuring that he was being managed optimally. So he can't duck responsibility for this occurrence but I don't believe it can be totally attributed to him and his care.

And the patient P238?-- This patient was initially referred by one of Dr Patel's predecessors, Dr Baker, to the Royal Brisbane Hospital in December of 2002, and there she underwent a partial removal of the pancreas and stomach and developed complications which required further surgery which almost cost her her life. She had a very stormy, complicated and complex and challenging admission, including a pseudomonas peritonitis. She finally was discharged from the Royal Brisbane Hospital but represented in Bundaberg with a recurrence of the problems she had previously suffered. In this case she'd developed a pseudocyst of five to six centimetres' dimension in the lesser sac posterior to the stomach. And I think it lacks judgment and wisdom to tackle - redo complex surgery under those circumstances in someone who had almost proved too much on a previous occasion for the experts at the Royal Brisbane.

Do you mean, doctor, that a reasonable surgeon would have advised her not to have this surgery?-- No, she needed the surgery but he would have sent her back to the people who'd dealt with her on the first time. I think it is interesting that Dr Baker, who I believe was a very competent surgeon in his own right, didn't for one moment hesitate to send her to the Royal Brisbane the first time round and he certainly would not have tackled - if Dr Baker had been there, he certainly would not have operated on her under any stretch of the imagination on her representation with her subsequent complication in Bundaberg. So I think it shows more than a lack of judgment on Dr Patel's behalf. I question the man's motive. I cannot understand how somebody could contemplate taking on that challenge under those circumstances given that preceding history.

D COMMISSIONER VIDER: What was recorded as her cause of death?-- I will - it will take me a little time to bring up the death certificate. I am sorry, I can't recall her certificate. It will be here but it could take me a little bit of time to actually locate it. Could I take that on

notice-----

Yes?-- -----and inform the Commission.

COMMISSIONER: Doctor, we normally have a comfort stop during the afternoon anyway, so perhaps if we do that now and give you an opportunity to look at that. Just before we rise, though, I would like to develop a point you made about motive. I guess we have heard a number of suggestions. One is that Dr Patel was keen to big note himself within the hospital and particularly by performing a lot of elective surgery bringing money into the hospital. Is that the sort of motive that you are hinting at?-- Well, that I think is one of the possible motives. I really don't - I haven't arrived at a determination as to what I believe his motive is, but that is the most striking one, I think, that he's run into problems elsewhere, has been castigated and now he is trying to reassert and re-establish himself and his abilities know no bounds. I came away with the impression that he was more intelligent than that and I even wondered whether there was some other motive which I haven't yet unearthed, I must admit. But I have a number of cases which I have earmarked of "query motive", and I can press a button and bring them up, and they are beyond explanation. I think it is even being generous to him to suggest it was just his personality and wish to reassert himself but that could well be the explanation.

The other thing I ask you to possibly consider during the break is this - just going through your table E - what has surprised me, just because it is something I haven't focussed on before, is there are a significant number of quite young people involved or listed amongst those in which you say Dr Patel contributed to an adverse outcome, fortunately none of them fatally, but the second one in the list, barely in his 30s, about six items down with the surname C, a child of about eight years with the surname P216, a person in his mid-30s with the surname P401, a fellow in his early 20s. The last item on the page we have heard a lot about. And then over the page surname P35, again a child of only six or seven years old?-- Mmm.

And I just wondered if when we come back you might comment on those because, you know, the terminal patients, it may be that Dr Patel hastened them to the inevitable but some people anyway, and I suspect I am one of them, are even more desperately concerned over young patients who have been mistreated?-- I think strikes on the very - the most important point of this type of survey. If we actually remove the patients that I don't believe we can attribute to Dr Patel, we're left - I am talking about demise at the moment in the first instance-----

Yes?-- -----we're left with a much smaller group with seven or eight absolutely non-defendable processes. In other words, his hit rate, for want of a better word, or his severe trauma rate is - he is not responsible for 88, and that is a nonsense, but his - if you look at the group that he did do major surgery on, half of them went wrong and that is a very

key point. And the same thing I believe is evident in the survivors, and one reason why my figures differ percentage-wise from Dr de Lacy's is that Dr Patel was involved in the tilt train accident and referred a lot of people from Bundaberg, quite appropriately, on I think it was the 16th of November, or thereabouts. They swell his figures in my survey because they are picked up as transfers.

Yes?-- And there was nothing really wrong with them. A lady burnt with a tea urn, someone with a fractured ankle, pinned in Nambour. And yet Dr de Lacy, on the other hand, has been asked to address people who have been injured and feel they have a complaint or some ongoing problem. So he has attracted people who you would expect to find problems with. A lot of the patients that I have been asked to look at expand Patel's group and make his performance look better, but if we cone down perhaps later when we get the chance, I have identified 23 very bad technical performances in the group that you are referring to.

All right. Well, we'll adjourn now for 15 minutes, doctor.

THE COMMISSION ADJOURNED AT 3.39 P.M.

THE COURT RESUMED AT 4.01 P.M.

PETER WILLIAM HAROLD WOODRUFF, CONTINUING
EXAMINATION-IN-CHIEF:

MR ANDREWS: Dr Woodruff, from my reading of your hard copy report, Exhibit 283, it seems that Table B3 shows six deaths within 30 days of surgery where the death was affected by Dr Patel's level of care, and Table C3 shows four deaths, also in the perioperative period where the deaths were affected by Dr Patel's level of care and Table D3 shows another three deaths but the time outside the 30 day period where these deaths were also affected by Dr Patel's level of care?-- Yes, correct.

And are they the 13 deaths in which you hold the opinion that Dr Patel's level of care was a contributing cause?-- Yes.

And it's appropriate to say that in respect of each of those 13 deaths, Dr Patel's level of care fell short of the reasonable standard you'd expect from a surgeon?-- Correct.

And in respect of one of those, that is, Mr Bramich, you've explained how it was because the death was - well, one for which Dr Patel was vicariously responsible but that there were others who also - whose level of care also contributed to the death?-- That's correct.

Now-----

COMMISSIONER: Are there any other of the 13 which you would put in that category, that is to say, that whilst Dr Patel was at least partly to blame and that he shares the responsibility with others?-- I'm having a little difficulty recalling the details of the 13-----

Yes?-- -----in the abstract.

I wonder whether the easiest thing, Mr Andrews, wouldn't be to go through the analysis and go through those 13 one at a time. Is that a convenient course, doctor?-- Yes, it would. Could I perhaps answer Miss Vider's question?

Yes?-- I was unable to find the death certificate, in other words, I doubt that if there is a death certificate filed in that case note, but I will scan it exhaustively tonight. There is a letter written in request from the police by Dr Patel and that's what I've put up in front of you now and that's his account of what he did and what he believed went wrong. It's self-explanatory.

D COMMISSIONER EDWARDS: And on review, do you think this is a fairly accurate summary of what happened?-- It's one of the questions I've sought to answer and my overall summary of his notekeeping is that I believe with the limitations of how I've

tackled the problem, that he is reasonably accurate in what he accounts and I can give specific illustrations to support that statement.

COMMISSIONER: I think from what we've been told, and I don't pretend to have done the exercise myself, that the areas where his notetaking was perhaps again suboptimal was where he stated things in generality, so an expression like, "Patient doing well"?-- Mmm.

Or can be contrasted with nursing notes which show that all the vital signs were actually fairly poor and there were large transfusions of blood and those sorts of things; did you come across those sorts of examples?-- He undoubtedly viewed things, as I've expressed, I think, with rose tinted glasses.

Yes?-- He tended to garner some reassurance, personal reassurance that things were on the favourable optimistic side rather than the pessimistic side.

Yes?-- There were instances of absolute oxymorons where he says haemodynamically stable and on the next line they're on inotropes Noradrenaline and Adrenaline, but as for deletions, substitutions, records out of sequence, nonsensical observations or illogical points, I found very little that I could criticise him on those scores.

And you've probably seen a lot worse?-- Oh, much worse, and in fact, his standard of notekeeping suggested to me that this was a person who's been down this road before and he's taking particular care to document everything to an exemplary standard.

Yes?-- Very few note audits would find the quality of recordkeeping over a consistent range that is evident in his series.

Anyway, we interrupted - I think you were about to take us through the 13-----?-- Right.

MR ANDREWS: Perhaps the sensible place to start is at Table B3.

COMMISSIONER: Well, Mr Andrews, I think this way we'll get it and it's probably easier for Dr Woodruff to work from his notes?-- So where would you like me to start?

So you've got B3 on your analysis, if we go to that?-- Okay. Well, the first, the first patient there is P215, and this is a gentleman who presented with jaundice, weight loss and anaemia. He had a five centimetre lesion in the head of the pancreas with streaming of the peripancreatic fat planes, displacement and encasement of the superior mesenteric artery vein, malignancy closely applied to the small bowel loops, considered there may be localised extension in the small bowel mesenteric artery. There was also a suggestion in the bony mode of the CT scan of a possibility of a few small lesions, in other words, there was more than a suspicion of metastatic

disease. He underwent a Whipple's operation in September and the early post-operative care appears to have gone reasonably well. The histology reports focal soft tissue metastases, particularly of the greater curvature area and the tumor extends to the surgical margin of the pancreas, in other words, it's not a curative operation and the patient develops hypoxia, the suggestion of oversedation and pneumonia and the patient dies 12 days post-operative of klebsiella pneumonia. This was thought to have followed the aspiration of vomitus. This in my mind raised questions of his motivation and his judgment, and I'm not sure how far we wish to cone down on the evidence to support these contentions, but these are key pages that I've listed on the left-hand side of your screen which I think are illustrative of various aspects. Perhaps it's labouring the point, but it gives an indication of how Dr Patel's clinical assessment worked in these issues and how he wrote his notes. For instance, here he describes how the tumor was dissected out of the interior mesenteric artery vein but noted to be adherent to the superior mesenteric artery, therefore there was an incomplete dissection, common bile duct confined 20 Dexon and divided. The body of the pancreas divided with bleeding vessels diathermy and/or tied with 20 Dexon. The duodenum mobilised through the ligament of trites and divided with the GIA 8 AD stapler, the gall bladder dissected off the bed and resected cystic bile duct clipped times two and divided haemostasis with diathermy, distal small bowel brought through the transverse mesocolon.

MR ANDREWS: Doctor, what do the non-medical people in the room deduce from the way those notes are written?-- Well, I believe you're entitled to think that this is a fairly thorough and reasonably detailed account of a complex operation and at some variance with some of the other evidence I've heard, I believe it indicates a procedure that can be followed. I think you do get an idea of what's going through his mind, what's planned to be done and what - well, what - this is an account of what has been done. Whether you can vouch for its voracity is a little more problematic, but this is, this is an account of a procedure that's been witnessed by the - at least three or four other people who'll have access to this record in real time, and so I think it's just not an occurrence in my experience that people can write that sort of detail that's - and have no bearing to the truth.

COMMISSIONER: But doctor, accepting that the notes are accurate, what went wrong?-- Well, I believe the patient should never have had such an extensive procedure in the first place with that extent of disease as evident on the pre-operative CAT scan.

Yes?-- In other words, I think there was a lack of judgment in even putting the patient forward for this type of operation.

Indeed, I saw on your earlier note that you've questioned the motive again?-- Yeah, yeah. I just can't answer that. I mean, if this fellow was - take, given that we're trying to find a motive for the fellow to behave in an abhorrent and

with behaviour outside the norm, one would have to ask is this person somehow abusing his trust as a surgeon doing procedures that aren't indicated for some sort of financial reward? But there's no indication of that. I mean, if this was someone operating in a kaiser permanante situation, you might ask why on earth is he doing it? Is he being driven by money? But I don't believe so - well, I don't know.

Yes. Certainly driven by something, whether it's ego or increasing his reputation or whatever?-- Mmm.

I wonder if Mr Andrews, if we can ask Dr Woodruff to go back then through the other similar cases, the other 12 and follow the process through of telling us why you regard them as examples of death to which Patel contributed?-- Well, the second patient, P224, was admitted with a history of carcinoma of the lung and thyroid cancer poorly differentiated. The CAT scan revealed a large thyroid mass displacing the trachea with retrosternal extension and obstruction of the jugular vein. The vein contained thrombose. The tumor's declared non-resectible. I'm not sure why he would even operate on the patient, but an incisional biopsy was retained. He records that the trachea and the tumor were inseparable. In fact, he couldn't even identify the carotid artery, so it's a very difficult dangerous situation to be in and one wonders what on earth is he doing there.

D COMMISSIONER EDWARDS: He attempted to do a thyroidectomy?-- Well, with the data that is in the chart, there is no - there is no justification for trying to do a thyroidectomy, I mean, the patient has carcinoma of the lung, he's got displacement of his trachea, retrosternal extension. Even if you thought perhaps for palliative reasons some form of surgery to protect the airway, non-curative surgery was indicated, you certainly cannot justify attempting that in Bundaberg, it shows an error of judgment or some other motivation which I can't - I don't understand.

D COMMISSIONER VIDER: Dr Woodruff, we have heard some evidence from people that have had some clinical opportunities, some opportunity to clinically review these cases where you could form the opinion that Dr Patel was very quick to make his own diagnosis and then act on that without being able to perhaps take note of the appropriate diagnostic tests and the variety of them that other surgeons might avail themselves of. These notes that you've compiled that are the notes before us here, were you able to match up, for example, the date that the radiology report came back and his decision to act? I suppose I'm really wondering whether you saw any evidence of the patient being operated on before it was conclusive as to what the real diagnostic picture may have been pre-operatively?-- I appreciate the question. I am not in a position to answer it without a little more recourse to the data.

COMMISSIONER: Well, we won't take time now. If we can continue the process-----

D COMMISSIONER VIDER: Certainly.

COMMISSIONER: -----that you're going through of giving us a thumbnail sketch of all of each of the 13?

MR ANDREWS: Doctor, do you mean with respect to the patient P224, the surgery performed can't be explained on the basis of improving the patient's quality of life nor on the basis of preserving his life?-- No, no.

The next patient in B3 was P236?-- P236 was admitted with a pancreatic mass and this mass was obstructing the biliary tree and also the gastric outlet. So he was jaundiced and vomitting, and the CAT scan revealed a four centimetre pancreatic carcinoma, and the CAT scan report is quite emphatic on that, and I think it's worth taking a moment to look at that in just a moment. Also the CA 19-9 which is a measure quite specific for pancreatic carcinoma, was significantly elevated at 90, and at laparotomy he was found to have a mass of 10 to 15 centimetre diameter, in other words, the mass at operation was considerably larger than the carcinoma described on the CAT scan. This is a common finding in this form of problem, because the surrounding tissue becomes obstructed and compressed and develops a degree of pancreatitis, and it explains why the biopsy, which in the pathology report is described as being a piece of tissue five by five by four millimetres, I believe, in other words, it's just a pea shaped piece of tissue excised from the edge of this larger mass and it showed nothing but pancreatitis, but that doesn't dissuade me from the diagnosis of carcinoma based on the CT finding and the CA 19-9. It was a correct procedure following that observation to perform a polycystic jejunostomy and a gastrojejunostomy and those procedures are seeking to drain the first one to drain the bile away from the bile ducts into the stomach - into the bowel, I mean, beyond the pancreatic obstruction and the gastrojejunostomy to enable the stomach to drain into the intestine without thereby curing the vomitting, and I think it's informative to look at the details that support these statements in his chart. There's the operation which describe - which once again, is a very detailed and accurate account of what I've just summarised and gives details of how it was performed, 30 Dexon with a lambdoid oversewn suture, and it goes through other surgical detail which makes it easy to follow what he was thinking and what he actually did. That's the second page of the operation note. The pathology report is summarised there and there's no evidence of anything nasty in the lymph node and there was none in the specimen that was submitted, but as I mentioned, it was only a small pea sized piece of material half a centimetre in dimension taken from the outer margin of this 10 to 15 centimetre mass. I think the disturbing things in this particular case are that the patient did well initially, and but then - I'm just looking for the correct page - I'm having difficulty locating - oh, here it is, this is what I'm after, the full blood count. Now, this is very informative. It supports Patel's contention that the patient did well in the early post-operative phase, but if we look at the white cell

count, the second row of numbers, they remain - and I'm having a little trouble with the date on the top of the page. I need to expand it further, but-----

It seems to be - that column seems to be 5 September and the next one looks like 9 September?-- Correct, yep, and then - so if we follow horizontally the white cell count, 13.9, 12.1, it's sort of upper limits of normal, just slightly elevated, 9.5, and then between the 17th and the 22nd, there's a significant deterioration, the patient's white cell count goes to 15, 16, 18, in other words, the patient's becoming septic, and he's also developing a temperature during this time and the bile that was draining through his drain, which I have on one of those progress pages, dries up and he develops pain, and so my reading of that is that he had the appropriate operation under the circumstance to relieve his symptoms to palliate him, but somewhere around about this time, the reconstruction leaked and he developed a peritonitis that caused pain, the bile stopped draining, he got - I think he got a biliary peritonitis and succumbed quite quickly after that.

COMMISSIONER: And Dr Patel did nothing to rectify that apparently?-- No.

D COMMISSIONER EDWARDS: Or even diagnose it?-- That's correct. Once again, and I think that would be an oversight on his, from the way he would normally view these issues. It's interesting that a small group of us were asked to review some of these cases by the Homicide Squad, and one of my colleagues in that little trio of clinicians recounted, when talking about this patient, that his teacher in England considered it more humane not to do this operation because it's such a particularly miserable demise in a carcinoma of the pancreas, that it produces intractable back pain and suffering, and that in some ways palliating the patient for a few months is probably - well, in the view of this emanant surgeon in London was not indicated and that their best - that's a minority viewpoint, but you could reasonably deduce from that that if someone gets a major complication following a palliation, that you've given it your best shot and you've subjected him to one operation and that things are not panning out. I'm not saying that that's necessarily the right way to go, but you could see some people thinking that way.

COMMISSIONER: And in this instance what's your conclusion as to what Patel did wrong ought he have not to have operated at all?-- Well, he set off in the belief that he was going to do a Whipple's operation.

Yes?-- And I think in the light of the findings - well, I think for reasons we've heard, that that's probably outside scope of practice in Bundaberg.

Yes?-- And as I say, that I think that was an error of judgment and then having found what he did, I think the drainage, the palliative drainage was in order. I think if I'd been the surgeon and it had leaked and the patient

developed peritonitis, I would have re-explored the situation, but that, that's a judgment decision.

Yes?-- But I think not exploring it is an error in his case.

And again, this was a case, I think, where you questioned the motive for performing the operation?-- Well, I think it's inappropriate to do this form of surgery in that environment, particularly with no recourse to any other colleagues, and I believe that this is indicative of the problems that Bundaberg poses in this particular instance. I think one of the most telling findings in this series that in the whole 47,000 pages of case notes in here of Patel's, there is not one letter from Patel to any other doctor, not one.

So I believe that he is in absolute clinical isolation and I think that that is part of the problem and it's certainly part of the solution to this question of overseas trained doctors. They've got to be inculturated and incorporated into clinical networks. They've got to - I've used the term hub and spoke. They've got to be part of a central organisation with well-established lines of communication and contact with peers that they can discuss these issues with. I think this man was working in total isolation and doing things (a) in respect of his own motivation but also without any knowledge of where perhaps he should get help.

The next patient on B3 is Mr Kemps, about whom we've heard a great deal already. Perhaps you can abbreviate your summary?-- Yes. Well, I think this is probably the most telling case of them all. He'd undergone a major aortic procedure in Bundaberg two years previous in the hands of a vascular surgeon and on day 4 of that procedure, through no fault of the operation but because of the nature of the parlous state of the patient, he was transferred to the Royal Brisbane Hospital for management in the Intensive Care Unit there. So, to two years later contemplate a major procedure such as an oesophagectomy, particularly when the CAT scan shows some ectasia or dilatation and disease of the thoracic aorta, which is an extension of the process that it had repaired two years previously, and the loss of tissue plane between the oesophagus and the thoracic aorta, you can almost guarantee that (a) the tumour is not curable and (b) any interference with or attempt to separate it from this diseased aorta is going to produce aortic bleeding, and suturing that type of aorta is not dissimilar from trying to keep the yoke inside a non-cooked egg, suturing the eggshell. It's calcified, sutures just make holes; the bleeding just gets worse with each suture. It doesn't surprise me - in fact, I could have told him, if he'd asked me, that he'd need at least 39 units of blood to successfully do that operation, and it - once again, and this one will be marked judgment and motivation because I cannot understand how anybody could even contemplate doing this operation with that history.

All right. The next one again we've heard a little about, that's Eric Nagle?-- My anaesthetic colleague thought, when we were discussing this with the homicide squad, that we - the two surgeons were being harsh here. This is a passage of a central venous line that pierced the pericardium and the patient suffered the demise that Dr Patel thought Mr Bramich might be suffering. It was an iatrogenic injury and it was a technical failure, contributed to by the fact that the patient had had previous cancer surgery and radiotherapy in the neck and that had the passage of a number of previous central lines that made it more difficult to achieve on this occasion, and one can understand perhaps over zealous force, but nevertheless an iatrogenic injury and undoubtedly responsible for his rapid demise.

Would your view of the seriousness of that - the errors that took place there be changed by information concerning previous failed attempts by Dr Patel to insert similar Tenckhoff

catheters? We've had it suggested, even by Dr FitzGerald this morning, that it was apparent that he just didn't know how to do them?-- Well, it - I mean, it's something that needed to be done and something that needed to be done in Bundaberg but if he had - if he'd shown his inability to do it appropriately, then someone else should have been - should have been enlisted to do it, but it's the sort of thing you would expect would be within the compass of the Director of Surgery or even a staff surgeon in Bundaberg.

My recollection is that Dr Miach told us, quite a few months ago now, that his experience as a nephrologist was that ordinarily these catheters are inserted by vascular surgeons in the major hospitals; is that right?-- Well, at the Princess Alexandra, where we do - where we have the biggest transplant unit in the country, no, the vascular surgeons don't do it.

Right?-- But they are done by experts. They're done by mainly the anaesthetists using ultrasound guidance and also by one or two of the transplant surgeons.

Okay. Can you take us to the next one, P98. Mr Andrews, while that's coming up, may I mention that I'm inclined to the view that the names of all deceased patients identified by Dr Woodruff as being attributable to Dr Patel should become released from existing suppression orders. I wonder if Mr Scott might be kind enough to liaise with the patient support group and with others to - and I don't expect any results this afternoon but, again, it's a situation where I think the public interest outweighs individual privacy in matters of this nature.

MR ANDREWS: Yes, Commissioner?-- P98 is a patient we reclassified. He was initially judged by me - this, incidentally, is the classification down here, if you expand that, "Did Dr Patel contribute to an adverse outcome?" I originally answered that question, "Maybe", on the basis that he died in the very early post-operative phase. It was not clear by what mechanism he died and I, myself, referred the case to the Coroner, because of the uncertainty that surrounded the case. So I thought maybe was all I could justifiably say of Patel's contribution. However, when I looked at the case subsequently, it's interesting that the patient was suffering obstructive jaundice and to admit a patient with obstructive jaundice on the day of surgery, having had the patient fasted from the previous midnight, is likely to - well, will certainly increase the risks of a potentially fatal hepatorenal syndrome which I think the patient probably succumbed to. So I think it is a gross error of judgment to admit this type of patient, dehydrated on day of surgery for this type of surgery. So having given weight to that decision of Dr Patel's, I've changed his contribution to, yes, he did contribute to the adverse outcome.

I think that was the last of the B3 items. I wonder if we can repeat that process with the table C3, the four patients there, of whom we've already dealt with I think the first and

the second, Mr Bramich and P238?-- That's correct. P28 underwent a sigmoid colectomy and colostomy in May of '03 for a bleeding diverticular disease. There was a past history of radium therapy for carcinoma in the prostate. The patient suffered a wound dehiscence in the post-operative phase. He developed abdominal distension ascites and the colostomy site stoma was obstructed with dressings and adhesive material, which is, you know, less than appropriate management. And I think that, once again, this is very exacting surgery to - to do major pelvic excisional surgery in a radiated field and I think that it perhaps does question judgment but at least it highlights inadequate technique to get the complications that he did get.

Yes. This was one of the - as you classified it, one of the non-terminal patients. In a sense, I suppose that makes it worse, that you're performing this operation on someone who would otherwise have a good chance of survival?-- Correct. I think the optimal management of this patient would have been referral to a major colorectal unit and I think that would have been quite appropriate.

The next one is James Phillips?-- Mr Phillips had a potentially curable oesophagogastric lesion and I believe surgery was an appropriate consideration in his case but it was complicated by the existence of renal failure, and that you would question the wisdom of major surgery of this nature in somebody who I don't believe was adequately prepared for what you could reasonably expect to happen. I draw the attention to this letter from the vascular unit at the Royal Brisbane Hospital and this figure here, "A scan shows the venous outflow of the loop graft" - the PTFE graft that he was to use for dialysis - "to be 430 centimetres per second." In other words, the graft has a stenosis of the order of 70 per cent and one and a half centimetres distal to the anastomosis. The challenge of a major procedure such as an oesophagectomy almost guarantees that such anastomosis will thrombose, and it did. And so, the patient was left with no dialysis access, a rapidly climbing potassium. Steps were taken to reduce the potassium with Resonium but it's no surprise that he's succumbed. Now, this would be as difficult an oesophagectomy as one could envisage and I'd think the appropriate treatment for this patient would have been at the Princess Alexandra Hospital because of the existence of the renal unit there and also the best oesophagectomists in the state as well.

But even in those circumstances would you have reservations about performing the operation? I don't mean you personally performing it but-----?-- No, no, it would - it would be a considerable challenge to those involved. It would rely on very detailed and informed consent. There are other options but I think - and it's outside my field of clinical expertise, I think a very small lesion does raise the - justifiably raises the question of surgery. In such a sick patient there are other modalities that might have been more appropriate.

There has been some uncertainty in the evidence to date as to

whether or not Mr Phillips - I'm pretty sure it was the case of Mr Phillips - was seen at the Royal Brisbane Hospital with a view to this sort of operation and refused it. Did you come across anything in the records to indicate one way or another?-- No. I have encountered counts from Dr Patel that labours the extent of the discussion he had with the family and he canvassed the options of other forms of treatment and that is much harder to verify or substantiate. That's the type of written comment that-----

Yes?-- -----could easily be written by somebody who's less than honest much more so than an operative note.

Yes. I think that's the end of C3 and then you've also got in table D3 three more patients. I think this is in the non-perioperative category, the next one along. Three more deaths which occurred outside the 30-day period?-- Mmm-hmm. The first of those is P180. P180 was admitted with a five-day history of constipation and abdominal distension, a past history of hypertension and cardiac arrhythmia, A-R-R-H-Y-T-H-M-I-A. The X-rays were consistent with a bowel obstruction and I thought Dr Patel's notes, which I could bring up, are an example of a comprehensive and lucid assessment. He's said that the surgery revealed an incarcerated epigastric hernia which was repaired, but during the course of this he inadvertently damaged the small bowel and then repaired it. And I made a note at the time that that's the sort of occurrence during an operation which a less than transparent surgeon might omit to record, but the fact that he recorded it I thought supported his reliability as a witness of his surgical procedures. But it is indicative of a technical error which indicates a less than adequate performance, although it is the sort of problem that can happen from time to time.

And was that the ultimate cause of death? The immediate cause I think was pneumonia?-- Well, she developed pneumonia and had a protracted post-operative course, plural fusions were drained, 800 millilitres of serosanguinos fluid, it was proving difficult to wean her from the ventilator and she was transferred ventilated to the Mater Private Hospital in Brisbane. I'd have to focus down further to remember exactly the cause of death. There was some suggestion she may have had a pulmonary embolus but I'm unclear on that. I think in the progress notes Dr Patel records that she was a 76-year-old with vomiting for four days, a longstanding history of abdominal wall hernia, not much abdominal pain. The last bowel movement on the preceding Wednesday. Vomiting is bilious and feculent. There is a past medical history of heart failure, a previous surgical history of an appendectomy. She is currently receiving Lanoxin and Isoptin for her heart. And he goes on examination to say, "This emaciated female is quite dry. The skin's quite dry. The abdomen is distended but soft. There's an irreducible midline hernia in the supraumbilical region non-tender and soft. No localised abdominal tenderness. Skin" - I'm not sure of the next word - "through with distended veins. Blood work okay. X-ray consistent with small bowel obstruction." His assessment:

"Small bowel obstruction. Irreducible incarcerated abdominal wall hernia. Dehydration." Plan: "Intravenous flow, nasogastric suction, Foley catheter. Assess the de-oxygen level. Most likely will need exploratory operation after rehydration." And we just happened upon that by chance and I think that again - that document of Dr Patel's. But I think that is consistent with the standard of notekeeping evident in many places in his chart.

All right. In this particular case there was a misadventure in the operation when the bowel was nicked. Now, is it the case that that contributed to the patient's death or was just an adverse outcome that was coincidental and the patient would have and did die from other causes?-- I believe that most likely contributed to an adverse outcome. I mean, peritoneal soilage from an inadvertent tear in the small intestine contributes to an adverse outcome.

All right. The next patient in this category is James Grave. Again, we've already heard something about him?-- Well, I'll just very briefly summarise the story. An oesophagectomy, partial gastrectomy. Metastases in the pericardium and nine of 14 lymph nodes positive. Evidence of technical ineptitude: a vocal chord paralysis, which shouldn't occur during the course of oesophagectomy, and the development of a myocardial infarction and peritonitis are also complications which are markers of things not going as one would expect. He was transferred to the Mater Intensive Care Unit and he also - he had two wound dehiscences, both requiring returns to the operating theatre and he also had a leak from the jejunostomy site. So this is a litany of surgical ineptitude.

Is it probably the worst example you've found in this audit of that degree of ineptitude?-- It's - yes. I mean, there are others of comparable nature I think but it's as bad as any I believe.

And the final deceased patient that you put in this category is P273?-- "I've concluded the 79-year-old lady because I believe that it's inappropriate to proceed with any sort of invasive procedure that's not lifesaving on somebody who is so disorientated, confused that she was unable to state what procedure she's having or the date of her birth." So, to me, this raised questions about the appropriateness of case selection and why he was actually doing the procedure.

Did you make any comments about the competence with which the procedure was performed or was it just an inappropriate procedure in the first place?-- I can't comment about that particular procedure but that is a very interesting question because during the course of our interviews in the original visits to Bundaberg, one of the doctors was given the responsibility of overseeing Dr Patel when he first joined the staff doing colonoscopy because at that stage he was working under supervision, and this doctor, who gave evidence to me but I've forgotten his name, and I didn't come prepared to recount it now but I think it is interesting, said that he gained the impression that Dr Patel was relatively

inexperienced in this procedure that he was supervising him at because he over inflated the bowel, he pushed too vigorously and caused a lot of pain. He said, "But within a very short period of time, he was equally as good at doing this procedure as I am", as the person recounting this to us. And I think that in the light of other developments, it supports the contention that Dr Patel was very keen to learn, was a quick learner and was loath to pull back from anything that he might just - might more appropriately have refrained from doing. I think that he did not like saying, "Well, I don't have much experience in this. Yes, I can do this", and I think, by and large, he did improve.

Mr Andrews, I think we might have to leave it there. What arrangements are listed for Dr Woodruff to come back?

MR ANDREWS: Dr Woodruff is prepared to come back tomorrow. He must finish his evidence tomorrow.

COMMISSIONER: Yes.

MR ANDREWS: There is an inspection at 8.30 tomorrow.

COMMISSIONER: At Herston.

MR ANDREWS: Yes. I anticipate that we'd be back by 10 and ask that Dr Woodruff be here at 10 tomorrow to continue his evidence.

COMMISSIONER: We have also got Dr Aroney coming back tomorrow afternoon, haven't we?

MR ANDREWS: I suspect that-----

MR BODDICE: No, Commissioner, I understand there was discussion with Ms Kelly and Mr Fitzpatrick and also with the Commission and I understand Dr Aroney is coming Friday afternoon.

MR ANDREWS: At 4 p.m.

COMMISSIONER: Have you got any other witnesses planned for tomorrow at this stage?

MR ANDREWS: Mr Atkinson wants to explain that.

COMMISSIONER: Yes.

MR ATKINSON: Queensland Health have delivered us over the weekend a list of witnesses that they ask that we call. We don't have all the statements from those witnesses yet but if Dr Woodruff is to finish early tomorrow, we were hoping Queensland Health would have statements from those witnesses or even they could get through their evidence-in-chief in the time available.

MR BODDICE: For our part, we have indicated we will try to accommodate that so that there isn't a lack of space in case Dr Woodruff were to finish early.

COMMISSIONER: Sorry to have to bring you back in tomorrow, doctor, but thank you for your assistance today and we will see you at 10 o'clock tomorrow. Mr Andrews and Mr Boddice, are you joining us in the morning?

MR BODDICE: Yes.

COMMISSIONER: We will see you at 8.30 at Herston.

THE COMMISSION ADJOURNED AT 5.00 P.M. TILL 10.00 A.M. THE FOLLOWING DAY