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Queensland Government
Department of Justice and Attorney-General

Transcript of Proceedings

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SIR LLEW EDWARDS, Deputy Commissioner

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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 18/08/200

..DAY 44

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THE COMMISSION RESUMED AT 9.35 A.M.

GEOFFREY ALAN DE LACY, CONTINUING:

COMMISSIONER: Mr Atkinson?

MR ATKINSON: My learned friend senior Mr Andrews has questions.

COMMISSIONER: Sorry, I keep getting you two confused.

MR ANDREWS: I can see why. Commissioner, I seek to tender a letter from Gilshenan & Luton lawyers dated 16 August 2005. It is a letter that answers two queries raised in Townsville with respect to Vincent Victor Berg.

COMMISSIONER: Oh, yes.

MR ANDREWS: The first was a question asked by you, Commissioner, "What extra information came to light over that period of 12 months to convince the Board by January 2003 that Mr Berg did not hold recognised qualifications to enable him to be registered?", and the Board gives a full page answer with the same kind of frankness that you would have been accustomed to from the affidavits tendered earlier in the inquiry. The second question relates to whether the Board would inform an employer during the investigative phase as to an allegation of fraud or forgery against an employee, and the question asked of the Board was what was their policy in respect of such matters, and they have answered and by their answer highlight the difficult position that the Board is in where during an investigative phase before an opinion can be formed about whether a person truly has behaved fraudulently, the Board is not in a position to inform the employer under its current policy.

COMMISSIONER: Yes.

MR ANDREWS: But will do so as soon as it forms the opinion - unless I find the actual paragraph I will have to paraphrase - forms the opinion that there is sufficient evidence to justify a conclusion that there has been fraud or forgery.

COMMISSIONER: Well, the letter from Gilshenan & Luton - what is the date of that?

MR ANDREWS: 16th of August 2005.

COMMISSIONER: That letter will be exhibit 288.

ADMITTED AND MARKED "EXHIBIT 288"

COMMISSIONER: Thank you, Mr Andrews.

MR ATKINSON: Good morning, Commissioner. You will recall, Commissioner, that Dr de Lacy gave evidence on the 5th of August and he wasn't Ross examined because parties didn't have copies of the relevant records.

COMMISSIONER: Yes.

MR ATKINSON: Where parties have requested records, they have now been furnished, and it is proposed this morning simply to make Dr de Lacy available for cross-examination. In terms of the order of play, Commissioner, it is proposed at the conclusion of that evidence to hear from Dr Wakefield who is one of the witnesses who Queensland Health has asked we call and heard. That's the plan so far.

COMMISSIONER: Thank you, Mr Atkinson. Thank you, doctor, for coming back. I realise these things are an imposition on your time. Ms Gallagher, you are representing the doctor?

MS GALLAGHER: Indeed that's correct, Commissioner.

COMMISSIONER: Is there any further evidence-in-chief?

MS GALLAGHER: No, thank you, Commissioner.

COMMISSIONER: Who wishes to go first with cross-examination?

MR MULLINS: Commissioner, may I request that I go last, only because if all the matters have been covered or nothing is challenged in respect of individual patients, it won't be necessary for me to cross-examine in respect of those matters.

COMMISSIONER: I think we might make it second last. It is usually convenient for Queensland Health to do the round-up, as it were, if that's good for you.

MR MULLINS: Thank you.

MR DIEHM: I would have asked, with respect, to go after Mr Mullins anyway.

MS McMILLAN: I don't mind, Commissioner.

COMMISSIONER: Instead of taking one step forward we might all take one step back. Mr Allen, do you have any questions?

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: All right.

CROSS-EXAMINATION:

MS McMILLAN: As I have introduced myself, my name is McMillan and I appear for the Medical Board. Doctor, I have provided you, have I not, this morning with a copy of the conditions in relation to Oregon where Dr Patel, as you are aware if not before but now, was prohibited from doing certain types of surgery, correct?-- That's true, yes.

Do you have a copy of it with you there?-- I do.

Could we just have that up on the monitor, thanks? Now, if you go to 2.1, please, on the first page? Doctor, in relation to - you will see that one of the conditions, it was an agreement reflected later in the condition, that excluded him from doing surgeries involving the pancreas, any resections of the liver and construction of ileoanal pouches. Doctor, are you able to comment for the patients that you've seen what if any of the surgery performed upon them might fall into any of those categories?-- Can I first apologise for my voice today? I have got laryngitis and it is going to be more difficult to hear me than it was last time. When I was going through these patients, to a large extent I wasn't aware of any of the allegations against Dr Patel.

Yes?-- And I hadn't read these specific restrictions on his practice. So I haven't compiled an exhaustive list by any means but I can give you some examples.

Thank you?-- The patient Philip Deakin, who I believe has been referred to previously in the Commission's evidence, who is the first surviving oesophagectomy, and a patient called Nancy Swanson-----

Yes?-- -----who is an elderly lady who was diagnosed with multiple polyps, which are growths, possibly cancer of the large bowel, and had an ileoanal anastomosis, specifically a contradiction to the ban that had been placed on him in the States. There are certainly others but those are the two that have sprung to mind this morning.

All right. You will also see that one of the restrictions in 2.2, just further down that page, was "complicated surgical cases". Now, I understand that might be a matter of opinion, would it not, as to what constitutes necessarily a complicated surgery. Is that correct, doctor?-- That's correct, yes.

Are you able to say what, again of the patients you have seen, would have struck you as definitely constituting complicated surgery?-- Well, taking the most liberal definition of what represents complicated surgery, at least half of the patients that I have seen would fall into that category, and with the less liberal definition perhaps three quarters of them. As I understand it, Dr Patel was the - well, in his position as Director of Surgery, he looked after all of the complicated

cases, and so whatever came through the door of the A&E department, or the outpatients department that constituted complicated gastrointestinal or other general surgery was referred to him. The only other surgeon on staff was - was primarily trained in plastic surgery and referred directly to Dr Patel in most cases.

This is Dr Gaffield?-- Dr Gaffield, that's right.

Right?-- And I think by the broadest definition of what represents complicated surgery, a bowel anastomosis definitely falls into that category, operating for thyroid cancer, complicated breast cancer operations, would all constitute complicated surgery, and, as I understand it, he would have been asked to get a second opinion for all of those cases. Certainly the pancreas operations, the oesophagus operations, the extraperitoneal rectal operations, which are ileoanal anastomoses, are complicated by definition.

Thank you.

COMMISSIONER: Doctor, having looked at this many times, I am just interested as to whether there is any sort of logical connection. You know, if you were going to choose what forms of surgery to exclude, why would you put it in terms of pancreas, liver resections and ileoanal pouches? Is there any sort of connection between those, or can we just presume that they are things that Dr Patel got wrong previously and that's-----?-- They are notoriously difficult procedures within the abdomen. He was primarily an abdominal surgeon, which is what the rubric general surgery means. Really it means abdominal surgery, and breast, and extracranial endocrine surgery, particularly thyroid/parathyroid. So within the abdomen there is a range of procedures from very simple to very complicated. A hernia is a simple operation. Liver resection or oesophagectomy or a Whipples or an ileoanal anastomosis are all complicated operations, complicated for anybody, and there are many general surgeons who don't perform them at all. Majority of general surgeons I think would not perform them.

Please forgive my ignorance, would an oesophagectomy ordinarily be regarded as abdominal or as thoracic?-- The oesophagus is 25 centimetres long. The terminal two centimetres of it is beneath the diaphragm in the abdomen. So most of it falls within the chest but the operations - but the pathology tends to be at the lower end, and so it is commonly performed by general surgeons, sometimes by thoracic surgeons. So it is a shared organ because it crosses into two anatomical areas.

It merely occurred to me that looking at the restrictions imposed in the United States, it comes across as if these restrictions being imposed on an abdominal or gastroenterological surgeon-----?-- Yes.

-----for the forms of abdominal surgery that are more complex or he is not good at, that would suggest it is even more

inappropriate for him to be attempting thoracic surgery?-- It is. It is a little more complicated and a little less cut and dry than it might appear on the surface. Every individual surgeon has specific training and some surgeons who are called general surgeons have actually had a lot of experience at operating in the chest, without having had - without having a thoracic fellowship which would make them a thoracic surgeon in our system. That doesn't mean that they are not very good at doing the procedure. So the boundaries aren't quite as hard and fast as they appear. However, regardless of whether a thoracic surgeon or a general surgeon operating on the oesophagus is a difficult undertaking, not every thoracic surgeon operates on the oesophagus.

Yes?-- So it is actually - there are some - there is some anatomical reasons for the oesophagus. It is just difficult to operate on - commonly leaks, commonly causes some of the problems that have been experienced by Dr Patel's patients - and so the physician who understands that might decide either one of two things; either to get enough experience to be confident to get good results, or to not operate on that at all.

And, again, at the risk of portraying my ignorance, some of the procedures, for example the ileoanal pouches that have been spoken of here, I would expect in our system to be within at least the primary domain of a colorectal surgeon rather than a general surgeon, although I imagine in a place like Bundaberg if there is a not a colorectal surgeon available, the general surgeon deals with it all. Is that a fair stab-----?-- Exactly right, yes.

D COMMISSIONER EDWARDS: Commissioner, I was just going to ask they also would be complicated post-operative care?-- Usually.

Usually?-- Certainly all oesophagectomies are because you tend to interfere with their lung function, if nothing else. Whipples because they take four to eight hours, and with the consequences of having somebody unconscious for that long, and ileoanal anastomosis, not necessarily just a technical effort to get into that area.

D COMMISSIONER VIDER: Doctor, would you not expect that even if the surgeon was unrestricted in the practice of surgery, that the total environment of the institution would be taken into consideration? In other words, what support services were available. I am thinking of the radiological services that are available in Bundaberg, as well as the pathology and a level of intensive care that's available before any surgeon would undertake that sort of work?-- Oh, you would hope. That would be the way that I would approach it, certainly from a service perspective rather than just a technical one, yes.

COMMISSIONER: Doctor, I don't want to embarrass you but are things like oesophagectomies and Whipples procedures procedures which you undertake in Bundaberg?-- No. No. I have done those procedures in other institutions but I

wouldn't do it in Bundaberg, for exactly the reasons that Commissioner Vider just outlined, because there aren't the support services there. I think I am technically capable of doing them, although somewhat inexperienced and out of practice now, but I wouldn't undertake them electively. If someone has a gunshot wound in the oesophagus, completely different story, but electively where there is the opportunity to send them to a surgeon with more experience in an institution better set up to look after them, I would and have referred them.

And all of the cases that we have been talking about with Dr Patel were done electively. Obviously the boy who lost his leg, that was an emergency situation, and we have seen a few of those, but the ones you are talking about, Mrs Swanson and so on, are all elective surgeries. In fact, I think all of the oesophagectomies were elective?-- It is never - never an urgent situation, operating on oesophageal cancer.

Ms McMillan?

MS McMILLAN: Thank you. Doctor, in relation to the restrictions in 2.1, pancreas and those other types of surgery I have outlined to you, you said a couple have come to mind. Would you be able or would you be prepared if other names come to mind to supply those?-- Yes.

All right, thank you. Doctor, in relation to evidence you gave on the last occasion, at page 3597 of the transcript, you referred to a patient who you said had been - had stitches right through the 20 loops of the bowel?-- Mmm.

Remember talking about that patient?-- I do.

Can you recall the identity of that patient?-- I should have looked that up before I came here today. I realise now. She was actually the first patient I was referred and I didn't ever see her in consultation. She was admitted acutely with small bowel obstruction. I can - I can't recall her name, in answer to your direct question. I can certainly supply it to you, though.

Thank you. Doctor, in relation to Trevor Halter, who is P20 on the patient key?-- Yes.

I wanted to ask you some questions in relation to him. Now, following the transcript, 3625 to 3626, now you indicate that his bilirubin levels - is that how you pronounce it?-- Yes, that's correct.

Were 80 to 100, and you said "four to five times the normal level". Do you say that his complications leading to that level, and also his colouring, which you indicate was yellow, would that have been obvious to a range of people in terms of after this operation?-- Bilirubin is not necessarily a word that everybody has heard. Jaundice is one more common within a general non-medical understanding, but bilirubin of 80 to 100 would mean the patient is clinically jaundiced, that's a

yellow colour obvious in the sclera, the white part of your eyes, and at that level obviously in the skin he would be yellow, and following a gall bladder operation that's a serious sign. So even without the pathology results, which are quoted bilirubin of 80 to 100, that should have been obvious clinically and always mean the patient's had a serious problem after a gall bladder operation.

Is that something you would be looking for-----?-- Exactly.

-----in terms of check-up after the operation?-- Exactly.

Doctor, you mention also at that page that he did not have an operative cholangiogram?-- Yes.

I take it you are critical of Dr Patel for not performing that?-- Yes.

What would that have shown if he would have had one?-- It would have shown the pathology. The reason that this gentleman got unwell was because he had his gall bladder removed, but the second half of that procedure, which is normally described as a laparoscopic cholecystectomy, that's removal of the gall bladder, and the gold standard is to add another procedure at the same time which is called intraoperative cholangiogram, which is instillation of some fluid which shows up on X-ray into the tube between the liver and the intestine called the common bile duct. An the reason that's done is because gallstones can leave the gall bladder, which is a pouch extending from the common bile duct, and go into the common bile duct, which is a much more dangerous situation and can result in jaundice, as it did in this patient, and a worse complication called cholangitis, which is an infection in the bile duct, which is actually this patient - this patient's diagnosis. And the reason that we're encouraged to perform the operative cholangiogram is specifically to identify this situation and to fix it at the time of the operation, which is not difficult but more difficult than merely removing the gall bladder.

Right. And you say - do you say that in this case that directly led to - effectively by not doing that, not picking up, what led to the jaundice?-- Impossible to say in retrospect but certainly that's - that's why we do the operative cholangiograms and why we remove the common bile duct stones so that this sort of complication doesn't supervene after a gall bladder operation.

When you say we are encouraged to do it, who encourages you?-- Well, the College of Surgeons.

You also said that his cystic artery was injured?-- Yes.

Is that something that is a common side-effect or complication?-- It is uncommon but it can happen. Can I make it clear the - I was repeating in my notes something that I'd read from the operative note written by Jayant Patel, or one of his registrars or residents. Having looked at 150 or more

of them, my general opinion is that those things are unreliable, the operation notes. What is reliable I think in this case is the patient bled. That's confirmed by the anaesthetic records. Whether he bled from a cystic artery or whether he bled from laceration of the liver or injury to the duodenum, impossible to say now, but that he bled and all of those are uncommon at the time of the gall bladder surgery.

D COMMISSIONER EDWARDS: When you say unreliable, do you mean they were inadequate or they just did not - therefore did not give enough detail to what actually was performed in the operation or the pathology?

COMMISSIONER: Or are you saying they are untruthful?-- Both. Before I had operated on the patients, I thought that they were slipshod, and having operated on them I think that they were untruthful. And let me qualify that, if I could. Most of them were written by junior staff and a lot of the junior staff don't have the anatomical training to actually distinguish what was specifically going on at operation. The standard process here is that a surgeon, if he is not going to write the notes or dictate the notes himself, basically dictates it, you know, verbally to the junior who then writes it down, and certainly Dr Patel knew what was going on, or at least I think he knew what was going on. Pardon me.

Earlier this week we heard from Dr Woodruff, who, as you would be aware, has done clinical audit merely from the files?-- Yes.

And his evidence was that, in effect, he was very impressed with the file notes, but that's, of course, without seeing the patients?-- Yes.

Comparing his evidence with your evidence, it strikes me that this wasn't a situation of slipshod or sloppy reporting; that Patel quite deliberately set out to create a set of operative notes that looked comprehensive but didn't tell the full story?-- And outpatient notes also.

Yes?-- Dr Woodruff would have read many times complication - in complications of the operation explained to the patient, "patient agrees to so and so procedure".

Yes?-- And having spoken to a lot of these patients, it just simply did not happen - at least I am convinced it did not happen. I think I went through it when I was here last time that patients can misremember, or if they are angry because of a complication, can be vindictive, or there can be lots of reasons for patients not agreeing with the doctor's assessment of what happened during a consultation, but I have certainly been convinced by the number of patients who said, "Oh, well, he never touched me", then I have read the description of the physical examination which was extensive in the notes. And that's happened many times.

D COMMISSIONER VIDER: Doctor, that led me to the observation after the evidence where some of the notes and certainly some

of the surgical records that we've seen have been almost text book-----?-- Yes.

-----in the drawing, the description, et cetera, and some of them have even been to the point of describing closure, materials used, whatever. That's not exceptional in itself but some of the clinical paths that patients have then followed have left a bit of a gap, certainly in my mind. So would you be of the opinion that what you read in some of the records might be a text book version of something but it is not quite what happened?-- Oh, I can be much more categorical than that. I have operated on these patients subsequently and it is just rubbish. A lot of it is rubbish. Just, you know, was not borne out by what we've seen at the time of reoperation.

We had evidence earlier on in the hearings, too, that certainly from the intensive care staff that there was a failure to document some of the complications. They only found out about them in the verbal handover. Have you seen any evidence of that?-- There is a patient - there is a patient called Victor Morris who springs to mind who had a - I don't have all of the details at hand but he was a middle-aged man who had acute cholecystitis and had an open cholecystectomy performed by Dr Patel, smoking, lung disease, admitted to intensive care afterwards, and the notes for the next couple of days would suggest he was making an uncomplicated recovery, except that having spoken to him, he ended up ringing his son from the intensive care and getting him to drive him from Bundaberg to Logan Hospital, five hours or more, to where he was admitted, and from what the patient tells me - I haven't seen the Logan notes - had pus and suture material discharge from the wound and was treated for acute urinary retention and ended up having to have a prostate operation at the PA.

Now, that's the kind of thing that the notes just don't - don't reflect that at all. It's just a "patient improving", you know, "vital signs okay". Nothing to suggest there was a problem.

Haemodynamically stable, that word we all understand?-- Yes, exactly. That sort of thing. Yeah, glossing over the problem. Similarly in outpatients in the post-op notes, wound review, no problems, discharge. I have fixed up at least 20 incisional hernias. And having read that in the post-operate notes, the hernias were there, they just weren't commented on. It certainly struck me how difficult it would have been to be in Dr Woodruff's position, they're relying on - relying on notes, having spoken to all these people.

D COMMISSIONER EDWARDS: Doctor, can I ask you about the compilation of notes because I guess that some of us have been taught from an earlier career these notetakings in hospitals is the most important aspect of a medical person's career?-- Yes.

And his responsibilities?-- Yes.

Have you seen notes like this ever in your experience? I'm asking that question because this to me is one of the most important aspects of the care of a patient, that adequate notes of both procedures and care are well-documented?-- Commissioner Edwards, I would have thought that in my experience they've actually been rather a low priority in lots of circumstances where I've worked - wrongly. But in terms of prioritising the sort of putting the finger on the blood that's squirting over your shoulder and then writing that you put your finger on - putting it down, because there's somebody else with blood squirting over your shoulder, you know, when you should have been doing the writing, it tends to be a lower priority than it should be because of the time pressures of the job. Having said that, in answer to your question have I seen notes like these, I don't think I remember seeing any that I thought were deliberately falsifying the clinical situation, no. I've certainly seen any number - any amount of evidence of slipshod sort of approach to it.

So you're concerned with not just the inadequacy but also the dishonesty of the notes?-- Yes, that was new.

COMMISSIONER: I've heard it said, not in these proceedings but elsewhere, that the ideal, again the gold standard for medical notes is that if the surgeon stepped outside the hospital and got run over by a bus, another surgeon would be able to look at notes and effectively pick - take up off where the previous surgeon left-----?-- Yes.

-----the patient. That doesn't happen in the real world?-- No, no, no, it's just very variable.

Yes?-- No, I think some of the - some of the surgeons that you've had here who I've worked for and with, I think you could pick out some of their notes at random over a 20-year

period and they would fulfil that criteria that you've just articulated then.

Yes?-- And others, unfortunately not. It's variable. But I think there's a big difference between that and what's gone on in Bundaberg.

Doctor, I'll be very open about my experience in the legal profession, that there's a huge difference between someone who fails adequately to document events and I'm not just talking about medical notes, I might talk about a director taking notes of what occurred at a meeting or business people who are taking notes about negotiations and preparation of contract, and in real world experience there's a huge variety between people who are very careful down to people who are slipshod or don't take notes at all?-- Yes.

But what really makes the hair stand up on the back of your neck is when someone creates that set of notes that on their face look very, very thorough and comprehensive and then when they're examined closely, the story doesn't stack up because that suggests a person who has set out to create a dishonest impression from the absolute outset, not someone who's gone back later and changed the story but someone who's created a false story from day 1. And what you seem to be telling us is that right back to 2003, there is the paper trail, if you like, of Patel creating a false appearance of his surgery, almost as if he expected someone to come back and look at it?-- Can I make a point about that?

Yes?-- I met him soon after he arrived or I arrived in Bundaberg soon after he did, or it was, anyway, within a couple of months, and I certainly had no idea about his past at that stage. None of us did. But he did.

Yes?-- And looking back through his notes over the last couple of years, he's been through this process - this process exactly, with other tribunals, but a couple of times.

Yes?-- And a lot of the notes - a lot of his outpatient and operation notes at least to my mind are sort - sort of reflect exactly what you just said, that he was covering his - himself.

Yes?-- And now there's a lot of stock phrases that he used to do that and they're sprinkled liberally through his notes. You know, "risks and complications of the operation explained", that's written down almost every single time, but the patient's practically - none of the patients that I've spoken to have said that he actually talked to them about that. The common comment is, "Oh, I was only in there one minute."

Yes?-- And so, these things were then written subsequently - this is all, I can assure you, supposition. I have got no way of knowing this except having looked through so many of these charts, and I think exactly what you said has gone on.

Giving him the benefit of the doubt, do you see any scope for the possibility that where the notes don't reflect what you've found out from a patient to be true, it may be simply that Patel had a rose hued version of what went on, where he, for example, describes a patient as haemodynamically stable and the notes show that the patient was losing blood and having transfusions and so on? Is it possible that a surgeon could be so wrong in his own assessment of the outcome of his own operation?-- I guess individually - in each individual case that may be true. Collectively, I don't think that was the - what was going on.

Yes.

MS McMILLAN: Thank you, Commissioner. P265 was a patient you gave evidence about and, as I understand it, you were critical, are you not, of Dr Patel because in fact the patient did not have an anastomotic leak but in fact he'd had had a heart attack?-- Yes.

Now, as I understand your evidence, that was an unusual effect of the complication, that he'd had a heart attack?-- Yes.

What is it that you're critical of Dr Patel, if that's a fairly unusual complication? What should he have done that you say fell short of the mark?-- P265 was an elderly man who had an operation described as high anterior resection for diverticular disease. I went through this, I'm sure, last time I was here but it is to remove a segment of bowel and join the two ends together again. There are certain rules which we adhere to to prevent leakage from that anastomosis and if for one reason or another an individual - if you can't follow those rules, the general teaching then is to add another part to the operation, which is called an ileostomy, which is, in effect, a temporary bag, we've just - which is then reversed in three months' time.

Yes?-- And that was the case in his - in his situation. He had a high anterior resection and also an ileostomy, and the ileostomy is created specifically to avoid a leak.

Yes?-- The patient deteriorated rapidly over the 12 to 24 hours after the operation and in my opinion - well, definitely needed to go to intensive care, which the only one available in town in this case was the Base Hospital. Because of other administrative situations, his care was taken over by Dr Patel and Dr Patel's assessment of the patient, and as I remember it, it was a brief assessment, was that the patient needed to be rushed back to the operating theatre, have his long incision re-opened to make sure the patient had a leak despite the fact that he had an ileostomy and that his clinical situation wasn't completely explained by a leak. My feeling was that he should be admitted to intensive care and investigate to find out - I mean, leak was a very unlikely cause for what was going on with this man and as it turned out, he had a heart attack and so was subjected to another operation, having had an heart attack in the previous 24 hours

and suffered.

He'd been your patient?-- Yes.

That's correct. I take it there would have been a letter of referral sent with the patient?-- Yes, yes.

Would that have indicated he'd had ileostomy?-- Yes.

So you say that Dr Patel should have perhaps looked further, do you, knowing that he'd already had that procedure and thought further what might have caused his deterioration?-- When it became clear that Dr Patel had to look after the patient, I spoke to him directly. I actually was there in the operating theatre when he was re-operating on him.

Yes?-- I certainly made it clear to him that I didn't think the patient had a leak and that I thought it was, you know, difficult to imagine how he could have had a leak causing these things in the presence of an ileostomy.

So you specifically pointed that out yourself-----?-- Yes, yes.

-----to Dr Patel. I take it, did he require a general anaesthetic-----?-- Yes.

-----for that further surgery? Given the fact that he had in fact had a heart attack, what do you say the potential consequences might have been to undergo a general anaesthetic when you'd had an undiagnosed heart attack?-- In that particular patient's situation, he didn't just have a heart attack; he had a heart attack and acute congestive heart failure. His chances of dying from that point were about 90 per cent. Nine out of 10 people in his situation would have died. He didn't, which is great, but-----

And I take it - sorry, Doctor - by that you mean that situation, that is, undergoing surgery again and having a general anaesthetic, do you?-- Yep.

Right. In relation to P288, which was under your heading "Failure to Remove a Tumour", this is an elderly man where there were in fact two tumours; is that correct?-- Are you referring to Mr Kitts?

I'm not quite clear of the name?-- James Kitts.

COMMISSIONER: 288 is - did you say 288 or 228?

MS McMILLAN: 288.

COMMISSIONER: On my list that's Carl Robinson.

MS McMILLAN: Carl Robinson, yes, thank you, Commissioner?-- Sorry. The two tumours was James Kitts. If there was confusion before, that does refer to another patient. But Mr Robinson is a similar case although not exactly the same.

To bring you up to date, Mr Robinson has just had another operation in the last week to have a second tumour removed and hopefully all will be well. He was a - these are difficult cases to work through but in his specific situation he had a - he had a tumour resected from his rectum which proved to be a villous adenoma, which is the stage before cancer. He had an unusual histology report. One of the things that I have relied on, those are written by pathologists at a different hospital, have got nothing to do with Dr Patel. And they've written that they were sent two specimens. One specimen contained a tumour; it was a length of bowel with the tumour abutting the edge of the cut margin, and we pay a lot of attention to that because if the tumour extends up to the edge, the inference is that it may be in the bit of bowel that hadn't been removed that is still in the patient. So having clear margins, is how it's referred to, is important. Now, in that one specimen that was sent they did not have clear margins the tumour extended to the margin. The pathologist also notes that another small segment of bowel was sent separately with the addendum that this represented the distal resection margin. That is another little bit, sort of on the other side of the tumour, and that did not contain tumour and therefore everything was okay. The - that's an unusual practice and unusual enough for the pathologist to comment on it and for them to call the surgeon. There is a note in the chart to say the surgeon is contacted directly and they were reassured that this - this bit of bowel they'd been sent was actually the bit that was contiguous to the bit that had been removed and so, therefore, all is well. The patient continued to have symptoms and had - had another colonoscopy, that is how the initial lump was diagnosed, and there was more tumour at the side of the join, which was removed colonoscopically and the patient was referred for another colonoscope in three to six months, I haven't got the details in my head, but I performed that colonoscopy and he had more tumour. Now, in his particular case, it's a tumour that I understand that was able to be removed at another colonoscopy by an experienced gastroenterologist in Brisbane last week. That's the sort of thing that we've been dealing with, you know, from the word go. The inference that I drew was that just that the tumour had been cut through. Where this other little bit of bowel came from, I presume it was the proximal bit. That's the bit at the other end of the bowel rather than the distal bit near the tumour. That's the - I think that's the appropriate inference to draw from that. And I know that's all sort of technical but it's just - the principle is removing the cancer from the body. That's not very technical and all - how we go about doing that and how we confirm that it's been done and - is what where we're trained to do. And it wasn't done in this case and this man suffered with continuous symptoms.

COMMISSIONER: Indeed, it's a case where, based on your explanation, the most likely hypothesis is that Patel concealed his mistake by pretending that the distal-----?--
Yep.

-----pretending that the portion of bowel was distal rather than proximal, with the real risk that that man without

further treatment would have had that existing cancer that hadn't been fully resected grow and ultimately prove fatal?-- Oh, definitely. That's what happens.

D COMMISSIONER VIDER: Is the spreading disease of the same pathology? It hasn't invaded?-- No, it was exactly - I think the point also was it was exactly the same pathology. All of the polyps that had been removed were described as villous adenoma with dysplasia, basically a tumour but not cancer, no, the stage before. But significant because they were the same in that you can get multiple polyps and you could be lucky to get a great big polyp just below and be missed by three colonoscopies, but not in this case.

MS McMILLAN: Doctor, just so I'm clear, the first issue, you say that he didn't cut it properly in the sense that he went right up to the margin instead of leaving the margin?-- Yes.

What you've described, is that a fairly well accepted way of sending that sort of part of his bowel off for pathology, that you should leave sufficient margins for all of that to be tested on; is that correct?-- Five centimetres in the colon, two centimetres in the rectum.

Is that a widely accepted margin?-- Yep.

The next issue I take it is you're also critical of Dr Patel because he reassured the pathologist that the way in which it had been sent was correct?-- Yes.

When in fact, clearly, it was not according to your evidence. Just - I'm sorry, I was confused, Mr Kitts?-- Yes.

That is P379?-- Yes.

This is the one with two tumours where one was removed and the other one wasn't?-- Yes.

Now, is it correct to say that it wasn't necessarily obvious so to speak that there was a second tumour there? One had been removed; correct?-- This situation, a second tumour at the time of laparotomy is a sequence tumour, happens in about six per cent of patients that we operate on for bowel cancer. Six per cent. Well, that's the quoted number anyway. So therefore you're taught to look for those things. The conduct of the operation for bowel cancer is that you open the abdomen.

Yes?-- And then you perform what's called a laparotomy, which is a formal inspection of the abdominal contents. You look at the liver to see if the tumour has spread to the liver. You find the primary tumour. You feel the rest of the bowel to make sure there are no other primary tumours there, and in six per cent of cases you're going to find one. And if you look for other abnormalities, which have - you know, which are there but not symptomatic and you're taught - for example, that particular situation, dealing with the second and unexpected tumour at laparotomy might be an exam question for

your FRACS, would be a good one. I wasn't personally asked that but that would be the kind of thing that you're expected to be able to handle at the end of your registrar training and would be considered the sort of, you know - the level that a an aspiring surgeon should be able to cope with. And it's actually a classic situation.

So, Doctor, you've read the surgical note I take it of the that Dr Patel did perform?-- Yes, yes.

Did it indicate whether he had done any search in the way that you've described?-- No, no.

Do you remember what it said?-- Can I - let me just refer to-----

May the witness refer to his-----

COMMISSIONER: Yes, of course?-- He commented that the liver was normal and the tumour was said to be at the rectosigmoid junction and that it was excised. That was it. The - what - the information that he had, that he based that on, was the colonoscopy, that's how the tumour was diagnosed, and that the tumour was described as being present at the rectosigmoid junction and unable to traverse with the colonoscope. Can I just - again, I think I've already asked, you know, your licence to, you know, be - make it more - not to give you a medical lecture, I really don't want to do that, but you can't understand any of these things without a little - some concept of what it actually means. A bowel tumour is a growth on the inside wall of a hollow tube which is your large bowel. We diagnose them almost always in our case with a colonoscope, a long flexible tube with a camera in it. You put that up the backside and you can physically see this growth. Usually you can also see the rest of the bowel. You can make the diagnosis of a cancer and then slide the scope past the cancer and have a look at the rest of the bowel. But obviously if you have an obstructing cancer, you can't get the scope past; the hole isn't big enough to accept a nine millimetre tube. In that circumstance, that's very relevant because of there's a six per cent chance that there's a second tumour. So what Dr Patel had to deal with was not just a bowel cancer but an individual bowel cancer in an individual patient, in this case one that was described at the rectosigmoid junction in the knowledge that that is not necessarily accurate. You can make mistakes. It's sometimes difficult colonoscopically to be sure exactly what level they're on, and that it was obstructing and that the colonoscope couldn't get past. And so, what is specific and individual about this particular gentleman's case is that not just that he had bowel cancer and at the rectosigmoid junction and that you were going to remove it and join the ends together, but that he certainly had an increased risk of having bowel cancer because he hadn't excluded that pre-operatively with the colonoscope because we couldn't put the colonoscope past that tumour. He didn't appreciate the significance of that particular detail and, unfortunately, Mr Kitts is going to die as a consequence. Now, that's a difficult to be 100 per cent certain of but what

we do know is that there was no evidence of spread of that cancer at the time of the operation and by the time I operated on him again to remove the lower tumour, he's got spread to the liver and lungs and he certainly will, I mean unfortunately, die of that now.

Doctor, when you say we don't know it's 100 per cent certain?-- Yes.

We know it's 100 per cent certain that he is going to die from that cancer?-- Well, close to 100 per cent.

What is less certain is whether even a competent operation could have found the other cancer and removed it successfully?-- A competent operation would have found the other cancer and removed it. Whether he would have been cured by that or whether he would have developed secondaries in his liver anyway in time is not certain.

For our purposes though - this isn't like a medico legal trial?-- Yes.

For our purposes, the important thing is that Patel's negligence deprived that man of his best chance of being cured?-- Of the opportunity, exactly.

MS McMILLAN: Do you say therefore that it - ordinarily the fact that they were unable to complete the colonoscopy, that would have put them on an extreme inquiry if you like?-- It would have been alarm bells, yes.

Doctor, the last topic I want to take you to, the removal of wrong organ as you've termed it in your annexure GAD2?-- Yes.

Now, Blight you went into some detail in any case about the removal as I understand it of the salivary gland; correct?-- Yes.

Leaving the primary tumour there; is that right?-- Yes.

Now, Mr Ell, can you just expand on what Dr Patel did that was removing a wrong organ in this patient?-- Sorry, which patient?

Mr Ell, E-L-L, and I have a copy of your report if you want to view that?-- I mean, I really don't want to be flippant about any of these people. A lot of them have suffered a lot; Mr Ell is not one of those. It is more of an amusing one. But he's a 45-year-old man who had a - who was seen at outpatients and with what was described as a paraumbilical hernia. Very common problem, very simple operation, perhaps the simplest operation that a general surgeon performs. Certainly would not fit into the category of the complex surgical problems.

He was seen assessed as having a hernia, went to the operation and the operation note reads that he had a small paraumbilical hernia, the hernia was reduced back into the abdomen, the defect through which it had come out was closed, and the skin was closed over the top, which no doubt was done, but when I saw him, the scar of the operation was beneath his umbilical - beneath his belly button perhaps half a centimetre, and his problem, which was approximately somewhere of a cricket ball sized lump above his umbilical by about 10 centimetres hadn't been operated on it, was simple to fix and he was fine. The issue is that - well, I really have no idea how those things came about, but he had an operation on a part of his body which was no doubt in my mind was completely normal and his problem, which was obvious, just was not operated on, he had exactly the same symptoms after the operation as before, as you can imagine, and by the time he got to see me it was laughable, they were simple to fix and he's now fine but it certainly would have been better to have fixed the problem at the first operation.

Do you say the hernia at the time Dr Patel operated would have been obvious?-- I have no way of knowing except to say that the hernias that are that size have usually been there for a long time.

Mmm?-- And, you know, I really can't comment on before I saw these patients but I can infer - or I can't be categorical rather, but I infer, but I just think he had a big hernia and he rushed in there and did an operation and just not the right one.

D COMMISSIONER EDWARDS: Dr de Lacy, could I ask the time when Dr Patel did the umbilical hernia and your seeing him was how long?-- Dr Patel operated on him on the 4th of February 2004, I saw him on the 25th of May 2005.

So that was only two or three months?-- No, 14 months.

14 months, thank you.

MS McMILLAN: Do you know whether from the operation note that in fact whether a different hernia, for instance, was removed?-- Well, according to the operation notes, he had a perfectly straightforward paraumbilical hernia repair, it's possible that he had one just to give you - just to put things into perspective, the scar that he had when I saw him was perhaps five millimetres long, that big.

Mmm?-- And sometimes paraumbilical hernias can be small, pathetically small and certainly they can be done with scars, like, that it's not impossible that he had a small umbilical hernia down there, but I think that the much more likely situation is that he was assessed at outpatients, the real hernia was identified and then by the time he got operated on, which was months later, no memory of the real event and just, you know, an operation was done, that's it.

All right. McCosh is another name, there's four names, it's

the third name down?-- Mmm.

What was it in relation to his operative procedure that was the removal of the wrong organ, as you've termed it?-- Mr McCosh is a 45 year old man who's add a failed vasectomy, that's it. He had little piece of scar tissue removed, not his vas deferens, and had a major complication after the procedure, he's been left with a painful scrotum and the vasectomy's not been performed.

COMMISSIONER: Vasectomy's do have a failure rate, don't they?-- All of these complications can happen-----

Yes?-- -----by definition, they all have, and they've happened before and you can end up with, you know, genital neuralgia as well after a vasectomy and a haematoma. In my personal experience, I haven't seen one particular patient who's had a failed vasectomy, that is, the vas deferens not removed on either side, a genital neuralgia and a haematoma which is what has happened to this gentleman.

He got the jackpot, all three?-- He got the jackpot.

MS McMILLAN: Mrs Hodder was the last one in relation to the removal of the wrong organ. That was an operation on one of her breasts, was it?-- Yep.

And the papilloma; is that how you pronounce it?-- Yes.

I understand from your letter, was not removed?-- That's right.

At the time?-- Yes.

Other flesh was taken and it was in fact fine; is that correct?-- Yes, that's right.

And the papilloma was still there; it had to be removed later?-- Subsequently, yep, that's right.

Now, can I ask you this: how possible was it to have missed it, so to speak, on the first operation?-- Possible, I mean, this - the lesion was perhaps five millimetres in diameter, so possible, but - well, everything was wrong with her care for a start, not just the fact that the tumor was not removed, she had a - she had a what's called a poly duct discharge from the nipple.

Yes?-- And normally we don't investigate those, it's only when they come from a single duct that we get concerned, but he elected to investigate that and identified a particular duct and instilled some fluid which shows up on an X-ray and found a filling defect and a column of contrast and the diagnosis made by the radiologist was a papilloma which was correct as it turns out. Now, I certainly wouldn't have proceeded in that way, but once that diagnosis had been made by the radiologist, then I certainly would think that you're obliged to remove that, even though the chance of that being

anything nasty, for example, a cancer, was very slim. So she then proceeded to the operation and another part of her breast was operated on and the tumor was not removed.

So are you saying that the part that the radiologist identified wasn't operated on?-- That's right.

A different part was?-- That's right, the same breast.

The same breast?-- He got the side part right.

But a different part?-- That's correct.

So radiologically the part not identified?-- So the problem that I had then was that I didn't think there was anything particularly wrong with this patient, and the investigation process up until that point wouldn't have been one that I'd undertaken myself, but when she presented to me, she had a lump on an X-ray which I can't say certainly isn't cancer, and so we had quite a long discussion and she ended up having to have another operation and we removed the right part of the breast and it did contain a papilloma and she's fine.

Right. So according to your letter, a lesion was excised?-- Yes.

So there was one removed?-- A lesion - it's a - lesion is a difficult word, lesion just means some abnormal tissue and breasts in perimenopausal women contains lots of abnormal tissue, most of it doesn't need to be operated on.

Mmm?-- So the operation note reads that something was removed, a lesion, I'm just quoting, and the histology, that is, what it looks like under the microscope, is the essential bit here, and it did not contain the papilloma, it contained other abnormalities, none of which had needed to be operated.

So the first issue was the wrong part was operated on and the second issue was that an infection she developed then?-- Yes.

How possible is that that an infection can occur?-- That can happen to patients in 5 per cent, it's possible.

So as I understand, you're really critical of Dr Patel saying that he fell well short, that he operated on the wrong part of the breast?-- The essential - the critical, crucial part of this is that he's looked at the pathology and said, "It's okay, we don't need to do anything else." That's the critical point. I mean, there are lots of errors, in my opinion.

Yes?-- But most of them are not critical, but there's a critical error in this which is he hasn't removed the right part of the body, it's critical, it's always critical.

COMMISSIONER: And what's most offensive about this is not just that he made a mistake in the first place and removed the wrong part, but then having removed the wrong part and getting the haematology result back, he then doesn't tell the patient,

"Look, I'm sorry, I cut out the wrong bit of your breast and the bit that I meant to cut out is still in there."?-- I agree.

MS McMILLAN: Is there any part of the chart that indicates that she was advised at all that in fact the papilloma was still there when the pathology was received back?-- I'd really have to look at the chart to say, I don't think so from memory and I haven't recorded it in my notes, those were the sorts of things that I was looking for, but I'd have to go through the outpatient notes. I'd do that for you if you like.

Excuse me.

D COMMISSIONER VIDER: Have you got any evidence, because you have seen these patients?-- Yep.

Would he have said to that patient at the post-operative visit, would he have said, "You've got nothing to worry about now, we've got it all" or "I've taken it out."?-- Yes, it was the junior doctors who were left to deal with the post-operative assessment and the standard post-operative note was "Wound healed, discharge from clinic."

MS McMILLAN: I have nothing further, thank you Commissioner.

COMMISSIONER: Thank you. Doctor, listening to your evidence today and also on the previous occasion, it occurs to me that a lot of the problems that you're talking about may not happen in private hospitals and with private specialists because in the private sector one now operates under such an intense scrutiny from insurers. In your experience, is that a factor at all?-- I wouldn't like to make that the distinction between public and private like that, but between metropolitan and regional.

Yes?-- Or between the scrutiny of working in a big institution and the, what you can get away with in an isolated circumstance.

Mmm?-- I think there's a lot of scrutiny within the big metropolitan public hospitals, and I think there needs to be a lot of scrutiny because the primary, the contract between a doctor and patient has sort of been broken in the public system. That is, you know, private, it's - you agree to care for a patient, you operate on them, you look after them, it's - you know, and you've met them face-to-face. In the public system, for whatever reason, that has been broken. One surgeon might see them in outpatients and another surgeon might operate on them two years later if they haven't been taken off the waiting list. What's been put in place of that in metropolitan public hospitals is intense security, is a lot of checks, and a lot of those - that replaces something which is now no longer there, that is, just that face-to-face you've, got a problem, a duct papilloma, I'll take care of you, we'll remove that and as you've said, mistakes can happen, all of these things can happen and have happened in

the past, and if you've got the contract with the patient, you've got to care for them, you've got to keep going until you get it right, and if you don't do that, they're not happy, the GPs are not happy, you get no referrals, the whole thing doesn't work as a business. Now, there's a lot more going on in medicine than merely a business, but that's also an important fact, you know, to take into consideration an important auditing tool in that it keeps you current, it keeps you trying your hardest to provide good outcomes for the patients, if you're - just native humanity doesn't, so while there is a difference between public and private, I think the main, you know, difficulty here is the isolation or the combination of public practice and the isolation of rural and regions and that allows things like these - this sort of stuff to happen, and though it can happen elsewhere, I mean, just infrequent, in my experience, and having worked in both.

One of the other suggestions we hear though is that the difference between the profit focus of the private sector?-- Yeah.

And the absence of that in the public sector?-- Mmm.

Is that administrators in the private sector are much more firstly, patient focussed because they're the paying customers, but also very much more clinician focussed, the clinicians, in particular, the visiting specialists are what bring the work, and that that's absent from the public sector.

Having worked in both?-- Yes.

Both branches, what's your experience in that regard?-- No, I agree, you know, with that. You know, I'm just loathed to, I mean, there's just so much good work done in the public system.

Yes?-- And I really don't want to make it sound like the solution to the problem is just to introduce just the market into public system, because I don't think that will work, but - and there are so many, you know, people working so hard in the public system, so I think from my point of view, the hospitals that I've directly compared are the PA Hospital in Brisbane and the QEII and the Bundaberg, you know, Base Hospital, and they are very different, both of them are public.

Yes?-- And I think the main, the main difference is that there's no shortage of specialists or, you know, much less shortage of specialists in the big metropolitan hospitals and it's really the isolation, the absence of peer review, peer support and just the rubbing shoulders with other people in your profession. Bundaberg Base Hospital was run by Jay Patel, there was one other staff surgeon there who was a plastic surgeon, and he could do what he liked and he did do what he liked.

Doctor, that's where, with the greatest respect, I wonder whether you're being too generous, you know, because Bundaberg

wasn't the back of Burke, as we know?-- Yes.

As we know, there were very competent surgeons, and I won't I won't embarrass you by including your name in this list, but there was Dr Brian Thiele in Bundaberg, Dr Anderson, Dr Sam Baker previously there, Dr Charles Nankivell previously there, others have been there from time to time, it's not as if Patel was sent to the hat man's corner and told to operate there, it's as if two things happened: one is that Patel chose to isolate himself from his professional colleagues?-- He certainly did.

And secondly, that someone at an administrative level seems to have decided that they didn't want to encourage VMOs to have a big role in what was going on at the hospital?-- Well, that's - I mean, true in my experience.

D COMMISSIONER EDWARDS: And could I add a third possibility? Inadequate surgical audits?-- Also true.

D COMMISSIONER VIDER: Yes, as Director of Surgery he really manipulated that process because we've had a lot of evidence that the clinical review audit as well as the M & M part of the function was controlled by him?-- That's correct.

And then he influenced the junior staff as to the nature of the cases that they presented and no doubt in the preparation of the cases in terms of the material that they presented from those cases, because we certainly have had very good evidence before us a very robust clinical review in the public sector and the outcomes of that have been some very forthright responses from clinicians here who have written and complained about the patient management because of their robust clinical review, but that didn't happen in Bundaberg, that was another failed bit in the process.

COMMISSIONER: And one other thing that I'm beginning to sense a bit of a pattern of, and I don't want to give names because it's unnecessary and could be offensive, but it seems that of Patel's junior doctors who were working with him, there were those who were ambitious, careful, raised questions and were thoroughly discouraged and those who were prepared to go along with the way Patel did things and were sheltered and encouraged; would you prefer not to comment on that?-- Yeah. Only in so far as it probably reflects their seniority and not their oppilation, but actually how far they'd sort of got to in terms of their training, but actually how many years they'd spent working with other surgeons. There must have been somebody dying on the surgical ward all of the time and there must have been horrendous complications physically being managed on the surgical ward all of the time. If that's your first experience in surgery, then your conclusion that you draw is that that's what happens in surgery, in general surgery, and that is not true.

Yes?-- If you've been - if you've worked in other units and then you'd know that wasn't true, and if you hadn't, well, that's just what happens. It certainly does happen in medical

wards, rehab wards, people die all of the time, but in elective general surgical patients do not die very often and they do not have these complications all of the time. So from my point of view, and I mean without knowing these people very well, I can understand that you just accept that this is what it's like, experience will teach you that that's not what it's like, that that's unique.

We might take the morning break and resume at 11 o'clock.

THE COMMISSION ADJOURNED AT 10.49 A.M.

THE COMMISSION RESUMED AT 11.16 A.M.

GEOFFREY ALAN DE LACY, CONTINUING:

COMMISSIONER: Mr Mullins?

MR MULLINS: Thank you, Commissioner. Ms McMillan-----

COMMISSIONER: I think she indicated she'd finished.

MR ATKINSON: She did.

MR MULLINS: Commissioner, can I put on the record an issue that I explained to Mr Andrews this morning, and he expressed some relief, that I don't intend to take Dr de Lacy through the 50 or 60 patients that form part of the Patient Support Group, and I really only intend to draw on a couple of major points. We're obviously walking independently with Dr de Lacy in respect of those cases. I am conscious of the fact of the time restrictions. We don't intend to go through-----

COMMISSIONER: Mr Mullins, I realise - and I don't mean this in any sense as criticism - I realise you and your clients have interests that go beyond the subject of this inquiry and I am comfortable for you to use these proceedings to some extent to assist you in pursuing those other interests, but it has to be within the limits of what is really relevant for our purposes, and we're not in a position to and, in any event, wouldn't attempt to make findings as to negligence in particular cases, but if - if you see some benefit in exploring individual cases, then I am happy to give you that latitude.

MR MULLINS: Thank you, Commissioner.

CROSS-EXAMINATION:

MR MULLINS: Dr de Lacy, just before the break you discussed with Ms McMillan four cases, the case of Hodder, McCosh, Morris and Kitts, and my search of the records of Dr Woodruff indicate that only one of those made the list of patients that he reviewed. I am interested in - if you could just explain again how it was that the patients have come to see you?-- As I understand it, they were - all of the patients that had anything to do with Dr Patel, either operated on by him or seen by him in outpatients, were sent a letter by Queensland Health or the Bundaberg Base Hospital giving them a number of alternatives, one of which was to see me at my rooms in Bundaberg.

So the patients that you have seen obviously have had ongoing problems?-- Yeah - yes, that's true. Some of them wanted reassurance, most of them have had symptoms of one sort or another.

So you also mentioned the last time you gave evidence that you have an expectation that there are a number of patients in the Bundaberg region who have attended upon Dr Patel who will have ongoing problems who won't know about that for some period of time?-- I can only comment on the 150 odd that I have seen and they've - they have really just walked through my door with no other winnowing process, and they wanting further - a second opinion or continuing surgical care. I would expect that there are others who are satisfied with their care or complacent at the moment who won't be so in the future based on symptoms that develop subsequently, yeah.

You mentioned during the course of your evidence that the limitations on Dr Patel's competence were certainly obvious in respect of the complicated surgery?-- Yes.

It is the case that there were significant limitations on Dr Patel's competence in uncomplicated surgery as well?-- Sorry, are you asking was it the case?

Yes?-- Yes, in my experience there was.

Can I just take you to one example, Mr Badke?-- Yes.

Who is patient 382?-- Mmm.

I think as part of your records-----?-- Yes.

-----you have a summary of Mr Badke's case. I will put the summary on the overhead and if you could just-----?-- Did you want me to go through his case?

Yes. We can see he is born on 2 July 1945-----?-- Mmm.

-----which makes him currently 60 years of age, and we see that he was referred to the Base Hospital on 16 July 2003, and your record indicates he had a moderate-sized inguinal hernia on the left, no obstructive symptoms repair?-- I am quoting from Dr Patel's outpatient notes.

Now, is that a complicated hernia operation?-- No.

Would any abdominal surgeon be expected to be able to carry that out?-- Yes.

Did you notice, from your experience with the patients, that Dr Patel had a particular problem in respect of hernia surgery?-- Yes, he did.

What was that?-- It is generally accepted by the surgical community that the best way of repairing hernias is with prosthetic mesh, which is made of various biomaterials. The common one would be polypropylene, plastic type material. A

hernia is a defect in a muscle wall, or in this case in the muscle wall with the protrusion of contents of the abdomen through that defect. The approach would be to make an incision over the protrusion, to reduce the contents back into the abdomen and to close that defect with mesh. In the majority of cases Dr Patel did not use mesh and certainly it is observable that the hernias have recurred. In some cases he did use mesh, as in this case, but used it inappropriately. The critical issue with Mr Badke was the mesh was placed not to plug the defect but into a different tissue plane in the body, in this case into the femoral nerve, which runs close to the defect but in a different part of the body. I mean, it really was a very unusual complication and the consequence for Mr Badke was that he was - as I understand it, in 2003 when he sought help, he was a tomato stacker, physical work, and was in generally good health, and when he came in to see me in 15th of June 2005, he limped in with a flexed hip couldn't - certainly couldn't work and also couldn't walk.

When you say he couldn't walk, can you describe his posture?-- Well, just - I don't want to make a fool of myself, but he walked like this, like that, with - unable to extend his leg because, in retrospect, anyway, we found, having subsequently operated on him and removed his mesh, that the mesh plug had been inserted into his femoral nerve rather than into the hernial defect. So that every time he tried to straighten his leg, it was irritating the nerve and causing subsequent problems.

Well, now, taking you back to your summary, firstly the note of 11 August 2003, Dr Patel conducted the surgery?-- Mmm, yes.

We can see the note on the overhead?-- Yes. It was a slightly unusual - or the operation notes suggest it was a slightly unusual operation. The term they use was a sliding hernia. Again, it is a technical detail. It happens in about one in 20 hernias, and there are lots of hernia operations performed. So, again, it is a common - it is a common variation of inguinal hernia. The rest of the operation notes suggest that he had a standard procedure, but the reoperation that I had to perform on him suggests otherwise.

Well, now, what you have seen in the notes there, do they conform to really the text book version of what the notes should be for that procedure?-- Yes, yes.

He was reviewed on 27 August at outpatients and then again on 3 September?-- Yes.

And you note that, from your conversations with him, he had in fact never been able to return to work-----?-- That's right.

-----since the surgery-----?-- Yes.

-----because of the complication. If we turn to the second page?-- Yes, that operation's subsequently been done. At that operation we removed a mesh plug that had been placed not

in the hernial defect but abutting and actually into the femoral nerve. A very unusual complication, not one that I'd ever seen before, but relatively easily fixed. He has had that piece of mesh removed, another mesh repair done appropriately, or I think so. He certainly had a good result and he is due back to work in October.

D COMMISSIONER VIDER: So he has got no permanent damage to his femoral nerve?-- No.

COMMISSIONER: But for two years this man was, in effect, a cripple?-- Yes.

Because he had the mesh put in the wrong way?-- Yes, I mean, he came in supported by his wife on a crutch, mmm.

MR MULLINS: So this is an example of a case of relatively simple surgery?-- Mmm.

Where we have text book notes?-- Yes.

Where there has been a mistake made that is below the competent skill of a reasonably competent surgeon?-- In my opinion, yes.

And a fellow who has been out of work for two years because of it?-- Yes.

In circumstances where it has been easily rectified?-- Correct. Can I make the point there have been many, many, many cases just like that. They haven't-----

D COMMISSIONER VIDER: But you have never seen anybody have that complication?-- Not in a femoral nerve but there are other cases where the mesh has migrated into the intraperitoneal cavity just, many, many, many examples and they have been fairly easily fixed.

COMMISSIONER: But, again, it is not just that the operation went wrong-----?-- Yes.

-----it is that the problem wasn't detected and dealt with-----?-- Correct.

-----with the follow-up. And just going back to the point I made before the break, my impression, from the very senior surgeons who have given evidence here and, I have to say also, from surgeons who are friends of mine, people I have spoken to over a period of time, is that most competent and self-assured surgeons want to have the best possible junior doctors working with them, and I am sure you would feel the same way. Patel seems to have been keen to have people around him who couldn't identify the problems and do anything about them?-- That's my opinion, mmm.

MR MULLINS: Thank you. I have nothing further.

COMMISSIONER: Thank you, Mr Mullins. Mr Diehm?

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

COMMISSIONER: Doctor, Geoffrey Diehm represents Dr Darren Keating.

MR DIEHM: Thank you, doctor. I want to ask you firstly about the - or about matters concerning your attempts to obtain a VMO appointment at the Bundaberg Hospital-----?-- Yes.

-----shortly after your arrival in Bundaberg in July of 2003. You tell us in your statement that Dr Keating told you that another general surgeon on staff was a low priority. You are, I gather, familiar with the circumstances of there being an ear, nose and throat surgeon who arrived in Bundaberg at around about the same time you did?-- I am, Dr Elphinstone.

I am sorry?-- Dr Elphinstone is his name.

I am suffering from some of the same problems as you, so we will not be hearing each other constantly. Now, are you aware that that doctor was also trying to obtain a VMO appointment at the Bundaberg Hospital?-- I am, yes.

And I suggest to you that it was to this effect: that what Dr Keating told you was that he was limited in terms of capacity - budgetary capacity for making VMO appointments and a higher priority for him at that point in time, given they had general surgeons, was to try and get that ENT surgeon a VMO position?-- I mean, it may well be right. He certainly didn't make that point to me at the time but that may well be correct.

All right. In any event, as your understanding is that surgeon wasn't able to get a VMO appointment at that time-----?-- Correct.

-----either. Now, you told us something about what did happen, in terms of you contributing to the weekend on-call roster?-- Yes.

Was it the case that you were doing that in those earlier times in effect as the nominated substitute for Dr Anderson?-- Correct.

And you weren't able to obtain a VMO appointment for doing that sort of work anyway, even aside from the other matter that I have mentioned, because you could only get a VMO's appointment if you were being given your own surgical sessions to carry out, usually during the week?-- Oh, no, I had a VMO appointment which was necessary. I mean to be credentialed at the hospital and look after any patients, elective or

emergency, I needed to be credentialed at the hospital. So I had been credentialed to look after patients, I just hadn't been given regular operating or outpatient sessions. They are separate.

You say you were credentialed. What process did you go through to be credentialed?-- Applied for credential. It is a common - well, it is a universal practice, actually, that to perform any function - medical function in any hospital you submit a CV, list of referees, get discussed at a credentialing committee and get credentialed to perform a service at a certain level, in this case VMO, or resident, or whatever.

Yes?-- That was-----

COMMISSIONER: Did you get back a piece of paper acknowledging that you had been credentialed?-- Yeah. Again it is a couple of years ago. I would expect so. I haven't actually got it handy.

Yes?-- But I would expect so, yes.

MR DIEHM: You expect so, though you don't specifically recall what you received or when you received it, is that what you are saying?-- No. The process specifically with Dr Keating and myself and my relationship with Bundaberg was that I spoke to Dr Keating in his office. I - he told me that, you know, my services were a low priority in terms of outpatients and routine operating, but that he would be happy for me to take a one-in-six call and to relieve Pitre Anderson of the burden and subsequently the work at the breast clinic, which was another redeemer to the practice. That's the common practice.

Doctor, was it the case that there had been - and before I go further with this question, can I assure you that I am not seeking to and I don't think we need to go into the details of the background to this - but was it the case that there had been, prior to your coming to Bundaberg, an administrative issue arise with Queensland Health arising out of some work you had done in the Fraser Coast area that affected your ability to receive a VMO appointment?-- Not - well, I don't think so. I think the issue you are referring to was that I had previously been a locum for Fraser Coast and working specifically at Hervey Bay and Maryborough, and I had been overpaid. Specifically, I had stopped working there and I was still on their, you know, payroll books for a matter of months. So I had been overpaid and we were still negotiating my paying back that amount, which had subsequently been taken care of. But if that's what you are referring to, that's the issue. In terms of interfering with my appointment as a VMO or credentialing, I don't think it had anything to do with that at all.

Well, can I suggest to you that your appointment as a VMO at Bundaberg was not finally formalised until October of 2004 but then when it was, it was backdated till June of 2003?-- I am not familiar exactly with those - with, you know, what

paperwork was swapped between the hospitals. What I am - what I was aware of was that I was working as a VMO there but not getting paid until I was - until this other legal problem was sorted out. So once that had been done, once that had run its legal course, I was paid for the work that I'd done for the previous year or so at Bundaberg Base Hospital.

All right. So what you did was you worked some of these sessions substituting for Dr Anderson and then later in the breast clinic?-- That's right.

You submitted forms?-- Yep.

Showing what work you had done?-- Yep.

But it wasn't until all of these other issues had been resolved-----?-- Yeah.

-----that you finally received payment for that work that you'd done?-- That's right.

You think that was about a year or so after-----?-- Something like that.

-----you initially started working. So that would sit, I would suggest to you, reasonably comfortably with what I suggested about October of 2004?-- Something like that, yeah.

And what I suggest to you is that Queensland Health, not Bundaberg Hospital per se, but Queensland Health would not finalise a VMO position for you in a formal sense until that issue had been resolved?-- If that was the case, this is the first I have heard of it today.

All right.

COMMISSIONER: Doctor, I don't want to cause you any embarrassment, or exacerbate any embarrassment over this issue, but as I understand it this is not an uncommon phenomenon for Queensland Health to overpay people, and in your case was it by direct deposit to your bank account?-- It was.

So you don't even have the chance, if you get a cheque that you are not entitled to, to send it back; money simply came into your account?-- To be honest, I had no idea it was there.

Yeah?-- And it was still sitting there when I was - when I was made aware of it, and - but it did take a little while to resolve the issue legally.

And then it is treated as your fault that you were sent money that-----?-- Basically, and, in summary, how it worked out was that it was repaid.

Yes.

MR DIEHM: Thank you. Doctor, the - one of the points of asking you about these matters concerns then the patient P265?-- Yeah.

Who you detail at paragraph 12 of your statement as being a patient in your care as at August of 2003. What I am suggesting to you is that at the time of P265's admission to the Bundaberg Hospital, you did not have an appointment as a VMO at the Bundaberg Hospital?-- Prior to attempting to get him admitted to ICU, and certainly many times afterwards, I looked after patients in ICU and operated on them between the hours of 5 p.m. on Friday and 8 a.m. on Monday. No different. Sometimes patients that had been operated on by other surgeons at private hospitals, sometimes patients in car accidents or who had been looked after - I mean, they were just - they were patients. I expected to be able to look after that fellow. I had been before and I looked after them afterwards. The issue with this particular patient was that it was not my on-call day and Dr Patel decided that he wanted to look after him, and that was the unfortunate situation. I don't think there was - there be - certainly had been no administrative barriers put in the road of my looking after other patients prior to that, other people's patients who happened to come in on the weekend, and as I saw it at the time the only reason that I wasn't allowed to look after this patient who I'd operated on 24 hours before was that Dr Patel wanted to and asserted his - asserted, you know, his right to do that and was supported.

The other patients - sorry, I will just make sure I have understood what you have said. The other patients you were talking about you had been looking after in the past, yours and other people's who had been admitted to the ICU, were patients whom you were to look after and, indeed, operate upon during your time as working as the on-call surgeon?-- Yes, yep.

Yes, thank you. Now-----?-- Could I just make another point just in relation to that?

Yes, go ahead?-- I had specifically discussed with Dr Keating in his rooms the issue of ICU when it became clear that I wasn't, you know, going to be allowed to have operating sessions and that the reason that came up was because what I'd actually agreed to do one-in-six on call - is the onerous part of the job. I think other surgeons listening to that would be going, "Why would he do that?" Most people accept that's a responsibility, an onerous responsibility, but one they are happy to accept because that allows them to look after the patients during the week. The only reason I agreed to do that - well, actually there were two reasons. One was to do a favour to one of the other private surgeons in town, Pitre Anderson, who was overwhelmed with work, and the other one was so that I could have access to intensive care, the only intensive care in town, for the inevitable patients of mine who were going to have complications as well. I mean, I don't for a moment want to suggest that surgery, general or otherwise, is free of complications - free of these sort of complications, perhaps, but - and this was actually the first

one. I had only been in town three months or so, and this was the first time that I tried to avail myself of that arrangement that I'd come to with Dr Keating. So we specifically talked about it, said, you know, "Can I look after these patients in ICU if there is a problem?", and so when I organised for him to be admitted to ICU, it was on the understanding that I was going to look after them, until I found out I wasn't only going to be able to look after them only subsequently.

When was that conversation with Dr Keating?-- During - it was a meeting in his office. I can't give you the exact date but it was a long discussion we had about my relationship at the hospital soon after I arrived.

Can I take you to some of the documents from the file of this patient - and I will do it by putting them on the monitor so we can all see them. Now, firstly, just to give us some time and dates, it appears that the date of the admission to the Bundaberg Hospital was in fact the 12th of August 2003 and that the time was at 9.35 p.m.?-- That's correct.

Thank you. If I can then have this document put on the monitor a page at a time, thank you. Perhaps if we can scroll to the top first, thanks. This would appear to be election form for treatment in the - in the hospital and would appear, you would accept, that the patient or the consent for these matters to be dealt with at the Bundaberg Hospital by Dr Patel was being given by the patient's wife?-- Correct.

Perhaps, just for the sake of it, can you scroll down to the bottom of the document in case there is something the doctor wants to comment upon as we go through, and otherwise go to the next page?

COMMISSIONER: Sorry, if we can just go back to that previous page at the top again. If this patient had gone to the ICU at the Base Hospital as your patient?-- Yeah.

The second box, which is ticked "yes", private patient, would have your name at the end of that line instead of Dr Patel's name?-- Actually, at that stage I didn't know that anyone could be admitted as a private patient to the - to the hospital. I've never seen one of these forms - one of these forms filled out but I can imagine how they are filled out, which would be a cleric - a member of the clerical staff or a nurse ticking boxes and receiving or shooting questions at a - the wife of this gentleman and subsequently ticking the boxes and then asking her to sign that. P265 at that stage was semiconscious with a blood pressure of - low, a low blood pressure hypoxy and in need of intensive care admission. I'm not sure exactly where the chain of logic is leading but these - the check boxes on admission largely have no - or in my experience anyway, have no relation to people's sort of health or their health delivery at all and I've subsequently seen Mr - once he recovered from all of this, the difficulties that he had, I've seen him and his wife many times and I'm sure that they - and she would agree, that they would much rather have me look after them than Dr Patel.

What intrigues me about this is that if - and I readily admit it's come as a surprise to me as well to see that it was possible for him to be admitted to the Base Hospital as a private patient. Would that mean that his health fund was paying money to the hospital for both the hospital service and for Dr Patel's service?-- I can honestly say that I didn't know that that kind of admission was possible at Bundaberg Base Hospital but with the caveat that I've had limited experience there and certainly none sort of in working hours. Certainly none of the patients that I looked after there, all of which were - all of which were acute patients admitted on the weekend, were admitted, as I understand anyway, with - under that arrangement.

And on the face of it, it's starting to look as if it wasn't just a sort of bureaucratic impasse that the patient couldn't be admitted as a private patient under your care. It's starting to look as if there was a deliberate attempt to make sure whatever fees the health fund was paying went into the hospital's coffers rather than into your pocket?-- I wasn't aware of that at the time. As I've said, this is the first time I've seen this particular form, not just with that patient but that form altogether. I dare say there is one of those at the front of every chart at the Base Hospital but as I don't contribute to their health care at all, I don't look at them.

Yes. Mr Diehm.

MR DIEHM: If we can go to the next document, please. Now, again, if we can just - focussing on the condition and procedure, this document seems to be a consent to a laparotomy procedure-----?-- Yes.

-----form. And under the - the title of section B, the procedure is described there. If we can scroll down to the bottom of the page, please. A standard form Queensland Health document apparently. We can go over to the next page, please. Again, the standard form continues. If we can scroll down. Now, we see down towards the bottom of the page, again we've got the signature of the patient's wife and the name of doctor who has apparently taken the consent with procedure, Dr Risson?-- Correct.

If we can go to the next page, please. I should pause to say if you need to see it again, that document appears to have been completed on the 13th of August, the next day?-- Okay. I'll just-----

By Dr Risson at least. Perhaps if we can go back to that?-- Yep.

Yes, in fact, by both signatories on the 13th of August. If we can scroll down to the bottom again. And over to the next page, please. I'm sorry, that's it, sorry. Now, if you can keep - keeping those documents over there, if I can then take you to this series of notes from the progress notes for the patient. This seems to be a note completed at 10 o'clock on the 12th of August 2003?-- Yes.

Taking your time to read through that and scrolling down as we go, and over the page. Now, that, I suggest to you, is a note that appears to be made by one of the anaesthetists at the hospital, I think it's Dr Joyner, who seems to have assessed the patient in intensive care and formed the view to have some X-rays carried out, some tests and to seek a medical opinion?-- Would you mind putting the operation note up there.

We will get to that shortly if you don't mind. Perhaps if we can, I'm sorry - I want to give you the opportunity to read through this page as well, Doctor?-- Sure.

If we can go to the bottom of the page, show the rest of the page?-- Yes.

Now, there seems to be - just before we leave that, there seems to have then been assessment carried out of the patient. Smalberger, who we know to be a physician, attended at the Bundaberg Hospital and then there is a further assessment carried out at 11.45 p.m. by Dr Risson, who was a Principal House Officer at that time, and he himself was at that stage querying whether there was an ischaemic bowel?-- Can I draw the Commission's attention to - I haven't actually seen these before but this is a classic example of a lot of what I've mentioned before. The - Dr Risson is a junior doctor and his assessment of the patient having an ischaemic ileostomy is a - well, proved to be untrue but that's not as important as the fact that it was also highly unlikely to be true. Stomas - bags - come in two forms. Basically, the ones on the right-hand side are ileostomies, that's what this patient had, and the ones on the left are colostomies. Not always but in

general. Colostomies, the ones on the left-hand side, sometimes become ischaemic. That is, the blood supply to the end of the bowel is not sufficient to keep them alive. Stomas on the right-hand side, ileostomies, because they're constructed differently and of - you know, are in a different part of the body, rarely, if ever, become ischaemic. Other things can happen to them, they can prolapse, they can retract - lots of things can happen. Because we make them differently, they rarely become ischaemic. Now, this patient did not have an ischaemic ileostomy and was basically extremely unlikely to have an ischaemic ileostomy. A consent form you saw up put up before was for a laparotomy plus or minus resection of bowel, was based on that assessment. And, I mean, it's just - you know, it's ill-advised and proved subsequently to be wrong and is an example of the sorts of things which, you know, I've been describing, having looked through these patients' charts in retrospect. This is one that happened prospectively. I certainly wouldn't blame Dr Risson for this. His level of experience wouldn't allow him to make the judgment.

D COMMISSIONER VIDER: In 2000 was Dr Risson an intern?-- The names vary. Principal House Officer. He'd been an intern and he'd had some surgical experience but he's a non - less than a non-training registrar, somewhere in between. Attempting to get on to a surgical training program. So therefore this patient's subsequent health was being dictated by an inexperienced junior doctor who was not being appropriately supervised by his superior, and I just want to make the point the only reason I make that point is that if I was looking after that patient, who'd actually constructed the ileostomy, and I've constructed many and looked at them, the appropriate decisions would have been made. And the appropriate decision was not made. It's easy in retrospect, it is easy, and - but this patient was taken back to theatre based on the erroneous diagnosis that he'd either leaked or he had an ischaemic bowel, neither of which happened and neither of which were actually likely to happen in this specific clinical circumstance. And I think you can cut through all of the technical stuff and to the point that if the - if the person who'd done the operation was looking after that patient, he would not have had an unnecessary laparotomy. That's the crux.

COMMISSIONER: Doctor, thank you for that. My concern is at a rather more fundamental level. Your evidence when you were here on the previous occasion was that you spoke to Dr Keating about this patient?-- Mmm.

And you were told that the patient had to be admitted under Dr Patel?-- Yeah.

That was because it was a public hospital?-- Yes.

Had you known that the patient was being admitted into the public hospital as a private patient-----?-- Oh, yes.

-----none of this would have happened?-- I - that is the

first I heard of that, that - just today. It was surprising. I didn't know that that system existed at Bundaberg Base Hospital. Now, perhaps the doctors who work there regularly all know that but I certainly did not know that that happened.

And as I understand the situation, being someone who has the benefit of private health insurance myself, one of the reasons you pay for private health insurance is so you can choose your surgeon?-- Yes, that's largely correct.

D COMMISSIONER EDWARDS: And your hospital?-- And your hospital.

MR DIEHM: But you don't get to choose a specialist who doesn't have a right to practice at that hospital with the hospital?-- Correct.

COMMISSIONER: And you don't get to choose not to have the wrong operation performed on you by an incompetent doctor.

MR DIEHM: Doctor, just before we leave that page, Dr Smalberger, whose entries we saw above, appeared to have assessed the patient for issues relating to his cardiac health and for an issue about poor urine output; do you agree with that?-- Sorry, could you just repeat that again.

Yes. Dr Smalberger appeared to have assessed the patient for issues about his cardiac health and also poor urine output?-- Correct.

Thank you. If we can go to the next page, please. Now, again, there seems then to have been the patient seen by a Junior House Officer at 11.50 who has written out his or her own details of that particular consultation. If we can scroll down to the bottom of the page, please?-- Can I comment on this as we go?

Yes, please.

COMMISSIONER: Yes?-- Past medical history: CEA, carotid endarterectomy, correct; TUR, a transurethral resection of the prostate, correct; PVD, peripheral vascular disease, not correct; diverticulitis, correct; HTN, hypotension, correct; IHD, ischaemic heart disease, not correct. To get a - this is - that's opinion written by - well, I'm not sure of the signature at the end but by a junior doctor, and we've talked before about record keeping. That's not untypical. That's certainly not trying to pervert the system but it's just not right. And we see these things a lot. Decisions were based - were made in this man's case based on the input of - or by the sounds of it, you know, a number of doctors, some of whom had more or less information which was more or less correct. Events proved that that culminated in a wrong decision being made. And that wrong - I mean, there were many things that contributed to that, including a couple of those lines there just in the past medical history, but primarily - I mean, I knew this patient. I'd seen him pre-operatively. I knew exactly what he had - what he'd had and what he hadn't

had, and that was the core of the problem. I know I'm repeating myself but that's - this is how - we're faced with this sort of thing constantly and ultimately what it boils down to is taking a history, doing an examination, reviewing the investigations and using your experience and your training to make the right decision most of the time, or just operating on them.

D COMMISSIONER VIDER: I've missed a bit here I think. Was there a transfer letter that went with the patient from the Mater?-- There certainly was. I'm not sure if that's part of-----

MR DIEHM: I'm coming to that?-- Thanks.

I'm happy to deal with that now, if you would prefer, Deputy.

D COMMISSIONER VIDER: It would just make - put a bit of logic into it.

MR DIEHM: Yes?-- This isn't it. This is the addendum from the anaesthetist. The transfer letter was in my handwriting.

It is written in your handwriting you say?-- Yep. I think that's Dr Haines' handwriting. Is a separate bit because I asked him - it is typical when I was - well, in transferring a patient to intensive care to provide a surgical summary and get the treating anaesthetist to also provide a summary for the benefit of the intensivist, who is usually an anaesthetist and was in this case, to help with their resuscitation. This is an addendum.

COMMISSIONER: Doctor, did you keep a copy of your letter of referral?-- Probably. I think it will be in the Mater. I think it will be in the Mater Bundaberg Private Hospital file certainly, and probably on our file as well. I haven't got it handy.

MR DIEHM: I'll endeavour to see if I can't locate it. In fact, what I will do in due course is provide the file to Ms Gallagher, who might look for it in the interim, Doctor, to see if there is anything on the Bundaberg file. If we might take that letter off the screen for a moment and go back to where we were. If we can just go to the bottom of that page unless there is anything else before the final entry and I will ask you about that entry in a moment. You can see the balance of what the JHO wrote out. We see at the foot of the page that the patient, who was reviewed by Dr Joyner, Dr Smalberger, Dr Risson, if we can go over the page, I think that elaborates that Dr Risson was in fact the JHO at that point in time?-- Yes.

It said that it was waiting review by Dr Patel and a planned management of the patient in the meantime was written out and we again have the signature of the JHO, Dr Bennett involved at that point in time?-- Yes.

The next entry we then have is at 12.40 a.m., written out by

Dr Patel?-- Yes.

I will allow you to read through that?-- I have read that, yes, thank you.

Thank you. If we go to the bottom of the page, that highlighted section there shows his assessment and I will ask you - with your technical knowledge, you might be better able to interpret the writing as to what that is?-- The highlight bit reads, "No obvious evidence of mesenteric ischaemic at this stage." Mesenteric ischaemia refers to deficient blood supply down the mesenteric vessels which supplies the small and large bowel among other things.

Right. The proposal at that stage was to simply continue supportive measures?-- Yeah.

And to review, is that blood gases?-- Yes.

Thank you.

COMMISSIONER: Doctor, is there anything on that page you wanted to comment on apart from what you've been specifically asked?-- Well, I'll say now what I was planning to say at the end. The assessment that Dr Patel made of this patient was based on a conversation I had personally with him in the lift and an assessment of the patient which took perhaps 45 seconds - I was there for it - and an operation which was done in 20 minutes. That was pretty much his total contact with the patient. That operation note and any number of other operation notes that I've read of his subsequently do not represent what actually occurred. This was my first complication, having come to a new - come to a new place, and they're devastating largely, as I said I think in response to a question asked by one of the other counsels. His - at some point he had a better than 90 per cent chance of dying of a complication and so I was following him through the hospital and his assessment. The unequivocal parts of this patient's care are what the results of his laparotomy was, which is - I was in the - you know, in the actual operating theatre to confirm, and what was subsequently found after transfer to the Royal Brisbane Hospital. And the rest, unfortunately, represents something that had gone on far and wide within the hospital both then and for the next two years. And I was exceptionally unhappy with the conduct of the whole - of his whole management and that - however, that little bit that you highlighted there, "No obvious evidence of mesenteric ischaemia", at this stage is correct.

And-----

D COMMISSIONER VIDER: Did I read on this, did this patient have a myocardia infarct perioperatively?-- Yep, yep.

That's a heart attack during the surgery?-- Oh, well, at some stage.

It's got to be perioperatively?-- This note was written about

36 hours after his operation.

And that presumably provides the pathology as to why you initially transferred him, is it?-- Yes. He - all that we were aware of at the Mater was that he became hypotensive, blood pressure dropped, his urine output fell, so he wasn't profusing his kidneys, and his central pressure that is measured, the felling pressure in his veins, went down and all that means is the patient is desperately unwell. Why they were desperately unwell, our provisional diagnosis was that he'd had a perioperative myocardia infarct, that's correct. Dr Patel's assessment when we got to the end of this was that he'd had an abdominal catastrophe. That's either a leak, and we have seen a number of them, that - or that he had a problem with the blood vessels supplying his - his intestine and that proved to be incorrect.

D COMMISSIONER EDWARDS: Doctor, could I ask you as a clinician, is it possible to make the statement from physical examination that there is no obvious evidence of mesenteric ischaemia?-- I could make the same statement about you. I'm not sure exactly what that means but it's a negative, it doesn't mean anything.

You'd have to actually see the bowel to notice ischaemia. You could not detect that clinically, is the point I'm trying to make?-- Well, the issue in this case is you could see the bowel. The ileostomy had been fashioned and we could see, certainly, that it was profused with blood. For example, you could cut it and it would bleed. You could make a - you can make a positive statement that mesenteric ischaemia was not the cause of this person's problem, not that there was no evidence of it. There was positive evidence that it was not happening.

D COMMISSIONER VIDER: This patient that had had a perioperative infarct 36 hours before; had been assessed at the Bundaberg Base Hospital as someone that they would give another anaesthetic to?-- They would - well, it is sometimes essential. I mean, if they've - it is true that - that's - if there's an abdominal catastrophe-----

But they haven't got any evidence that there's an abdominal catastrophe?-- Exactly, exactly. So that would happen very occasionally, perhaps once a year in a major teaching hospital, that kind of frequency, where you-----

My point is if they can make the statement - I'm sure it's on that page somewhere. If you can just roll it down a bit about. The perioperative infarct?-- Yep.

What were they doing to treat that?-- Well, nothing, basically. They were supporting his vital signs-----

It's there: "Transferred to ICU from the Mater Hospital with perioperative MI"?-- Yes. That was the provisional diagnosis.

Yes?-- As I'm sure you're aware, sometimes it takes some time for the diagnosis to be confirmed, for the blood tests to come back in and the rest of the criteria met. But they were doing nothing.

COMMISSIONER: Following up the Deputy Commissioner's question, if you assume that there was an abdominal catastrophe requiring further surgery?-- Yes, yes.

Then further anaesthesia, general anaesthetic-----?-- Yes.

-----is the only thing you can do to deal with that. So once - once Patel got to the wrong diagnosis of the problem, it was inevitable that the patient would be subjected to a GA?-- Yes.

And that was life-threatening for a man who'd just suffered a heart attack?-- Very, very much so. Was lucky to survive the whole process.

And, again, none of this would have happened if the patient remained under your care?-- With the caveat that it's impossible to say what would or wouldn't have happened if, you know, things were different. But the issue with this man is that (1) he did not have mesenteric ischaemia. That you can usually only infer that except in the circumstance we've actually got a little bit of bowel exteriorised for an ileostomy or colostomy, which we did have in this circumstance, to make a positive assertion he did not have mesenteric ischaemia or that he had a leak. Patients who have ileostomies are - rarely leak and that's why we - that's why we perform that - that manoeuvre. And so, I was - the conversation that we should have been having, which I wanted to have, was, "Is a patient who is only 24 hours post laparotomy able to have, you know, streptokinase or other licensed therapy to try and improve his prognosis for MI", because that makes you bleed. That's the situation he was in, that could happen. That was the conversation we should have been having but instead we were having a conversation about whether he should have another laparotomy or not and my feeling was strongly no, but I was a bystander.

Yes, Mr Diehm.

MR DIEHM: Thank you.

At what point in time did you have that conversation with Dr Patel? Is it around the time of this 12.40 note that we've just been looking at?-- I can't recall. During this process.

Okay. Thank you. If we can go to the next page please? Again, we appear to have another set of observations made by the Junior House Officer, including apparently blood gas results, and I'll allow you the time to look through that as you need to?-- Yes. It shows a deterioration over a three hour period in summary.

I'm sorry?-- It shows a deterioration over a three hour period in summary in the patient's condition, that's what those numbers refer to.

Thank you. Can I just say that I'm told that a search of the Bundaberg Hospital file hasn't resulted in there being any letter - or at least a copy we've got here - a copy of any letter from yourself to there - it means nothing more than it's not there.

COMMISSIONER: Well, it means that it should be there?-- Can I make another - can I give you another version of that fact? I write the letter - hopefully I will be able to put my hand on it, Dr Haynes whose letter you were going to show wrote his letter at my request sitting next to me and that letter has disappeared from the file. Would not be the first time in going through the files of these other patients that I haven't had to do with anything personally that I've noticed that.

Doctor, I'm wondering if whether we broke for an early lunch, you'd be able to get in touch with the Mater in Bundaberg and actually try to get that faxed here?-- Yes, I'll try to.

Perhaps, Mr Atkinson, you could liaise with the doctor, take him upstairs where there's a fax machine?

MR ATKINSON: I can do that.

COMMISSIONER: Would that suit, Mr Diehm?

MR DIEHM: Commissioner, on a personal level, I've made an appointment at 1.30 today so I was kind of hoping that the lunch break would be overlapping that.

COMMISSIONER: I see.

MR DIEHM: I can keep going.

COMMISSIONER: Keep going on other things.

MR DIEHM: Yes.

COMMISSIONER: But I did want to ask, doctor, you told us on

the previous occasion about your conversation with Dr Keating?-- Yes.

Did you convey to Dr Keating any of these concerns you're now telling us about?-- Well, I was working under the impression that I would be looking after the patient.

Yes?-- And when it became clear that I wasn't going to be looking after the patient, I asked for clarification. Now, I mean, I'm not sure whether I called him or he called me, that part of it I can't recall, but we had a conversation on the phone and the conversation, the gist of it was that Dr Patel was to look after the patient if he was to be admitted to the Bundaberg Base Hospital. That was the summary.

But did you ever alert Dr Keating to your concerns with the way that your patient was being treated by Dr Patel?-- No.

Or anybody else in authority?-- No.

No.

D COMMISSIONER VIDER: Doctor, are you aware that in some situations where a private patient is transferred to a public hospital?-- Yes.

For intensive care services, it is understood that the patient will go under the Director of Intensive Care Unit's care?-- Yes, yep, no, that was the situation as it existed at the PA, I think, and it's an awkward situation, but those specific situations are that if, I mean, the Director of Intensive Care, who's either a physician or an anaesthetist wouldn't assume to make surgical decisions that there is a need for a laparotomy or not because they can't perform them, regardless of whether or not it's necessary.

Your discussion with Dr Keating was if the patient was transferred?-- Yes.

The patient would be under the care of Dr Patel?-- Yes.

Not the Director of the Intensive Care Unit?-- No, no, no, definitely Patel.

COMMISSIONER: I take it you wouldn't have had a concern if this patient had been under the care of Dr Carter as the head of the ICU?-- No, and in fact, I thought that was most - that would be the most likely arrangement. This was my first experience with transferring a patient like that and no, that would have been fine, I've certainly worked under those systems before and they also work. Whose name is on the front page of the admission is less relevant than who's actually making the decision of whether they need a laparotomy or not, and certainly no Director of ICU who wasn't a surgeon would not do that. They might suggest based on those sort of blood gases, for example, in another circumstance that there's something serious going on, and if they were entertaining the possibility that in a surgical catastrophe that they might

need another laparotomy, that might be possible, but that wasn't the situation here at all.

Mr Diehm?

MR DIEHM: Indeed, from the notes that we've seen, it wound appear that the first doctor who consulted with this patient on the patient admission to Bundaberg Hospital wasn't in fact an anaesthetist, Dr Joyner?-- Yeah, I'm not - based on what we've seen here.

Yes, and Dr Joyner determined to get a medical opinion, so he sought out Dr Smalberger as a physician to come and see the patient and then a view seems to have been taken, as we've seen from the notes, a surgical opinion needed to be obtained?-- But that's not how it happened though. The process of making these referrals is that you contact somebody personally and it's - I was - I contacted ICU in this case because it was clear that the patient needed ICU and it was after - and that was the evening that I was making the transfer, it became clear that it was going to be Dr Patel who was looking after the patient, I spoke to him and that's the way it's done, it's, you know, you speak to the person who's going to be taking over their care, and despite my, you know, reservations or whatever, I mean, the patient definitely needed intensive care, no doubt about that at all, and so no, I - the first communication was to the surgical team - well, was to ICU and then the surgical team. What actually happened after he, you know, was transferred was unfortunately completely out of my control.

Doctor, why, if your perception is that, as you've described, that this patient needed to be admitted to ICU?-- Yes.

Because of medical issues?-- Yes.

Why would you liaise with the surgical team?-- Because they've had an operation within the last 24 hours.

All right.

D COMMISSIONER EDWARDS: And that's not unusual?-- That's - well, it's essential.

COMMISSIONER: Is that because surgical teams have experience of looking after post surgical patients?-- Regardless of the heart attack or not, the patient's still 24 hours after a laparotomy and needs to go through the process to make sure that that's attended to, and that means they go - as a minimum they need to be seen by a surgeon every day, assessed to make sure this - none of these other complications that I've elaborated about have supervened.

Yes?-- And it's standard practice, it's transferring somebody to an ICU, it's actually common, especially from a provincial centre, the patient has a medical complication, a heart attack, pneumonia or many others, they would be transferred down under the care of the physician who's specifically

concerned about that problem but there also needs to be a surgical team involved to make sure that they get seen every day and that they have a standard progress through their recuperation.

Doctor, how did this work when you were at QEII, say there was a patient at Sunnybank Private who had to be transferred to ICU?-- Happen many times.

And could that patient be transferred under the care of the surgeon from Sunnybank Private?-- In general, can I go back a bit? Rather than QEII to PA?

Yes?-- Because that happened, it's a much clearer example.

Yes?-- In general, the patients that were transferred to a major metropolitan hospital ICU were disasters.

Yes?-- With multi organ failure and requiring six - either six intensive care specialists or six different specialists in different areas, infectious decisions, respiratory physician, et cetera, et cetera. Usually what happened under those circumstances was that the private surgeon ceded his care to a surgical team in a major metropolitan hospital after discussions with them. If that surgeon was also on staff at that public hospital, then they always looked after them, I mean, they just - it never was - I just never came across this issue before where you were operating at that hospital on exactly the same kinds of patients and were - had been prevented from looking after them, this was a first and was unexpected.

I was in a sense more interested in QEII to PA would be public to public, as it were?-- Mmm.

I was more interested in the example of private to public, if the patient were coming from - and I don't know which private hospitals do have their own ICU - but if the patient was coming from North West or Turrawan, Turrawan's closed but Sunnybank or whatever?-- Yep.

That didn't have ICU or adequate ICU facilities, whether the treating surgeon or gynaecologist or whatever, cardiac surgeon or whatever the relevant specialist was would normally transfer with the patient?-- The situations are much more individual than you would think. The vast majority of situations that you describe actually occur from country to the city.

Right?-- A lot of the private hospitals have their own ICUs, all the big ones do, and it's certainly possible to refer from a private hospital that does not have an ICU to a private hospital that does.

Yes?-- And so the actual, the specific situations tend to be private surgery done in the regions-----

Yes?-- -----referred to and then a private or public ICU in

the metropolitan circumstance. So for those reasons, that there are private ICUs in the metropolitan circumstances and they can accept those patients, if they've got beds.

But even in that situation you've described it, a referral from a country to the city?-- Yes.

Would you expect the treating surgeon at the city hospital to act under the guidance of the referring surgeon?-- Well, the problem - it's the problem of distance.

Yes, of course?-- Because that surgeon can't physically get from Maryborough or whatever to Brisbane.

But would you expect him to pick up the phone and say, "Look doctor, I'm looking at your patient, I think there might be an anastomosis" or something like that?-- Yes.

Do you agree that that's the appropriate approach?-- I certainly would have been offended - well, offended - I would have taken it as a matter of course that they would be involved, that they would be calling.

Yes?-- Providing the kind of expert opinion that only the person who's done the operation has, you know, not just that the patient had a high anterior resection but it was an individual patient with an individual operation with all of the bits that go along with this, and that in most cases then they follow their care up as well.

Yes. Yes, Mr Diehm.

MR DIEHM: Thank you, Commissioner. If we can go to the next page please - I'm sorry, just before we do, we'll just go back to where we were then before. The JHO on having obtained those results and written out his or her own impression, then talks about discussing those matters with Dr Risson and Dr Smalberger?-- Yeah.

And a further plan for the patient's management was set at that stage?-- Yes.

If we can go to the next page please? Perhaps if we can leave that out, go to the next one. Then have a further note from Dr Patel is the one you've seen before as well?-- No. Mmm-hmm.

And further down the page please?-- I can't read the last.

You can't read the last line?-- The plan, Mmm. May need ventilator support.

Can you just - again, that seems to be a plan; can you just help us?-- Yes.

If you can just help us with the last highlighted portion. What does that tell us from there?-- "Restart MS infusion and 1 milligram per hour". I think that's what it says, I'm not

sure whether he means - I'm not exactly sure what that refers to. "Will need aggressive diuresis" which is lasix "to get rid of some fluid. May need ventilator support." That is intubation and ICU.

Thank you. If we can go to the next page please?-- Mmm-hmm.

If we can scroll down and if we just stop there, again, there appears to have been an assessment made by Dr Smalberger and that appears to be part of - or in part at least an assessment with respect to the patient's ability to withstand an operation; is that right?-- Are you referring to the highlighted parts?

Well, indeed, some of the earlier parts as well, I can't see them on the screen at the moment. Perhaps we can just go back up a little. Where we see the plan, "Advise perioperative...therapy to reduce risk."?-- Yes.

Okay. If we can scroll down from there? Now, this next note would appear to be that's Dr Patel's writing, isn't it?-- Yes.

And the highlighted part talks then of a discussion with Dr Carter, Joyner and Smalberger?-- Yes.

And what's the next part of the highlighted part say as you could make it out, doctor?-- "Safest thing at this stage to have a second look laparotomy to rule out acute mesenteric ischaemia, this will give us"-----

"Better idea"?-- Yeah, "better idea of the pathology I think we're dealing with. It's quite likely we may not find acute mesenteric ischaemia. All seem to agree with the plan."

All right. Now, that assessment, am I right in thinking, actually accords with your assessment of - but where you depart is you say you shouldn't perform the operation?-- No, no, I think it's a disgrace.

Yes?-- I think that assessment is obviously wrong and based on independent documentation from further off the screen is I think any surgeon in the world would agree that that's not the right diagnosis, and to put it to say that we need to do this to rule out something that had already been ruled out by observation of their ileostomy, it's just typical. I mean, as a general comment, this patient's care by the other doctors, Dr Joyner, Dr Smalberger and even Dr Risson is adequate to good. The issue here is the contribution made by Dr Patel which is bad to terrible. If you want to go - could you go down a little bit just back the way we came? Just hold on - sorry, keep going, I'll just see if I can find it again - sorry, if you can keep going up now - sorry, the other direction, there's a comment he made in here which he said the ileostomy is pink, the 13/8 - all this has happened, I might say, in a period of 12 hours, to talk about it sounds like he's been a week making these decisions, but it's 12 hours and it's clearly stated that the ileostomy is pink. That clearly

means that the patient does not have mesenteric ischaemia, not that you need to do a laparotomy to establish that, but that the patient doesn't have mesenteric ischaemia, he subsequently had a laparotomy to establish that fact. It's easy in retrospect, I've said that many times, and there's some independent disputable fact here that the patient did not have mesenteric ischaemia, but there's also another fact, which is that it was obvious that he didn't have mesenteric ischaemia. Obvious in a way that is only in patients who have ileostomies, and it's technical and I guess only surgeons really appreciate the importance of that, the general physician wouldn't be expected to, an anaesthetist wouldn't be expected to and a junior surgical non-training resident wouldn't necessarily be expected to, although a lot of them would, but a general surgeon would understand the significance of that and in this case, the general surgeon made an assessment and it was the wrong assessment and it was obviously the wrong assessment and he performed an unnecessary procedure and there's no taking that back. I was in the situation of not being able to prevent that happening and that's it.

D COMMISSIONER VIDER: Did you have any discussion? I think it's the next page that says everybody's in agreement with the-----?-- Yes.

And they all seem to agree with this plan?-- I have subsequently - I did at the time actually but Dr Joyner at least, I don't remember talking to Dr Carter. Dr Patel's approach to someone who questioned his decision-making was to threaten to resign and various other things. His approach also was to write down that he discussed potential complications and outcomes of operations which he didn't, and without having any, you know, clear knowledge of whether this happened or not, but it sounds like it would be easy to establish whether he did, I would think that he was writing that into the notes prior to this operation exactly the same way that he wrote things in notes in many other operations, and it actually bore no resemblance to what had happened. I know for a certain fact that Dr Carter and Dr Joyner were not happy with many of these operations. After a discussion subsequently with Dr Joyner, I know that he wasn't happy with this particular operation at the time, but whether they'd actually sat in a room and come to that consensus, I've just got no way of knowing.

MR DIEHM: Doctor, that takes the notes as far as I wanted to go with them, but you did ask to see the surgical note?-- Yes.

Which we haven't come to yet, so perhaps if we can go to the next page - well, scroll down the page in case it starts on this page there but it's probably on the next one, I suspect. I hope it's one that I've given you?-- "Plan prognosis and rationale of second look laparotomy discussed with wife. She agrees with the decision." I have read those kinds of words many times.

I don't think anybody would suggest it means much, doctor, in the sense that what else is she to do other than to agree with advice that's given? Perhaps if we can have the document put on the screen, it might be what you're looking for.

D COMMISSIONER VIDER: Which one is this? Is this the first one or the-----?-- This is the operation that Dr Patel performed.

MR DIEHM: So the first operation was performed by you?-- Yes.

At the Mater, wasn't it?-- Yes. Would you like me to read that out too?

Doctor, I'm only showing it to you because you wanted - you asked to be taken to it so I'm allowing you that opportunity.

COMMISSIONER: Doctor, rather than reading that out, if you can tell us what from our previous discussions you regard as the significant features of this?-- That it was all completely normal. That's it. There was no leak and there was no mesenteric ischaemia and the operation took 20 minutes and was unnecessary.

And unnecessarily subjected this man who'd recently had a heart attack to a general anaesthetic?-- Yes, Mmm-hmm.

MR DIEHM: Commissioner, if I can tender the bundle of documents I've shown the doctor?

COMMISSIONER: Yes. Exhibit 289 will comprise bundle of medical - just call it extracts from the medical file relating toP265.

ADMITTED AND MARKED "EXHIBIT 289"

MR DIEHM: Thank you, Commissioner. Doctor, were you around at the hospital following this patient? And I don't mean literally physically but following his care?-- Actually I was literally and physically following him.

Yes, throughout the whole of that series that we've just been through?-- With what I thought the important bits, I was certainly in there for the operation.

So you were there for the operation?-- Yeah.

Were you there at times during the course of the night when some of these other assessments were carried on?-- I saw him the next morning and then subsequently at the operation.

Did you go to the hospital with him that night?-- I don't recall, I don't think so.

So you think that the first time you might have actually come into the hospital physically was early in the morning at some stage?-- I think so, yes.

Did you effectively stay with him from that time through until the time of the operation?-- No. Again, it's a long time ago, but as I recall, I mean, it was a weekday, I think, and I certainly left him and then returned for the operation.

Do you recall at what point in time you had the discussion with Dr Keating?-- I don't, I don't.

You would have been unlikely to ring him and in what would have been almost very late at night or the middle of the night, around the time of that consultation or initial transfer, I should say?-- No, I was - my best recollection is that it probably was, it was just, it was - it's just a long time ago and I can't remember whether it was at that time or when the decision was made to operate, but I spoke to him about this case certainly prior to the patient having the operation.

All right. Doctor, I now want to ask you about the University of Queensland appointment?-- Yes.

COMMISSIONER: Well, that might be a convenient time to break, Mr Diehm.

MR DIEHM: Yes.

COMMISSIONER: What time will you be ready to continue?

MR DIEHM: The earlier that I will predict will be 2 o'clock.

COMMISSIONER: Well, we'll be back at two or shortly after, but if you're running late, don't be embarrassed.

MR DIEHM: Thank you, I appreciate that.

COMMISSIONER: Thank you, Mr Diehm. Mr Farr?

MR FARR: Commissioner, we were just wishing to organise the next witness who I understand is to be Dr Wakefield.

COMMISSIONER: Yes.

MR FARR: He spent some considerable time on Monday waiting and he's outside at the moment. I'm just wondering if we might be able to give him a time to come back?

COMMISSIONER: Indeed. Mr Diehm, how much longer do you expect you will be?

MR DIEHM: 15 or 20 minutes.

COMMISSIONER: Ms Feeney?

MS FEENEY: Nothing, thank you, Commissioner.

MR FARR: I'll be brief.

COMMISSIONER: So probably 2.30?

MR FARR: All right.

COMMISSIONER: Sounds about right. Are you expecting much re-examination, Mr Atkinson?

MR ATKINSON: No, Commissioner.

MR FARR: No, 2.30, that's fine, thank you, Commissioner.

COMMISSIONER: Ms Gallagher?

MS GALLAGHER: Very little, Commissioner.

COMMISSIONER: Yes, 2.00, thank you.

THE COMMISSION ADJOURNED AT 12.41 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.07 P.M.

GEOFFREY ALAN DE LACY, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Mr Atkinson, did we have any success retrieving that document?

MR ATKINSON: No, Commissioner. We have made real inquiries of the hospital and they can't locate the document at this stage, the letter of referral.

COMMISSIONER: Yes. Well, we should wait for Mr Diehm. Just while we are waiting, may I place on the record my particular thanks for those of you who gave up your Ekka holiday yesterday to accommodate the Bundaberg sittings. Mr Andrews, of course, Mr Angus Scott, and also Mr Farr, thank you for your assistance and cooperation, particularly since you were pulled in at the last moment. We really are very appreciative.

MR FARR: Thank you, Commissioner.

MR ATKINSON: Commissioner, I don't think Mr Diehm is even just outside. He may not have come to the building yet.

COMMISSIONER: All right.

MR FARR: Commissioner, I have some questions but they don't seem to be related at all to Mr Diehm's questions. I am happy to conduct my brief cross-examination.

COMMISSIONER: That's probably not a bad idea. Mr Diehm can read the transcript and let us know if it is of any concern to him.

MR FARR: Yes.

COMMISSIONER: That will certainly be a sensible use of time.

CROSS-EXAMINATION:

MR FARR: Doctor, my name is Brad Farr. I am appearing on behalf of Queensland Health and I just wanted to ask you briefly, the picture which seems to have emerged from the evidence that's been provided thus far to the Commission, including your evidence, is that Dr Patel was, at least in some areas of practice, below inappropriate level of competence. You would agree with that, I dare say?-- I would.

It would appear also, from your own observations of the notetaking that you have referred to already in your evidence, that there was less than - well, there was dishonesty involved, I think is your evidence?-- Right. I concluded that.

In relation to at east some of the notes. You would agree with that?-- I would.

We have heard other evidence, which I dare say you are familiar with, but we know, for instance, that he lied in his applications, if you like, about his history of problems in the States. So there was this aspect of dishonesty that has become apparent there. So we have the picture emerging of a person who has acted incompetently or less than competently at times, as well as acting dishonestly in relation to his behaviour whilst in Queensland. I take it that your observations, from what you have done so far, is consistent with that?-- It is. They are.

You would also have observed from your own investigations in these matters, no doubt together with other things that you have learned, that he has conducted himself in such a way that he closeted himself from peers, those of similar experience or greater experience and knowledge and training. That seems to be consistent again with what you have been able to find and your own observations and discussions with patients?-- Yes. I would agree with that.

He seems to have adopted an approach in the workplace which, whether by design or whether it is just the way he normally is, one can't say, but he - we have heard he is frequently aggressive and threatening to particularly junior staff, and I understand that is the picture which has emerged again from your own observations of matters?-- Yes.

And he has, when questioned, retaliated, if you like, providing attack with attack, threatening to resign or threatening - well, pointing out how valuable he might be to the Bundaberg Hospital or to Queensland Health or to the community in general, that type of thing, all of which would seem to discourage criticism, and again I understand that's consistent with those matters that you have been involved with that touch upon those issues?-- Yes, I agree with that assessment.

If we were at any given circumstance dealing with a medical practitioner, a surgeon using the example in case, who was an honest person but incompetent or below appropriate competence in certain areas, would you agree with me that in those circumstances often the act of incompetence or the problem area becomes obvious very quickly because incompetence itself alerts attention, or alerts the attention of others?-- Usually I think that follows, yeah.

I appreciate that that might not always be the case 100 per cent of the time but as a general statement you would agree with that?-- I agree, yes.

And in the medical context, would you agree that when you are dealing with the situation of a dishonest, incompetent person, one that's intending to conceal and hide either background or present day behaviour, one might have almost the opposite situation, where rather than things jumping out because of incompetence, their being secreted away some how so that people don't see what's going on?-- I would agree with that, too.

And I understand, from what you have said in your evidence and from what you have found, that that seems to be the picture which you took the view was emerging as you go through each of these cases?-- I thought these were - I mean, in general, you know, things of commission rather than omission, certainly in that there was some active aversion, protecting a guilty secret, to use a phrase, rather than merely misunderstanding clinical scenarios, certainly.

You have placed particular emphasis on the fact - and the quite obvious fact - that Dr Patel, of course, knew his own background and the problems in his background, whereas nobody else did, and that whatever we look at, we must look at in that context when considering his own behaviour. That's the position you have adopted?-- It is.

Now, in the medical context - and please, if you disagree with this, say so?-- Mmm.

But would it be the case when dealing with that type of situation that we can see emerging from the evidence, that those perhaps closest to Dr Patel would be those most likely to reach the realisation that there is something not right happening? And I am not putting a time-frame on that at all?-- Can I give a fuller explanation of what I thought was going on rather than a simple yes or no?

Yes?-- Because I think that requires some elaboration. The answer to your direct question is not necessarily-----

Right?-- Those closest to him were also most threatened by him.

Certainly?-- And most - and he spent most of his energy intimidating or in otherwise isolating his practice from them. There are systems in place, albeit faulty ones, to try and prevent this happening, and my personal opinion is that this tragedy wouldn't have occurred unless there was both active subversion by the individual and complacency at best by the supervising body that was supposed to identify these problems, and I think that either - either one of those by themselves would not have been enough to cause these problems. That's my assessment.

All right. And that's probably consistent with a topic which I took you to a few moments ago. If you were dealing, for instance, with a completely honest but incompetent person, we would unlikely be here undergoing this process right now, I

dare so?-- I agree with that.

So it is the combination of features that is unique to this situation, that brings us here and-----

COMMISSIONER: I am not sure it is unique, but it is a combination.

MR FARR: Well, okay. The combination of features which brings us here, and I appreciate the force of your statement that those closest are those most intimidated, if you like, particularly given that they might be junior people?-- Yes.

But in the system that existed - and I am not suggesting that the system was a good system or a poor system, I am just referring to whatever the system was - it would seem to me that those most likely to first have the realisation that he is not what he says he is-----?-- Yes.

-----would be those that probably are working closest to him?-- Again, I think that's a similar question or similar assertion you made a minute ago.

Yes, it is?-- The distinctive issue from my point of view is that he wasn't just a surgeon among a group of peers.

Yes?-- But he was the Director of Surgery.

Yes?-- And therefore in a position to isolate or insulate himself from peer scrutiny and protect his secrets, and I think without being in that position he would have found it much more difficult. May have been successful, nevertheless, but both of those problems I think had to - or both of those situations had to have occurred concurrently to result in this kind - this magnitude of problem at least, and if he had been employed as a - in another capacity, I have no doubt that he would have - the patients he'd operated on would have suffered, but he wouldn't - I don't personally think it would have taken two years and a Commission to unearth the problem.

D COMMISSIONER VIDER: And, therefore, the most common group of people that he worked with in a position to observe him medically were PHOs and JHOs?-- They certainly would not be in a position to audit his work.

No?-- The other specialists outside his specific field would also not really be in a position to audit the work. I have tried to keep my discussions of patient technical details as simple as I can but there is no way of doing it without referring to specific technical details that aren't obvious, necessarily, even to a vascular surgeon, for example Dr Woodruff. Certainly not to a neurosurgeon. But would be to another general surgeon who's performing those procedures all the time, and unfortunately there wasn't another one of those on staff.

Yes.

MR FARR: We have heard evidence that scrutiny of the records relating to his cases has revealed not one letter to another surgeon, if you like-----?-- Yes.

-----in any other location. I think I am correct in saying that in the oral evidence we have heard in the past few months we are yet to hear of any other doctor say, "Oh, yes, Jayant Patel contacted me to ask me about such and such, or to ask my opinion on this topic." I think we have no evidence in that regard. Assuming that to be correct-----?-- Yes.

-----is that absence of both written and/or oral contact with other similar professionals unusual in your experience?-- Yes.

Is there any explanation available other than for the explanation of Dr Patel wishing to closet himself away from others to avoid scrutiny that you can think of?-- None that I can think of, no.

No reasonable explanation?-- No.

And given that he was in the position of Director of Surgery at the time, I take it that would mean that even that type of behaviour would be subject to far less scrutiny, if at all, than perhaps a junior surgeon or a trainee?-- In his position he would be responsible, among other things, for liaison with the referring GPs as part of the surgical service. So he would be taking over all responsibility for letters being written back to the GPs, describing the care of their patients in hospital, not just for his patients but for all of the other surgeons working there.

Right?-- Now, I am aware that the other surgeons did write letters, because I have received some, and that would be standard. I am also aware he didn't write any and that is not standard.

So are you of the view that when one looks at the evidence that we have just been discussing, in the overall context of his behaviour, that he appears to have been on a deception and concealment exercise prior to even arriving in the country and continuing throughout the time in the country?-- Yes.

It would seem, therefore - and, again, please tell me if you disagree with this - that his deception really knew no bounds, in that those who were deceived would include - and I am not saying this is exhaustive, but would include patients, staff at the hospital, administration, Queensland Health, the Medical Board. It seems to go from the beginning to the end?-- No, I would agree with that.

All right?-- May I also say that in my personal opinion, that's necessary but not sufficient cause of why we're here.

I am sorry, I couldn't hear you?-- That that - while it is a necessary cause, it is not a sufficient cause for why we're here.

No?-- That I think there has been a deliberate, you know, effort of subversion, but that by itself would not have resulted in the injuries to the patients of this magnitude.

And by that do you mean that one needs to look at the system which existed at the time?-- Exactly.

To discern where the problems lay to ensure that it can be corrected so it can't happen in the future?-- Exactly - yes, that's exactly what I mean.

Thank you, doctor. That's all I have.

COMMISSIONER: Mr Diehm, on the basis that Mr Farr's cross-examination didn't really cut across areas you were covering, I thought it would be useful to fill in time. You have in fact been present for about three quarters of his questions. I assume there is no harm been done?

MR DIEHM: I have no difficulty with it. In fact, Ms McMillan told me, noting the precise time I arrived, I was coming in on the first question.

COMMISSIONER: Right.

MR DIEHM: So I have missed nothing and I have no difficulty.

COMMISSIONER: Thank you.

FURTHER CROSS-EXAMINATION:

MR DIEHM: Doctor, I was about to ask you, before we broke for lunch, about some matters concerning the university appointment. The first thing I wanted to take you to was the interview at the time that your application was made concurrent with Dr Patel's application?-- Yes.

To suggest to you that there was in fact an interview panel of three members that comprised Dr Keating, which you have specifically recalled, but also then as a second member a doctor by the name of Peter Bore?-- Yes.

Do you recall him being on the panel?-- There were two people in the room, Dr Keating and another man who was an academic surgeon from the Mater, I remember. I think that was his name.

I was certainly going to suggest to you that he was associated with the university and its Department of Surgery and was a surgeon?-- Yep.

The third person present who was a member of the panel was Dr Llew Davies, who was at that time the University of

Queensland's Acting Head of Region and was a physician?-- Yeah, not present.

You say he wasn't present?-- Definitely not present.

Okay. Now, with respect to the matters concerning your more recent discussion with Dr Keating this year-----?-- Yes.

-----after Dr Patel left, can I suggest to you that that conversation was one that occurred after you had initiated an appointment with Dr Keating?-- That's correct.

And was it the case that you originally intended - or that it was originally planned that you would be coming to that appointment with Dr Gaffield as well?-- Correct.

Because Dr Gaffield at that stage was proposing to enter private practice in Bundaberg?-- That's right.

But as it happened, Dr Gaffield wasn't able to make it to the meeting?-- That's how it happened.

Yes. And what transpired at the meeting was that firstly you were there to make your services available in whatever way was able to be done to deal with the extra work that would be coming through the Bundaberg Hospital uncatered for after Dr Patel had left?-- No, I was specifically there to talk - I was there to talk on my own behalf about the university appointment. There was more on the agenda but it was not a written agenda, for example.

No?-- But a phone call had preceded that. How this had - I got there via a rather circuitous route by Dr Steve Margolis, the Dean of Rural Medicine section of UQ, who advised me to talk to Darren. When Dr Patel left at about Easter time there was still students currently in Bundaberg with no academic surgical coordinator. I spoke to Dr Margolis and he advised me to talk to Darren Keating, so I was specifically there to talk about that.

Okay. Let's - I don't want to bog down in technical details about motivations or who thought what was on top of the agenda, but was the topic discussed at the meeting about you trying to help with the increased workload that there would be at the Bundaberg Hospital - perhaps increased workload is a misleading statement - trying to help fill the gap, as it were, that arose at the Bundaberg Hospital after Patel's departure?-- Well I didn't take notes of the meeting. I don't recall that, actually.

All right. Was it the case that prior to coming to this meeting to discuss the university issues, that you had been talking to a Dr Denise Powell?-- That's correct.

And Denise Powell was a general practitioner in Bundaberg?-- She is.

And is she - does she play something of a role in the

University of Queensland's medical education program?-- She does, yes.

I am sorry?-- She does.

She does. Now, had that conversation been part of what had informed you that there might be a need to get involved in the - or there might be an opening to get involved in the university program for training medical students?-- Yes.

Was that role at that time temporarily being filled by Dr Nydam?-- I am not - I am really not sure about that. How it came about was that it was obvious that there was a need. Dr Patel had left the country-----

Yes?-- -----and the students were currently - were currently there, so I didn't really need a conversation with Dr Margolis or Dr Powell to alert me to the fact that there was, you know, a problem. It was obvious.

Now, these students who were there, as you say, were students who were there intending to be trained by working with a doctor, at least some of the time at the Bundaberg Hospital?-- The initial - the initial plan was that they were to be shared between the three hospitals in town, two private and one public hospital, and that that, to some extent, has been fulfilled. But under Dr Patel's reign, the majority of their teaching was at the base hospital because he was at the base hospital. Subsequently the students have been shared between the hospitals, the Mater, the Friendly Society Private Hospital and the base hospital.

At the time of your discussions with Dr Keating, it would have been contemplated by you, and presumably him as well, that by coming into this role there would be - at least some of the time being spent with the students would be whilst performing services at the Bundaberg Base Hospital?-- Well, that wasn't - I certainly didn't mean to give that impression. The - what I wanted to teach them, in the way that I am currently teaching them, which is for them to come to my private consulting sessions at the private hospital, as I was not working at the public hospital during the week at that stage, and that's actually what's transpired, I might say.

Doctor, if that was the arrangement - I am not questioning you now that that is what has happened - but if that was the arrangement that was being contemplated at that time, Dr Keating in the Bundaberg Hospital would be irrelevant to the question, wouldn't it?-- If I could hark back to 2003 when the issue - when I was first approached by the then head of the Rural Medicine Department of UQ, John Bourke, he called me to say that they - that the Rural Medical Department wanted to introduce a new thing into Queensland which is - which is medical students who previously had all been taught within the public system, being taught in the public and private system and how relevant - how much more relevant that was to the regions than it was to metropolitan situations, the regions being full of private surgeons who are part of the community,

and itinerant public surgeons who came and went in a year, and he thought that it would be most appropriate that someone who had set up private practice in town was responsible for their teaching. So that's how it came about in 2003. I got a phone call. I was subsequently introduced to the Dean of Medicine at a function who reiterated that and I was encouraged to apply for a position by John Bourke, who subsequently retired.

When it came time to apply for the position, it was common knowledge in Bundaberg that the position was going to be given to Jayant Patel. Common knowledge amongst the other surgeons in town, a topic for discussion in terms, and I think a letter of complaint subsequently by one of the other surgeons after the fact. So that had all happened when Dr Patel was first appointed and it had been my experience up until then. Dr Patel was appointed. The patient - the medical students were taught, largely within the public system, contrary, I think, to certainly the intention of Dr Bourkes, who had initially approached me. And when I subsequently saw Dr Keating, after discussions with Dr Brown and Dr Margolis and others, it was with the intention of reconstituting the original idea, which was to teach them in public and private. It wouldn't just be me teaching them. It would be a variety - it would just be me coordinating them, and that's just subsequently transpired. They're now taught in the public and private system, that's it.

So to be taught in the public system obviously requires the cooperation and involvement of the Medical Superintendent of the Bundaberg Hospital?-- It does.

Now, Doctor, what I was getting to with all of this was that the comment that you attribute to Dr Keating about the hospital not wanting to lose the money from the university it had been receiving when Dr Patel held the position?-- Yep, mmm-hmm.

I suggest to you was a comment - I don't expect you to remember the precise words of it, which will no doubt be difficult for anybody to recall-----?-- Yes.

-----even after this period of time, but it was in the context or to the effect of that the hospital would not want a situation whereby a doctor who was performing rounds, performing duties as a doctor employed at the hospital either as an employee or a VMO, doing that work and also being paid by the university separately at the same time for the same duties?-- Well, I'm not exactly sure what he meant but I can tell you what I - how I apprehended it from - as the listener, which was-----

COMMISSIONER: What I would ask you to do is to tell us whether, to the best of your recollection, Dr Keating conveyed anything along the lines of what's just been put to you. That it wasn't about getting money for the hospital; it was about not paying someone twice?-- No, no, there was nothing along those lines mentioned at all.

MR DIEHM: Doctor, again, in this - well, firstly, can I ask you: do you recall the precise words that he said to you?-- As well as I can recall them, they were as - as I articulated in the evidence-in-chief, which was that an arrangement would have to be come to - that we would have to come to some arrangement so that the hospital didn't lose money.

All right. And if I suggest to you that the words were to the

effect that the hospital would be wanting to - if it was paying the doctor who was doing the teaching and the training, the hospital would be wanting to receive the money from the university rather than allowing the doctor to receive that in addition to the doctor's salary or VMO payments, what do you say to that?-- That that - that that certainly was not said.

Right. That's all I have, thank you, Commissioner.

COMMISSIONER: Thank you. Is there anyone who wanted to cross-examine Dr de Lacy who hasn't had an opportunity to do so? No. Mr Farr, you had finished.

MR FARR: Yes, I had, thank you.

COMMISSIONER: Ms Gallagher, any re-examination?

MS GALLAGHER: No, thank you, Commissioner.

COMMISSIONER: Mr Atkinson.

MR ATKINSON: A couple of questions, thank you.

RE-EXAMINATION:

MR ATKINSON: Dr de Lacy, you were asked questions early at the outset of proceedings by my learned friend Ms McMillan and she asked you questions about those three operations that were the subject of bans in Oregon?-- Yes.

The liver resection, the pancreas and-----?-- Ileostomies.

And the ileo-anal pouches. Can you tell us from your memory of the patients you have seen-----?-- Yes.

-----whether there was a higher incidence of those operations amongst the catchment, the ones that Patel did, than you would expect?-- No, I can't comment on that, sorry, as I said, I was - I - the only patients I saw were survivors. As I understand it, only one of the oesophagectomies survived. I certainly didn't see any of the others and I put - I don't have access to any of that data.

Dr Woodruff suggested in his evidence that it looked as if Dr Patel had set out to prove himself in complex surgery or the ones that were the subject of the ban, but you can't say either way whether that's the case?-- Not really, no.

You were asked questions by Ms McMillan about the patient Hodder?-- Yes.

I showed you the records from Ms Hodder's file over the break this morning. You recall that?-- I might have to refer to Ms Hodder's file again, sorry.

It is the one you saw on the computer?-- Yes, sorry.

I wonder if you can agree with these three propositions from the-----?-- Yes.

One, that the radiology preoperatively showed that she had a duct papilloma?-- I agree with that.

Second, that the post-operative histology showed that the duct papilloma hadn't been excised?-- I could agree, correct.

Thirdly, that the case note that you studied don't disclose any record of her being told of that outcome?-- Correct.

You mentioned that in a tertiary hospital like the Princess Alexandra there were lots of checks which might have prevented the trail of wreckage that Dr Patel has left behind?-- Yes.

Can you just tell us in a short summary what checks they are?-- Starting from the ground up, there's an academic environment surrounded by teaching which provides its own auditing, patients being selected to be examined by medical students. There's training registrars who are consultants who, you know - in training who are completely up-to-date in terms of the contemporary approaches to certain problems and they keep you honest in terms of your assessment, prevent slackness in the system. Robust morbidity and mortality meetings, which is consultant to consultant review. And then numerous other institutional approaches to quality control which are thought to be outside the purvey of individual surgeons. For example, prevention of blood clot in the legs after - after operations is something that all surgeons in all speciality fields have some experience with but institutions, for example - but because, sorry, they're uncommon events, it's thought that an individual practitioner doesn't have enough experience in their cohort of patients that they've looked after, the couple of thousand or the 10 or 20,000, whatever it is, to make judgments about that, so institutions or sometimes - sometimes states or countries will make a - will make an assessment and compel more or less a surgeon to follow those rules. So there's - there's sort of auditing processes all the way along the line. Colleges, sorry, also fall into that group. So, you know, from the ground up and sort of with the surgeon in the middle from there above, it all asserts some sort of quality control.

And you can't expect quite such a snug, well-knit, comprehensive set of checks and balances in a regional hospital?-- It doesn't take much. It takes - it takes medical students which are currently there which weren't there in 2003. It takes training registrars which have been at Bundaberg Base Hospital in the past but aren't there now for - for technical reasons. You need two people with FRACSs for a college to agree to put a training registrar there. There have been in the past; there could have been in 2003 with Dr Peter Anderson and I are both FRACSs. We have been on staff. That would have been enough to get a training

registrar there. Morbidity and mortality reasons it's been discussed at length, and the - you know, the other sort of supra-institutional organisations, the college itself don't - unfortunately don't apply to a person who is not a fellow. So, there was none. And they could have all been there in Bundaberg and without that much difficulty I would have thought.

You mentioned in your answers to my learned friend Mr Farr over here that two things had to happen, two threshold things for this crisis to unfold?-- Yes.

The first I understood was a surgeon who was prepared to subvert any scrutiny and the second was some slackness on the part of management?-- Yes.

With the second one, to what are you referring there?-- I'd actually put them around the other way. There was a - in my opinion there was a predisposition in the system to allow a rogue surgeon to be placed in this position of power and allowed free reign.

How do you mean that, predisposition?-- That regional centres have difficulty attracting staff and end up, you know, accepting anyone. Poor candidates. That because they have so much difficulty, the emphasis is on filling the position rather than filling the position with a good candidate, and that has - there are a lot of issues surrounding that, specifically just the difficulty of getting any services out into the rural and regional Australia not just health. And I went into that a little bit during the evidence-in-chief and - but they can be summarised as the attraction of the-----

COMMISSIONER: Doctor, I'm sorry to interrupt you but I'm concerned that you might be being far too generous to Queensland Health with what you're saying in this sense: what we've heard in the last week is that Jayant Patel was appointed as Director of Surgery without going through any checks or whatever on the footing or perhaps the pretext that he was a locum Director of Surgery until someone competent to handle the position was available.

MR ATKINSON: Or to be fair, Commissioner, until he got his fellowship.

COMMISSIONER: Or until he got his fellowship. What we hear also is within a few months after that, you arrive on the scene and you're refused a position as a VMO?-- Mmm.

We've also been told there is no reason in principle why that a Director of Surgery could not be a visiting surgeon rather than-----?-- Mmm.

And you'd in fact held the position of Director of Surgery-----?-- Previously.

-----at one of Brisbane's most prestigious hospitals. Had it been put to you that, "There's this locum Director of

Surgery position vacant. We'd like to you hold that position as a VMO", would you have had any difficulty with that?-- No, I would have accepted.

It is not just a predisposition in the system. It's people deliberately avoiding having competent surgeons coming to the hospital?-- Well, it's money. It's the fact that VMOs are more expensive than staff surgeons and that they - because they have an independent practice outside the hospital as opposed to being an employee of the hospital, they have - are more difficult to control. That's the general consensus amongst doctors. Let me just say that my experience with Queensland Health is - has not been confined to Bundaberg Base Hospital. It has not been all bad.

Yes?-- So I'm not being overly generous. I'm just trying to give you the benefit of my particular experience. I know you've heard a lot of other people's experience but I've - you know, my time working in other institutions has not reflected what's gone on at Bundaberg necessarily, that's for sure.

Yes.

MR ATKINSON: Doctor, I was trying to pin you down to that second threshold issue which should be the first one, the slackness in management?-- Yes.

As I call it loosely. You mentioned in the course of setting out what you meant by that. First, you spoke about the predisposition in the system?-- Yes.

And that's really a financial issue?-- Yes.

Is there anything else that you think was done badly that should have been done better?-- I mean, obviously this individual should not have been given a position of a surgeon in Australia, much less as a Director of Surgery in a moderate sized institution.

You've worked, Doctor, at eight to 10 hospitals I guess over your career?-- Yes.

Do you know of any hospitals where somebody who wasn't a fellow of the college has been appointed as a Director of Surgery?-- No.

Have you heard of that happening in other hospitals in your time in Queensland or New South Wales?-- No.

Okay.

D COMMISSIONER EDWARDS: And those appointments should not be made to anybody who does not have a fellowship really, in your view?-- In my - it removes the auditing of the college as a minimum and, yes, no, I'd agree with what you said Commissioner.

COMMISSIONER: I suppose it's possible to imagine extreme

cases, where, for example, a person who is a fellow of the English or Scottish or Canadian college and hasn't yet achieved his or her fellowship in Australia, and I imagine you wouldn't have difficulty with that sort of person being appointed?-- No, I - it's the individual that would matter to me. But as a rule, if we're talking rules, it introduces another possible failing in the system. Remove - as I said, it removes the auditing of the college. And the particular institution can be lucky and get a fantastic person-----

Yes?-- -----regardless of where they're trained or they can be unlucky and end up here.

And I suppose, really, they can be unlucky and have a less than optimal Australian-trained surgeon as well?-- Of course they can.

MR ATKINSON: Doctor, just to flesh out the slackness, there's the appointment itself?-- Yes.

There's a predisposition in terms of finance. No doubt from the last time you gave evidence there is the issue of the rigorous M&M meetings?-- Yes.

Anything else in terms of how management might have assisted in stopping this happen?-- There was a period in the history of the Bundaberg Base Hospital - I think you've had Dr Nankivell sitting in this chair, not someone I'm familiar with personally but I've heard any number of reports about his period as director and all good. All good. At that stage, as - and this - I may get some of the detail wrong but to give you a compare and contrast, there were surgical registrars, there were medical students. He was a - he was a fellow of the local college, attending college meetings and just participating in the general community of surgeons to the benefit of Bundaberg from what I've seen, and it was very different in 2003 to 2005.

Doctor, you were asked questions by my learned friend Mr Diehm about that discussion in about July 2003 when you were seeking to work as a VMO?-- Yes.

And it was suggested that there might be some connection between the overpayments from Queensland Health-----?-- Yes.

-----and the appointment as a VMO. Was there anything in that discussion between you and Dr Keating in July 2003 that might have touched on-----?-- No.

-----such a connection; indeed, even on the issue of overpayments at all?-- No. I hadn't been paid for perhaps six or nine months. I hope this doesn't sound ridiculous but it was a relatively small income from the public hospital working just one weekend in six and it was only on making inquiries about why there didn't appear to be any lines on the bank statement coming from Bundaberg Base Hospital that this issue arose and I had to actually specifically talk to somebody in the pay office at Bundaberg Base Hospital, who

subsequently did the investigating on my behalf and found out what had gone on, for it to come to anyone's attention. And so, the assertion that was made before that that was a reason for not employing me as a VMO was ludicrous.

One last question, Doctor. Dr Woodruff has suggested through his audit on the records that there may have been eight to 13 deaths to which Dr Patel contributed?-- Mmm.

Dr O'Loughlin said in his statement to the Commission, "That you need to appreciate in any review that surgery is not a benign undertaking. It carries with it lots of risk." Two years, 13 deaths; can you say whether that's outside what's normal or whether that can happen to a surgeon acting competently when he's unlucky?-- Well, as I understand it was two years and 80 something deaths. Those 13 deaths refer to deaths that in Dr Woodruff's opinion were related to poor practice. I mean, the right number there is zero, zero deaths. You can certainly die after a general surgical procedure for many years but dying of negligence, incompetence, or whatever, that's not one of them. You can die because the organism becomes frail, because you've intervened in the disease process too late and it only becomes apparent after the fact. You can die for all of those reasons, but dying because you - in the way that some of these patients have been reported to have died, and, again, I'm not privy to any special information about them but I'm extrapolating from those patients who survived, no, it's not acceptable. The right number there would be zero.

COMMISSIONER: Just so that I understand what you're saying to us, of those 86 or so?-- Yes.

Dr Woodruff has already excluded those who fall into the category where a competent surgeon-----?-- Yes.

-----could be expected to lose that patient anyway?-- Exactly.

So when we come down to the 13, 13 isn't three or four times the number?-- No.

There should be zero in that category?-- There should be zero.

MR ATKINSON: Even if you're working for two years in Bundaberg?-- Twenty years. The point is - I think the statement that he was making is that those are the people for whom Dr Patel can be held accountable for their death who would not have died under the care of a competent surgeon as opposed to the others who may well have died anyway regardless of who was operating on them. You interfere in the disease process, you are one factor in this continuum of the patient's life. And to give you a concrete example, if you lose blood for any reason, in a car accident, there's a particular quantity of blood that you can lose roughly and survive with prompt treatment and if you lose more than that quantity of blood before the flow of blood is stopped, despite best treatment, you still die. And so, anybody could be expected to if that patient - even though they're not dead when they

arrive, they are unsalvageable. And that's a concrete example. They actually come up a lot more frequently than you would think in the complexities of looking after people. And as I understand it, and I don't read the transcripts and I haven't got any access to his - to weed all those out, the ones that are left are where a competent surgeon would make different decisions. P265 is very lucky to be alive and he just would have been another one, that's all. Just another - he would have been number 88, no more than that. But he's not. He's alive.

MR ATKINSON: Commissioner, that's all I have. I haven't actually formally tendered the case notes that Dr de Lacy prepared and since they have been so thoroughly referred to, I think I probably-----

COMMISSIONER: I think that's probably right. Can you remind me of the number of Dr de Lacy's statement?

D COMMISSIONER VIDER: 252.

MR ATKINSON: Thank you.

COMMISSIONER: 252. Well, we will make Dr de Lacy's case notes Exhibit 252A.

MR ATKINSON: Can Dr de Lacy be excused then, Commissioner?

COMMISSIONER: Thank you. Indeed, Dr de Lacy, but can I say I make the practice of - because I think it is polite, to thank each witness when they conclude their evidence but on this occasion I do want to make it clear to you that your evidence has been absolutely invaluable. Of the witnesses we've heard over the past three months, your testimony has been the most comprehensive, clinical analysis from a person who's actually seen Patel's patients as compared, for example, with Dr Woodruff, who was going solely from clinical notes. As I see it, speaking as a non-medical person myself, there is nothing more valuable than the testimony of someone who has actually seen the patients and dealt with them personally. The fact that you have not only done that but been able to present their stories and your observations often in an articulate and detailed way will make our job a great deal easier at the end of the day. We are extraordinarily grateful to you for your assistance and particularly for the trouble you've come to in coming down from Bundaberg to give your testimony over two separate days. Thank you, Dr de Lacy, you're excused from further attendance.

WITNESS EXCUSED

MR ATKINSON: Thank you, Commissioner. The next witness is Dr Wakefield and my learned friend Mr Morzone will call him.

COMMISSIONER: Thank you.

JOHN GREGORY WAKEFIELD, SWORN AND EXAMINED:

COMMISSIONER: Sit down and make yourself comfortable, Doctor. May I inquire whether you have any objection to your evidence being filmed or photographed?-- No, Commissioner.

Thank you. Mr Farr, do I see-----

MR FARR: Sorry. I seek leave to appear on behalf of Dr Wakefield.

COMMISSIONER: Yes, such leave is granted.

MR FARR: Thank you.

COMMISSIONER: Mr Morzone.

MR MORZONE: Thank you, Commissioner. Your full name is John Gregory Wakefield?-- Yes.

You're the Executive Director of the Patient Safety Centre, employed by Queensland Health?-- That's correct.

And you've prepared three statements in this matter, one a very large statement which exhibits your curriculum vitae and which is dated the 16th of August 2005?-- Mmm-hmm. Yes.

A smaller, middle size statement, if I can call it that, which is dated also the 16th of August 2005?-- Yes.

COMMISSIONER: Is that the one which has following paragraph 3 a subheading "Initial Appointment at Bundaberg Hospital"?

MR MORZONE: That's correct, Mr Commissioner, yes. And finally, a smaller statement which you signed on the 20th of July 2005?-- That's correct.

COMMISSIONER: Mr Morzone, I'm sorry, I don't seem to have the smaller statement.

MR MORZONE: I will hand copies of those up.

COMMISSIONER: For the record, the three statements of Dr Wakefield will become Exhibit 290A, B and C in the order in which Mr Morzone has identified them. So 290A will be the statement of 52 paragraphs dated 16 August 2005.

ADMITTED AND MARKED "EXHIBIT 290A"

COMMISSIONER: B will be the statement of 32 paragraphs, also dated 16 August 2005.

ADMITTED AND MARKED "EXHIBIT 290B"

COMMISSIONER: And C will be the statement of 17 paragraphs dated the 20th of July 2005.

ADMITTED AND MARKED "EXHIBIT 290C"

COMMISSIONER: Thank you, Mr Morzone.

MR MORZONE: Thank you Mr Commissioner.

Doctor, are the facts contained in those statements true and correct to the best of your knowledge and belief?-- They are

And to the extent you've expressed opinions, are they opinions which you truly hold?-- Indeed, they are.

You also were a co-author of the review team report which I can tell you became Exhibit 102. Similarly, are the facts contained in that report true and correct-----?-- They are.

-----to the best of your knowledge and belief. And are the opinions expressed in there opinions which you hold conjointly with other people?-- Yes, they are.

Can I ask you about a number of topics without going to all of the detail in your statement. First of all, clinical privileging?-- Mmm.

I don't think that your statements deal with clinical privileging, but there might be something you can tell me about in that regard. There are relevant policies, quite comprehensive policies dealing with accreditation and clinical privileges for medical staff and at a State level that policy is a policy which has been tendered, which I assume you are familiar with a policy number 15801, Exhibit 279 which also

contains with it a health instruction and a set of guidelines dated July 2002. Now, I can show you those briefly if you wish to see them?-- Yes please.

They follow one another under those tags. Is clinical privileging and/or the monitoring of that process something that falls within your responsibility as within the Patient Safety Centre?-- No, it does not.

Where does that - whose responsibility is that, can I ask?-- Okay. In relation to - the Patient Safety Centre commenced in January of 2005 and prior to that time, my understanding is that credentialing and privileges was a project under the previous quality agenda of Queensland Health, and to my knowledge that sits in one of the zonal management units for Queensland Health.

Now, the policy in the health instruction, which speak for themselves largely, plainly impose the responsibility for clinical privileging on the district manager to ensure all medical staff operating within the district have their credentials periodically reviewed?-- Mmm.

As well as initially put in place, and we heard and know from your review report that this didn't occur in Bundaberg?-- Mmm.

Other than to the extent of some minor temporary privileging having occurred without peer review. The questions that I had for you were first of all, do you know of any auditing or review process which is in place for checking whether or not relevant districts implement the statewide policy?-- I'm not aware of any specific process. I guess perhaps, if I can answer in two ways: firstly, as you're aware and as the Commissioner will be aware, I was the medical superintendent at the Bundaberg Hospital and that was prior to this policy, the date of this policy for Queensland Health, and there was an onus upon the medical superintendent at that stage to manage the process of clinical privileges in their own facility. However, that poses problems in a small facility because of difficulties of obtaining the relevant peer oversight or involvement of the colleges. Nevertheless, that was something that I set up when I was medical super at Bundaberg. In relation to my position now as executive director of the Patient Safety Centre, as I've already said, it doesn't fall primarily within my brief and I'm not aware at this stage that there is any sort of external compliance checking process or internal compliance checking process that that occurs, and there seems to also nothing within the wording of the policies that I could see which provide for that review process.

Would you agree that that auditing or compliance auditing process would be a useful thing to occur?-- Yes, but it's a qualified yes. I think that compliance is essential to be able to demonstrate that clinical privileging is actually undertaken, but I think the compliance without the correct support mechanisms to provide support to those people

responsible for doing that, undertaking credentialing and privileging is only one side of the equation, so the answer is very much yes, compliance would be essential, but I think that we need to certainly look at better support mechanisms for people for the responsible individuals.

COMMISSIONER: What do you mean by "support mechanisms"?-- I think there needs to be - my opinion is that it will be far better to manage credentials and privileges on an area or zonal basis so that there could be a greater degree of rigour around the process. I think it's very difficult to do that in every small hospital, given the logistics, and so I believe that that needs to occur.

What do you mean by "support mechanisms"?-- The tools to enable that to be done, so the relevant documentation, templates, the relevant terms of reference for the committee and the privileged committees support. So, for example, peer review, a peer review committee should attract privilege so that those discussions can be in the appropriate context.

Doctor, I've only received as we came down, I haven't had a chance fully to read your statement, including all of the attachments?-- Mmm.

But as I read it, you're part of a body within Charlotte Street called the Innovation and Workforce Reform Directorate; is that right?-- That's correct, although I don't actually work from Charlotte Street.

And there are six divisions in that directorate?-- Yes.

And one of those three divisions is the Safety Improvement - no, sorry, the Patient Safety Centre; is that right?-- That's correct.

And that Patient Safety Centre in turn has three units?-- That's correct.

Is that right?-- Yes.

One of those units is the Safety Improvement Unit?-- Mmm-hmm.

And that unit consists of five teams; is that right?-- Yes.

And none of those has been able to put together the tools that you say are essential to enable regional hospitals to undertake appropriate credentialing and privileging?-- Commissioner, that is not within the brief of the Patient Safety Centre at the time of its inception.

What are all of those administrators doing?-- In the Patient Safety Centre?

In all of these divisions, directorates, units, teams and so on and so forth, you say it's critical that we have proper credentialing and privileging and that that can only be done if people are given the right tools; who's doing that?-- As I

indicated before, Commissioner, my understanding is that that is being - that is a project that is being run out of the southern zone management unit.

That's yet another project, is it?-- That's my understanding, that that is not - that is not part of the brief of the Patient Safety Centre.

Dr Wakefield, would it be unfair if I suggested that the best way to improve patient health and safety would be to take all of the money that's being spent on divisions, directorates, units, projects, I mean, your statement is just a repeat with all of these different organisations, quality improvement evaluation program, improvement development project, patient safety project, patient safety program, innovation of workforce directorate and so on and so forth. If all of that money was actually spent on having more doctors and nurses looking after patients so we didn't have 100,000 Queenslanders lining up to see a specialist, don't you think the patients would be a little better off?-- Commissioner, I can only speak for the work that the Patient Safety Centre and some of the other centres - some of the other units are doing. This is a huge reform agenda, more and more money can be put into health care to provide health services and I fully support that, but without a focus on safety and the safety improvement, we will continue to inadvertently cause significant patient harm.

Aren't we already causing inadvertent patient harm because people are dying while they're waiting to see a doctor? Isn't that happening now?-- I presume that if patients can not get to see doctors, that they are suffering because of that. The issue is how is that going to be addressed.

And it's certainly not going to be addressed by having more bureaucrats, is it?-- Well, it's going to be addressed by putting in place the right solutions to the problems, Commissioner.

Can I ask you to have a look in your lengthy statement that on it marked A?-- Mmm-hmm.

This policy statement, Safety Improvement Unit - I'm not sure of - the exhibits don't seem to be - do you have something called a "Queensland Health Policy Statement", it's JGW6 to your statement?-- Mmm-hmm.

"Queensland Health Policy Statement, Incident Management Policy"?-- Yes.

Now, this document reflects, as I understand it, official Queensland Health policy regarding management of incidents; is that correct?-- That's correct.

If you go to page 17 of that document, there's something there called a "Queensland Health Risk Matrix"?-- Yes.

Are you familiar with that?-- I am.

And consequences are identified in that matrix from negligible through minor, moderate, major and extreme?-- Yes.

And to take the first example in the table, an adverse clinical incident is described as major if someone dies and described as extreme if it results in multiple deaths?-- Yes.

The next item is "Damage to Reputation or Outrage" as it's called?-- Mmm-hmm.

And that ranges from negligible, which is minimal adverse local publicity, up to extreme which is "Queensland Health's reputation significantly damaged"?-- Yes.

Right. So as far as Queensland Health's official policy is concerned, the loss of one life isn't nearly as serious a matter as Queensland Health's reputation being significantly damaged?-- According to this risk matrix, Commissioner.

Yes, and is that why the people of Queensland haven't been told that between two and three per cent of the citizens of this State are on waiting lists to see a specialist, because that would adversely affect Queensland Health's reputation and that's worse than patients dying?-- I can't answer that question, Commissioner.

Do you know who can?-- I presume that the people responsible for managing the waiting list issue and the senior executive of Queensland Health.

So we start from Dr Buckland down, do we?-- I would presume so, I cannot answer.

We might take the afternoon break and resume at 3.30.

THE COMMISSION ADJOURNED AT 3.14 P.M.

THE COMMISSION RESUMED AT 3.44 P.M.

JOHN GREGORY WAKEFIELD, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Just before we resume the evidence, I am sorry we took longer than expected. There have been a couple of developments I need to deal with. The first is a letter which we have received from the Minister for Health. It concerns the Berg issue that we heard about in Townsville. The situation, as everyone will recall, is that Berg was practising in the Townsville Hospital as a psychiatrist, apparently on the basis of false credentials until he was found out.

The head of the psychiatric unit at Townsville, along with the Medical Superintendent at Townsville both considered that the matter should be made public on account of the fact that they didn't know all of the patients that Berg had seen and therefore there would be no opportunity to follow up with patients that Berg had seen unless the story was released through the media. Regrettably, that decision was overruled in Charlotte Street with the result the story remained suppressed until it was made public as a result of this Inquiry in Townsville two weeks ago.

Following the revelations in Townsville, Townsville Hospital very properly set up a hotline, client liaison officer to discuss matters with ex-patients of Berg's. As a result of that process, it has come to their attention in the last 24 hours that Berg made an unofficial house call to one of his patients who was being treated for an emotional breakdown and was having problems with her medication. Berg attended at her home to deal with those issues. Whilst Berg was at her home, he also offered treatment for the patient's son. He then encouraged the patient, and I think her partner, to take themselves and the rest of their children to McDonald's so that Berg could have some time alone with the patient's son.

It is alleged that whilst the patient and her partner and the rest of the family were away, Berg committed serious acts of sexual interference with the son. Those matters, as I say, have only just come to light, they have been reported to the Queensland Police Service and are under investigation.

What this demonstrates to my mind is the arrant stupidity of an administration that says that problems of this nature should be covered up rather than made public so that they can be properly investigated, and so that patients who are at risk have the opportunity of seeking redress and support.

I would emphasise, as the Minister has asked me to emphasise, that both the original patient and her son are considered to be at risk of further distress as a result of any publicity involving their names or details, and I would urge the press

and media not to attempt to identify them or to identify any circumstances which might lead to their identification, but it seems to me that this is the clearest possible illustration of the harm which can be done when people in administration decide to cover up a mess rather than discussing it openly and frankly and dealing with it publicly.

I will ask the secretary to mark as an exhibit, exhibit number 291, the letter bearing yesterday's date, the 17th of August, from the Honourable Minister for Health Mr Stephen Robertson, which is deidentified as regards to the names of the patient and her son. That will be exhibit 291.

ADMITTED AND MARKED "EXHIBIT 291"

COMMISSIONER: The other matter which has been brought to my attention is of quite a different nature. It is an article which appeared in the Western Star newspaper on Tuesday of this week. The Western Star is, of course, based in Roma, and it appears from this article that matters which were discussed in Townsville between the Commissioners and various witnesses relating to one-doctor hospitals, have created alarm and led to difficulty in attracting doctors to one-doctor hospitals.

What I want to make very clear is that it is not and has never been on our agenda to consider the closure of one-doctor hospitals. What we do think needs to be considered is how services and resources at one-doctor hospitals can be better integrated with regional hospitals in accordance with the hub and spoke model about which a number of witnesses have spoken.

In the 21st century, it is unrealistic to expect any medical practitioner at any one-doctor hospital to provide the full range of medical services which 50 or 100 years ago might have been provided by a medical superintendent or a GP with rural experience in a remote hospital. In the 21st century with modern communications, electronic and road and air, the emphasis needs to change towards providing acute and chronic care at a local level and providing more sophisticated forms of medical treatment at regional centres. It is, in a sense, interesting that this article refers to a number of towns - Mitchell Wallumbilla, Injune, and Surat - and they are all towns with which my family has had a connection over generations.

I would like to take the opportunity to assure the people of those towns in particular, but all other towns in Queensland which are currently serviced by one-doctor hospital, that, as I say, it is not and never has been on our agenda to suggest that doctors be taken away from those towns. What we do think needs to be considered is whether there is some form of reconfiguration of the provision of medical services in places like that so as to ensure that people in remote communities have the best of both worlds, access to prompt medical

treatment in their local community where it can be provided at an adequate level, but access to more sophisticated services in regional areas when it is inappropriate or impractical for that service to be provided in a one-doctor hospital.

Those are the matters I wish to mention. Does anyone wish to raise anything arising out of either of those two issues?

MR FARR: No, thank you.

COMMISSIONER: Mr Morzone?

MR MORZONE: Thank you, Mr Commissioner. Dr Wakefield, before the break the learned Commissioner took you to page 17 of that exhibit JGW6 which was the Incident Management Policy?-- Uh-huh.

Just to finish with that line of questions that were asked of you, can I ask you to go to page 18 of the policy, and at the end of the table to which the Commissioner took you there is a heading "Explanation of the degree of severity of consequences". Do you see that?-- Yes.

And "negligible consequences" are stated there. It seems to me to be measured by a budget overrun of 1 per cent of the monthly project budget, minor; then a budget overrun of 2 per cent, moderate, 5 per cent; major 10 per cent and extreme 15 per cent of monthly project budget. Is that right?-- Yes, according to this risk matrix.

Am I correct in understanding that to mean that the severity of consequences is effectively budgetary driven; the more likely it is going to have effect on the budget, the more severe it is rated?-- This risk matrix applies to the whole organisation, and it is fundamentally covered within the integrated risk management policy. In relation to the - to clinical incidents, the only part of the matrix which counts is the clinical - is the adverse clinical incident component.

COMMISSIONER: Doctor, if Queensland Health had external insurance, such as private hospitals have, each Queensland Health hospital would be compelled to adopt safety procedures which are governed by consideration of protecting the hospital against litigious claims?-- Uh-huh.

There would be no concern about issues such as budget overruns or adverse publicity; it would be looking after the patient as a way of saving money, and that's, I think, the point that we're trying to illustrate here. Whoever wrote this seemed to think that protecting Queensland Health's reputation is an issue on a par with preventing multiple deaths and more significant than preventing a single death?-- Mmm. Commissioner, I think I would like to answer that by saying first of all that certainly the reputation of Queensland Health is very important as a determinative of how patients feel about receiving care, and possibly does contribute to whether patients access services or not and the way they feel about services.

Even if that reputation is false?-- Sorry?

Even if that reputation is achieved by falsely suppressing the truth?-- I don't support that in any way, shape or form.

Well, let's take the situation with waiting lists?-- Mmm.

If I am a person on a modest income who has to make, as many, many Queenslanders do, the decision whether to spend my limited income on private health care rather than sending my children to a better school, or having a holiday, or having a bigger house, or something like that, surely I am entitled to know that if I don't go into a private health fund, then there are 100,000 people in the queue in front of me before I see a specialist. Isn't that right?-- Absolutely. I will agree with you.

Surely the people of Townsville are entitled to know that the man who may have come to their homes, as it turns out, but who was certainly treating some of the people of that city for psychiatric illnesses wasn't a doctor at all, there can be no justification for suppressing those facts, can there?-- As far as I am concerned, absolutely not.

The point you are making - and I think you are making a very valid point - is that Queensland Health's reputation is important for reassuring patients that they are getting the best standard of care, but the way to achieve that, I would suggest to you, is to ensure that they do have the best standard of care; not to falsify the facts so as to create an impression which isn't justified?-- Absolutely agree.

Thank you.

MR MORZONE: The Incident Management Policy that we're looking at is a policy that was first released, it seems on its face, the 10th of June 2004?-- Yes.

Were there policies in existence before that time that dealt with the reporting of clinical incidents?-- To my knowledge there was no statewide policy in relation to the reporting of clinical incidents, and, indeed, this policy is a generic incident policy, it does not just cover clinical incidents. But each facility would have had to develop its own procedure or policy around clinical incident management and therefore there would have been wide variety of procedures, probably from very good procedures to absent procedures.

Okay. Well, we see in that policy - and you have mentioned already - that under the policy it is mandatory to report certain events higher up the line managers from the district manager?-- Uh-huh.

They are primarily sentinel events and events in the extreme and very high risk ratings?-- Correct.

And the policy then sets out the responsibilities of those

higher up the list at page 12 and those include responsibilities through to the Director-General?-- Yes.

I note that in your affidavit, the Patient Safety Centre now is responsible for this particular policy. Where would your position fall within the names of persons on page 13, for example?-- Okay.

Is it a different name now?-- The role of the Patient Safety Centre is to utilise the information within those reports. So it is not the notification that an event has occurred, it is the analysis report. So in other words what happened, why did it happen, and how can it be prevented? It is our job at a statewide level to analyse that information along with a range of other data sources and provide the Queensland Health department with the priorities for prevention, if you like. So to drive initiatives aimed at improving safety around those key areas of harm. So we would be-----

There is a Risk Management Advisory Committee. Would you be that or is it something again different from that?-- We would be at the level of - probably at the level of the Chief Health Officer. This policy, I might add, has - is currently - since commencing as the Patient Safety Centre, I have ordered a review of this policy. It has been out for review with the districts and we have a scheduled workshop to revise this policy, and it is my intention to make this policy specifically focussed around clinical incidents because I don't believe that this generic policy properly covers the requirements of clinical incident management.

Okay. Now, I want to ask you about that in a moment?-- Yep.

You say in paragraph 50 of your statement that between July 2004 when the policy commenced and June 2005, that only one sentinel event was recorded from Bundaberg?-- Yes.

And it was an unexpected death of a mental health patient?-- Yes.

The inquiry knows of at least - well, at least one and probably three other incidents that would qualify as sentinel events, being the Kemps incident in December 2004, the Bramich incident in July 2004, and another patient. Do you have any knowledge of those incidents having come to your attention or to the attention of anyone in the line above the District Manager?-- No, they were not, to my knowledge, reported through to - of course, this was prior to the Patient Safety Centre being commissioned, but they were not, to my knowledge, noted - reported to the then integrated Risk Management Unit that had responsibility for this.

Okay. Again, I see under that policy, "The responsibility for ensuring the implementation of this policy is on the District Manager, by the district then creating their own policy." Again I see no provision in there for there being audit checks or compliance checks done on various districts to ensure that that's happened. Is that the case or does your centre have a

role in that?-- It is the case that as far as I am aware there is no compliance function. The reason - my statement outlines the fact that - in fact, I have a long 17 years' history mostly as a clinician, in fact, but as more recently as an administrator, and it is certainly my experience that policy is written and driven from Queensland Health without a true estimation of the impact on district health services to be able to comply. So that one of the significant roles of the Patient Safety Centre is not to be a policy maker, but it is actually to be a supporter and implementer at a hospital level so that we could be out there assisting districts to make sure these things happen. It is my view that it is not our role to be policemen, that there should be a separate compliance or clinical audit component to come along and check that these things are in place. I don't think you can - you can be the policeman but also the implementer.

In your affidavit at paragraph 31 you have referred to many districts reporting being unable to comply with the incident management policy due to inadequate training and resources. Does the Patient Safety Council assume a responsibility for overcoming that difficulty, or is that a responsibility of someone else?-- No, absolutely we do. That is the work that we do.

And what is being done to overcome that difficulty at present?-- A range of things. The Patient Safety Centre is currently implementing an information system which will assist districts to both collect, analyse and report on clinical incidents, and, more importantly, to act on the information to improve.

We have sought funding to provide additional people resource to help clinicians in districts with the analysis of serious incidents when they occur. It's important - the analysis component is actually a fairly technical process. It's been developed from other high risk industries and really has had the commitment of all the health ministers across Australia. So we are providing 25 - in fact, 26 full-time equivalents across the state to assist districts comply. We are providing training for districts and I personally, with my staff, will be visiting every district - we have already commenced that process - to work with them, to assist to train them in this process and, also, to continue work that has already been happening over the last four years, very important work in relation to safety which has delivered improvements, which I'm happy to elaborate on if you wish.

Perhaps you can answer this for me. In the period from 2003 to 2005?-- Yes.

Did you have any contact with the Bundaberg Hospital?-- No.

What about since the commencement of this policy in 2004, July 2004, did you have any contact with the Bundaberg Hospital?-- Since?

Since July-----?-- Since July 2004?

Yes?-- My only contact - when I started on - in January of this year at the Patient Safety Centre, I was handed over the information from the Integrated Risk Management Unit of the sentinel events that had been reported since July.

COMMISSIONER: Doctor, would I be wrong if I were to question what strikes me as the perversity of having these projects and programs and systems and so on, spending a lot of money developing them without having worked out in advance whether individual hospitals have the resources and facilities and personnel to run them? Why have a unit or a division or a directorate or someone else crank up a system that isn't going to get used because people don't have the resources? Wouldn't it make a lot more sense to give hospitals the resources and if there's anything left over, then spend that on developing a project?-- I'm trying to understand your question, Commissioner. You're asking me whether it's worth spending this money on this activity versus patient care?

I read in your statement that - for example, on page 9 paragraph 41(c)(i), the first dot point, where, "QH has had an incident management policy since June 2004 and that many districts reported being unable to comply due to inadequate training and resources"?-- Yes.

Well, shouldn't we be focussing on making sure hospitals are adequately resourced and then, if there's money left over, put together a team in Charlotte Street to devise a program rather than spending money on devising a program which no-one is going to be able to implement because they don't have the resources?-- I can only speak for - from January of this

year. I do accept the fact and I accept it is a problem that - and have been on the receiving end of it, of policy that is delivered from Charlotte Street, as you say, without the resources to be able to implement. A significant amount of the work of my team is to provide the resources to districts which they desperately need to be able to take part in this vital work.

See, one of the things that we have heard many times during this inquiry is that hospitals throughout the state are funded essentially on a historical basis?-- Yes.

And what that means in practical terms is that if Biloela didn't have enough money last year, that guarantees they won't have enough money this year and they won't have enough money next year. But there doesn't seem to be any shortage of money for running projects in Charlotte Street. I just wonder whether the overall solution to all of this is to have someone independent like Queensland Treasury work out that there is 5.3 billion, I don't know, dollars, whatever the current figure is, to be spent on health and earmark that money to hospitals based not on some artificial historical footing but based on what they actually need by reference to the population, population growth-----?-- Mmm.

-----health of a local community and so on and say, "All right, of this $5.3 billion, $5.1 billion is going to be distributed in lots to all of the hospitals and districts throughout the state and if there is anything left over, then Charlotte Street can spend that on projects and programs and systems and committees and forums and anything else that flitters across their minds", but the first priority is to make sure there is enough money to actually run the hospitals?-- I agree with you, that there needs to be - that health needs to be adequately resourced to deliver the appropriate care to patients and I have no argument with that question. The second issue is a very real one and it is the subject of major international reform and national reform. It's backed by a decade of evidence, which suggests that the rate of patient harm caused by unintended, unintentional injury is too high in health care. That is not related to deliberate acts such as Dr Patel or Dr Shipman in the UK and so on and so forth. So that is, not to address that issue I think is - I don't agree with that.

I agree with you entirely and the primary cause so far as my reading goes, and you're much better informed on this than I am, of accidental mishaps is not having enough staff, the staff being over worked and under resourced in terms Junior House Officers and people like that working 80 hours a week, working shifts literally 24 hours and more, being exhausted on their feet and not being able to look after patients properly, whilst people in Charlotte Street can pack their bags and go home at 5 o'clock. It just seems to me that we have got priorities all wrong?-- Certainly, over-working or under-resourcing of health care is a significant contributing factor to safety.

See, one of the other things that really caught my eye in your statement is paragraph 49 on page 14 and this tells us that, "Dr Buckland" - the previous Director-General - "agreed to preliminary work on drafting changes to the Health Services Act in line with the New South Wales changes. The QH legislative projects unit is currently working on this project." Well, this is something I do know about because I happen to be a lawyer. I would have thought that that project would take anyone - any competent lawyer about half a day to finalise and yet we seem to have a whole unit working on it, and you don't say when they started working on it but they're still going?-- Commissioner, I raised this probably within the first four weeks of my commencing as the-----

That was in January, was it?-- -----the Patient Safety Director, that it was essential if we were to move forward that we had to have legislative reform in this area.

Yes. Yes. And we're now, what, eight months down the track and people in the sheltered workshop at Charlotte Street are still trying to come up with a legislative amendment to give effect to what you think is essential. That's the reality, isn't it?-- Yes.

D COMMISSIONER VIDER: Can I just make a couple of comments on the patient safety program. We've heard-----?-- Yes.

-----evidence of the patient safety program when we were in Townsville as well from Dr Andrew Johnson-----?-- Yes.

-----and it seems a very comprehensive program. I'd comment that I think health care, certainly in Australia, be it in the public or the private system has been corporatised and I think one of the things now happening is the pendulum is starting to swing back the other way, we are starting to own - this is not a business. The emphasis can't be on the bottom line. It's got to be on the fact that it's a service driven industry and we are caring for people and, therefore, the approach now is coming on to being able to evaluate the outcome of the service we deliver to the patients, and there's no other reason why we exist, except for that purpose?-- Yes. I agree.

Therefore, I think the patient safety program is one way of bringing it right back to the clinical outcomes version and the satisfaction that patients will get from the treatment that they receive. During this inquiry though we have had a lot of evidence presented to us that talks about the over bureaucratisation of the health care system. In the Queensland example, the centralist approach, so that everything goes to the top, it is a one-way flow of communication and nothing is coming back down. I can see that one of the potential issues of having this as a unit is that it is all going to come to the unit but that's a long way away from the service delivery point. Do you in the future see that it will be the district that will be the central focus for the reporting of patient safety outcomes and not, if you like, Charlotte Street? And the other thing that we've heard a lot of is duplication. We've had a lot of evidence where

people in administration are very busy, they're in committee meetings all day long but a lot of the work that they're doing is the committees are duplicating one another. In Australia we've utilised the framework provided by the ACHS. I'm not at all promoting that as being the be all and end all and I think that there can be - with the input of clinicians and administrators, that system can be improved. But I think we need one system, not duplication, and that system needs to have the appropriate hallmarks. But we all need to come together and work to provide one national system and if there's a better system that someone knows about, let's beat that into a national approach so that virtually in Australia, we've got benchmarks that we can compare across the nation. Would you agree with that?-- I'd like to respond to those comments if I could. First of all, there are actually some - I don't think we should throw the baby out with the bath water. Andrew Johnson is a colleague of mine and we've worked very closely on developing patient safety systems over the past three years in the respective hospitals before I co-authored this submission to drive this at a state level. There is significant potential benefits to drive - to having a statewide approach to some - to certain activities. Safety is one of them. I would like to give you an example. Prior to three years ago, every hospital in this state, all 108 hospitals, had a different medication form.

Yes?-- And doctors and nurses move around hospitals and had to complete - had to face a different form in every hospital. Now, that form is a key communication tool and there are huge vulnerabilities in that. Many, many adverse events relative to that process. We have managed to standardise that process across the state and have now led the nation in - with a ministerial commitment to standardise that across the country. There are many examples of that. Infusion pumps for example; many deaths and serious injuries are caused by multiple different types of infusion pumps that are programmed in different ways. We set our staff up to fail. And you cannot solve that with an individual cottage industry approach. You have to have some expertise centralised. Having said that, much of our resource - that seems to be a very lean function and much of our resources needs to be the - in the districts to help them do the primary analysis and do their own learning, which is why we've put the resources into districts and we work very much with districts. In fact, we're located at the Royal Brisbane Hospital. We're not located in Charlotte Street, and I was absolutely committed to being where care is delivered. So that's the first point. It is worth maintaining some - a centralist approach on some things and I think many of my clinical colleagues would back that up. The second point about the ACHS, I think that there is precious little evidence that the - that accreditation processes have led to improved safety outcomes. I'm sure there has been obvious value from opening your books and your services to be reviewed. However, I do need to point out that some of the major health care inquiries occurred in hospitals that had been fully accredited and some only recently fully accredited. So I think to use accreditation as the only tool in pursuing safety and quality is wrong. So whether it's King

Edward Memorial, Camden, Campbelltown or, in our case now, Bundaberg, they were all accredited hospitals.

That's fine.

MR FARR: Just before we continue, I think the third part of the question that the doctor may have overlooked was the issue of feedback, which I don't think he addressed.

D COMMISSIONER VIDER: Yes?-- Sorry, could you repeat that bit again.

My comment was really about the centralist model that had a one-way communication and we had head evidence that nothing really came down. Now, that's not specifically in relation to this program but that's in relation to people's evidence in terms of a centralist approach?-- Yes, I think that, traditionally, a lot of centralist functions are about control. Our function is about support and coordination. So, we actually turn the information around and share it. I have here an example of a - of an alert which has come from a recent serious incident and this is the sort of thing that we then circulate throughout the state to the various safety and quality committees and the clinicians so that they can learn and review their systems in relation to this. So we have a number of ways of providing feedback for the information that's provided. We're of course - I need to draw your attention to the fact that, you know, we've been going since January of 2005.

Yes?-- So I think that we have a range of work under way which I would be happy to talk to you about in detail.

My comments about the ACHS are not it as an organisation. It is really talking about standardising something-----?-- Yes.

-----so that as we move forward, we have got a common language, because health care workers move across states as well as within states and it will be a lot easier-----?-- Yes.

-----and we will have a lot more meaningful data if we do have a standardised approach, but it doesn't need to be controlled?-- I absolutely agree with that and I think that Queensland has led the way in many areas in fact. I mean, it is easy to talk about the bad news. There is lots of good news and some of the other states are actually very jealous of our ability to be able to standardise where we do need to standardise, which you can't do if you have lots of independent fiefdoms if you like.

Yes.

D COMMISSIONER EDWARDS: But, Doctor, could I suggest that health is not the only industry that has had a decentralised base with head offices, banking, we can say all of these, and they dealt with this 20 years ago. I was on - I've been until recently a director of a major bank and we have a thousand branches but we don't go into the bureaucratic models that

seem to be coming forward but never seem to really achieve what many of the business activities, banking, other kinds of provincial services, Woolworths, whatever we might say. And the thing that I cannot understand is why we are still trying to re-invent the wheel.

D COMMISSIONER VIDER: Yes?-- I quite agree. Much of what we're trying to do now aviation and other high risk industries have been doing for 30 years.

D COMMISSIONER EDWARDS: And it's shocked me, quite honestly more than anything else, is why we are still trying, as I said, to re-invent the wheel when patient care has been the basis of any health system for a hundred years in this country?-- Commissioner, I totally agree. I think our focus and, clearly, the purposes of this inquiry is to review the very serious issues that occurred in Bundaberg and the very serious harm that occurred to those patients, but I would - I think it's very important that we don't lose sight of the fact that doctors who misrepresent themselves or set out to harm patients are a tiny, tiny fraction of what we're dealing with. For the most part, half caused by good, well-intentioned, well-trained people who make mistakes, because we all make mistakes, and it's setting up those - it's dealing with those human - those issues that make it harder to make a mistake, which is what aviation and all these other industries have-----

Can I interrupt you and say it is not the matter of making mistakes because if you can invent a way of stopping somebody making a mistake, you're a genius?-- Yes.

But you cannot stop people making a mistake. You have got to find a system which detects early mistakes?-- Yes.

And deal with it. And that's what worries me about the system that I'm hearing about for the last 44 days or whatever it might be: that we are still trying to re-invent the wheel?-- Yep. I agree and I take your point about, no, you can't stop people making mistakes but you have to - the systems trap those errors and make it harder to the - I mean, I can give you an example and I think is a useful example to show you how we are just not learning in health care. There is a drug called vincristine, which is a powerful drug which is normally administered into the vein. Now it is often given with a drug that's administered into the spine. Now, in more than 15 cases worldwide, those have been switched around, inadvertently resulting in the death of a patient, and the most recent one was in New South Wales last year. Despite numerous warnings, alerts, et cetera, et cetera, those deaths continue to occur. Why? Not because there are bad doctors and nurses but because the systems set those people up to fail. A simple intervention like - like making one of those drugs in a large volume so you physically can't inject it into the spine will actually stop you from making that mistake. So we rely too much on vigilance and memory and training and not enough on engineering in safety procedures.

So I think that that's our task, is to try and engineer safety into health care, and it's - health care is 30 years behind other industries.

Thank you.

COMMISSIONER: Doctor, you said something in answer to Sir Llew's question which I'd like to follow up with you on. You identified the problem with Patel which, of course, is the source of all of this, a doctor who misrepresents his qualifications and so on, but the longer we go on for, I see Patel as the symptom of a problem rather than the problem itself, and to tell you candidly, members of the medical profession have said to me over recent weeks that when this is all over, Patel should be given a medal for creating the environment in which the whole system gets re-examined. Some of the things we identified with Patel are the overuse of foreign-trained doctors, even in a place like Bundaberg which on no view is an Area of Need?-- Mmm.

You know, to call it an Area of Need is a distortion of the English language, it's got two private hospitals, it's got excellent surgeons, it's got a very large range of highly skilled general practitioners. It wasn't just Patel, it wasn't just that he misrepresented his qualifications, it wasn't just that he wasn't the world's most competent doctor, it's the fact that a system exists which not only permits but encourages substandard surgeons to achieve positions like Director of Surgery at Bundaberg, that's what we've got to fix, isn't it?-- Yes.

And it's not going to be fixed by projects in Charlotte Street, it's going to be fixed by things like giving the local community more control over its hospital; having systems in place where there are clinicians rather than people who have chosen, for very good reasons and who are no doubt extremely skilled in their own field, but have chosen not to pursue clinical careers making final decision on clinical issues; those are the sort of changes we need to prevent another Patel; do you agree?-- I beg to differ perhaps in - and partly agree with what you say. I mean, there's no doubt, you can't take away doctors and nurses and pharmacists and others from practice and expect the system to work.

Yes?-- They have to be there and so the right people with the right credentials, the right qualifications to be able to do the work, there's no, there's no getting around that. But the evidence suggests, and I keep coming back to the evidence, that if we don't apply those, what they call human factors issues in the way we set up our health system, we are not improve - we will not improve.

But as Sir Llew says, that's just a matter of re-inventing the wheel. You can almost buy these models off the shelf, you can go to England and the United States and New Zealand and Canada and South Africa and see how it's done and implement it. You know, it really does frustrate me when I hear about these projects that go on for year after year after year setting up a new system when you could just as easily take one from any of our neighbouring jurisdictions and then after all the work's done and all the money's spent, there's no money to implement it anyway. You know, it just seems, I don't know how much of Queensland Health's $5.3 billion get spent on these unimplemented projects, but every cent of that should be

spent on doctors and nurses?-- As I say, I think that I'm not sure we'll agree necessarily on that, I agree there needs to be - health needs to be adequately resourced and people and its staff are our most important asset beyond a shadow of doubt, but we need to learn, we need to learn from the evidence and experience of those other high risk industries and other, and other health care systems overseas in how we can make health safer. I spent several months in the US last year working in the veteran's health system that have a very highly recognised patient safety profile, and the veterans health system 20 years ago in the States was considered to be one of the worst health systems. They now - they have invested heavily in a patient safety program and particularly in the information technology components to that so you can walk into any of their facilities, they are four times as big as Queensland Health but similarly distributed across the country, and if you're a doctor and you want to - and you need to prescribe medication, you do so through computer and it stops - there's decision support in there which stops you using the wrong dose, it stops you prescribing drugs that the patient's allergic to and so on and so forth, and at the other end when those drugs are delivered to the patient, the patient is bar coded as well as the drugs, individual tablets bar coded so that, for example, I'm giving drugs to Mr Smith, it does not allow me to give those drugs to Mr Smith in the wrong dose or to the wrong patient which are frequent errors in our system. There are many - they use infusion pumps that are preprogrammed in with dosages that stop you putting in the wrong program. So if you like, they're setting their system up to make it hard for people to do the wrong thing. Now, it's not just about IT, but you actually have to make the investment in dollars and time to create the right system, and if we don't do that, then we will not end up with a contemporary safe system.

Well doctor, I'm glad you raised that example because in Townsville a couple of weeks ago we had evidence from Dr Johnson and the district manager there, Mr Ken Whelan who have, as I understand it, implemented a review system based on the veterans health administration system in the United States. What particularly impressed me about that is that they didn't set up a committee to spend years examining 20 different systems and say which one is perfect, and when they were giving their evidence, they said quite candidly we don't know that the VHA system is the best in the world and if you spent 20 years looking at it you might ultimately decide that one system's better than another, but having any system functioning is better than none at all, and that's what I keep coming back to, you know, those men were able to achieve at Townsville, without an extra cent of funding from Queensland Health, without extra resource of any kind at all a system which is a good system, and that seems to me a lot better than spending money devising the world's best system and then not implementing it?-- Commissioner, I can comment about Townsville and Andrew's a colleague of mine. We both set up systems, I was at the Princess Alexandra Hospital, in fact, there was additional resource required for that and that came out of the previous quality funds - Commonwealth quality funds

which both Andrew and myself used to get a patient safety officer on board to assist, because you have to have someone, the legs to help you do this.

Well, I'll have to check the transcript but my recollection of Dr Johnson's evidence is that they managed to put a patient safety officer on the staff by cutting down on expenditure in the hospital administration, that they didn't get one extra cent out of Queensland Health in order to do that?-- Okay. Well, I haven't read or I wasn't there when Andrew gave his evidence, but I'm sure he would agree with me that one of the good things that Queensland did is quarantine those Commonwealth funds for activities like this, and one of the problems is that once those funds dry up, some of those resources go. Again, and I stress that this is what I've been fighting for and thankfully I've been given an opportunity to address this by setting up a small patient safety centre and providing resources to districts to fund Andrew's patient safety officer and patient safety officers under a similar model around the rest of the State, and in fact, the reason why Andrew's model was successful and I believe the model at Princess Alexandra Hospital was successful, apart from the having money and not a lot, a little bit of money, was actually strong leadership, passion, drive, enthusiasm to drive that for the right reasons, gaining clinical support in the hospital, and I'm sure Andrew would join me and - in actually stressing how vital that is, and it doesn't just stop at the hospital level, the Director-General has - and the Minister, I believe, have to be absolutely supportive and demonstrate the support that patient safety is the prime reason we're in business, and it's essential.

Doctor, we did touch on the issue relating to Dr Patel. Can I ask you to have a look at Exhibit 102, which is a report? You're one of the four joint authors of this report?-- Yes, Commissioner.

All right. Can I take you to page 20 of the report? And at the foot of page 20, you set out the Terms of Reference of your review team, that's the review team comprising Dr Mattiuissi, yourself, Professor Woodruff and Professor Hobbs?-- Yes.

Can you identify for me which part of those Terms of Reference as set by the Director-General was regarded at the time as justifying any of the members of the review team rifling through the personnel files at Bundaberg to review Dr Miach's registration status?-- Commissioner, I have made a statement in relation to that.

Mmm, can you answer my question please?-- Yes. Term of reference number 6, "Consider any other matters concerning clinical services at Bundaberg that may be referred to the review by the Director-General."

So there was a referral of Dr Miach's registration status by the Director-General, was there?-- No, we were instructed by the Director-General prior to undertaking or at the time of

being appointed as investigators under the Health Services Act to check into all of the credentials and privileges of all of the medical staff at the Bundaberg Base Hospital to check that there was no other problems existing there with other doctors, with other practitioners.

Correct. These Terms of Reference were issued by the Director-General on the 18th of April; is that right?-- I would have to go back-----

Well, if you go back to page 20 on the 18th of April the Director-General appointed investigators?-- Yes.

And at the same time he gave you Terms of Reference?-- Yes, Commissioner.

All right. When do you say that he referred other matters to you?-- I recall a meeting on or around that date - in fact, as I recall, it would have been on the day that we were formally appointed-----

Mmm?-- -----to conduct this inquiry, I recall a meeting with the review team and the Director-General whereupon he advised us to check the credentials of all of the doctors in Bundaberg Hospital.

And how did that relate to clinical services at Bundaberg? You see, paragraph 6, which is the one you identified, refers to other matters concerning clinical services at Bundaberg?-- The Director-General advised us in relation to those clinical - made a specific request that we undertake that review, and I guess on the review under the Terms of Reference number 7 also, "Should the review team identify other areas of concern outside the scope of these Terms of Reference, the Director-General is to be consulted to extend the Terms of Reference if considered appropriate."

But Dr Wakefield, paragraph 7 plainly doesn't apply, it wasn't a situation where, for example, from interviewing staff at Bundaberg you identified another area of concern and went back to the Director-General to ask him to extend the Terms of Reference, did you; there was nothing like that happened?-- No.

And in fact, there was no extension of the Terms of Reference, was there?-- There was no extension of the Terms of Reference.

So you agree with me paragraph 7 cannot conceivably apply?-- Commissioner, in relation to the instruction by the Director-General, I certainly personally regarded that as a specific instruction by the Director-General to extend the scope of the review to include that.

Did the Director-General by any chance put this instruction in writing?-- Not to my knowledge.

How curious. Now, whilst one of your team was digging around

in Dr Miach's personal file, you came across the fact that there was an anomaly with his registration; is that right?-- I'm informed that that was the case.

You didn't - you weren't involved in that exercise?-- No.

Who did it?-- Dr Mattiussi reviewed the medical staff, senior medical staff personnel files.

You would agree with me that that anomaly had absolutely no impact on Dr Miach's competence to provide services as a highly qualified and highly respected nephrologist in Bundaberg?-- I don't know that we were - I don't know that we were in a position to indicate that, Commissioner.

You knew that he was - had been a nephrologist in Victoria?-- I was aware of that, yes.

Yes?-- In fact, I think I employed him.

You knew he was fully qualified to hold his position in Bundaberg?-- As I say, I did not review his file.

Well, do you agree with me that as one of the four joint authors of this report, the anomaly mentioned on page 65 is not something that in any way compromised Dr Miach's clinical competence?-- As a matter of fact, I don't believe that it would.

Well, why wouldn't a decent person say to Peter Miach, "Look, we came across this irregularity in your registration. Why don't you make a phone call to the Medical Board and get it fixed up.", instead of putting it in a formal report, sending it to the Director-General and then seeing it get leaked to The Australian?-- Commissioner, the Health Services Act precludes us as investigators from providing any information to individuals.

Well, that's the point, you see, we go around in circles; it wasn't part of your Terms of Reference, you had nothing in writing from the Director-General, apart from a hint that he'd like you to look for some dirt on a few of the individuals there, and now you use the excuse that it was part of an investigation under the Health Services Act for not telling Dr Miach-----

MR FARR: Commissioner, I object to that question. That is not the evidence that the witness has given as you're putting it to him as a statement of fact from him.

COMMISSIONER: Well, what's wrong with getting it as what I've said? Those are the facts, aren't they?-- I would, Commissioner, I'd like to restate the facts: that the facts from my recollection were that we were appointed as investigators under the Health Services Act, we were made aware of our responsibilities under that Act, the Director-General provided us with a specific instructions, verbal instruction at the time of appointment that we were to

extend the Term of Reference to include the review of - or an assessment of the credentials of all of the doctors in Bundaberg Base Hospital so that he could be assured that there wasn't another Dr Patel "lurking" quote unquote, and the review team duly discharged that request. I personally was not responsible for analysing the report, I did not see the report, I signed off on that on the basis of what my - what Dr Mattiuissi told me.

Do you say to Dr Mattiussi, "Look, this is a bit of trivia, it will cause Peter Miach some embarrassment. Can't we speak to Steve Buckland and tell him about it privately rather than putting it into a report since it doesn't have anything to do with our Terms of Reference anyway."?-- Commissioner, as I said before, our understanding was that we were not permitted to do so under the Act, that there is penalty under the Act and that in fact if - I guess my question would be where would we draw the line in terms of what we would or would not disclose to individuals under that process? I stand by the actions that were taken by the review team.

And when Dr Miach orally extended the Terms of Reference, it didn't occur to you to say to him, "Look, Dr Buckland, if you want us to do your dirty work for you, then we want it in writing."?-- I guess at that particular time we considered it to be within the scope of what we were being asked to do.

And how did it find its way into the pages of The Australian?-- I have no knowledge of that.

Do you know Mr Sean Parnell?-- I have never met Mr Parnell, I do not know him.

Have you ever spoken to him?-- I have no recollection of speaking to him ever in the past.

Do you know any - of any connection between either of any of the other authors of this report and Mr Parnell?-- None whatsoever.

Or anyone else at the high echelons of Queensland Health?-- No sir.

Is that a convenient time, Mr Morzone?

MR MORZONE: Certainly, Commissioner, it is.

COMMISSIONER: Doctor, is it convenient for you to come back tomorrow?-- I will come back tomorrow, Commissioner, yes.

Is it convenient to?-- I'd prefer to come back tomorrow and complete my evidence if I could.

And is that in order with our schedule of witnesses?

MR MORZONE: It is. We have Dr Gaffield following this witness and then Dr Aroney in the afternoon.

COMMISSIONER: All right. Would 9.30 suit you, doctor?--
Yes, Commissioner.

9.30 tomorrow it is then.

THE COMMISSION ADJOURNED AT 4.49 P.M. TILL 9.30 A.M. THE FOLLOWING DAY