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Queensland Government
Department of Justice and Attorney-General

Transcript of Proceedings

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SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 19/08/200

..DAY 45

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THE COMMISSION RESUMED AT 9.55 A.M.

MR P APPLEGARTH SC (instructed by Minter Ellison) for Dr S Buckland

JOHN GREGORY WAKEFIELD, CONTINUING:

COMMISSIONER: I hope everyone will accept my most sincere apologies for the delay this morning. There have been some discussions about administrative matters connected with the inquiry which couldn't be put off any further. Mr Morzone.

MR MORZONE: Yes, before we start-----

COMMISSIONER: Oh, Mr Farr.

MR FARR: Just before we continue with Dr Wakefield's evidence, can I raise a matter which arises from yesterday?

COMMISSIONER: Of course.

MR FARR: In the course of your questioning of Dr Wakefield yesterday, you referred him to paragraph 49 of his statement that - the Patient Safety Centre statement, if I can call it that.

COMMISSIONER: Yes.

MR FARR: That was the paragraph that refers to the QH Legislative Projects Unit and the changes in legislation Dr Wakefield has been proposing since January.

COMMISSIONER: Oh, I recall, and I made some intemperate remark about that.

MR FARR: And it is that remark that I wanted to refer to.

COMMISSIONER: Yes.

MR FARR: I would like you to reconsider the remark that you made. I note it was not a prepared question and I'm not suggesting to the contrary but it has caused a great deal of offence to some people and - I probably don't need to go into the detail of that.

COMMISSIONER: No, I understand that entirely, and I do withdraw and apologise for the remark when I referred to a sheltered workshop at Charlotte Street. It's both inappropriate with respect to the people who work there and also inappropriate with respect to those members of the community who are required to work in such circumstances. It was something said in the heat of the moment and it was

inappropriate, as I said.

MR FARR: Thank you, Commissioner.

COMMISSIONER: Mr Morzone.

MR MORZONE: Mr Commissioner, Mr Applegarth is also here.

COMMISSIONER: Yes.

MR APPLEGARTH: May it please the Commission, I seek leave to appear for Dr Stephen Buckland, at least when he appears to give evidence, which is programmed for next Thursday.

COMMISSIONER: Yes.

MR APPLEGARTH: May I mention one other matter and that is this: when Dr Aroney was here and at page 3953 of the transcript, you, Mr Commissioner, mentioned, in the light of some evidence that Dr Aroney had given, that perhaps Dr Buckland, Dr Scott and others might - would have a chance to put their version of events to Dr Aroney.

COMMISSIONER: Yes.

MR APPLEGARTH: Can I just identify a practical problem that I have in that regard. I have only come into the matter in the last few days.

COMMISSIONER: Of course.

MR APPLEGARTH: And I have had a quick look at that passage of transcript. Just this morning, those who have instructed me obtained a copy of Associate Professor Aroney's statement through the good officers of the Commission but we don't have the annexures yet.

COMMISSIONER: Yes.

MR APPLEGARTH: So I'm conscious that Dr Aroney is due to give evidence today and the last thing in the world I would want to do is inconvenience the Commission, or Dr Aroney or his patients. Can I just flag though that I would like to obviously look at the statement, look at his evidence, take instructions and if I possibly can and if Dr Aroney is here this afternoon, to cross-examine him then, if I have instructions to cross-examine him. I may not. I simply can't say at this stage.

COMMISSIONER: By all means, Mr Applegarth, and we will do whatever is necessary to ensure that your client is not prejudiced, even if that means bringing Professor Aroney back on another occasion, possibly in the evening or at some other time that won't inconvenience his patients.

MR APPLEGARTH: Thank you very much. I hope it won't come to that. Normally I would think that in the time of the next few hours I could get on top of the matters because I wouldn't

expect that my cross-examination would be at large over all the broader issues that Associate Professor Aroney has dealt with. I imagine there'd be cross-examination, and any cross-examination I undertook would be in relation to anything he specifically said against Dr Buckland I apprehend.

COMMISSIONER: Yes. Yes.

MR APPLEGARTH: But I point out that difficulty. My other difficulty is I can't prepare all of that today because I've got to confer with my client today because he's been asked to give a statement to the Commission.

COMMISSIONER: Yes.

MR APPLEGARTH: So I find myself in that practical difficulty and I'm sorry if it causes any inconvenience.

COMMISSIONER: Look, it won't cause any inconvenience. It is unfortunate that Dr Buckland has not been represented in these proceedings for the last couple of weeks because there are quite a number of issues which have arisen on which no doubt he will wish to say something and, unfortunately, we're not in a position to having had his version put to other witnesses. But even the evidence we heard in Townsville involving allegations of Dr Buckland having covered up the situation in relation to the allegedly unqualified psychiatrist, those sort of issues-----

MR APPLEGARTH: Just so I - when you say cover up, you mean the decision that there shouldn't be a public release of that matter?

COMMISSIONER: That's what I understand cover up to mean.

MR APPLEGARTH: I just want to be sure because we haven't been told, and I'm happy to be told in greater specificity, not now - I don't want to take any time - if there are those sort of allegations, precisely what they are. Mr Morzone counsel assisting has indicated there will be a letter coming to us hopefully this morning identifying some matters that Dr Buckland would be asked to address in his statement.

COMMISSIONER: Yes.

MR APPLEGARTH: And so, we take what you, Commissioner, have said about matters that Dr Buckland will need to address in his statement and in his evidence, and we're doing our best, just having come into the matter, to get on top of those.

COMMISSIONER: The difficulty, Mr Applegarth, and I fully appreciate the delicacy of your position, is that Commissions of Inquiry tend to be a bit of a movable feast. We can't anticipate everything that will arise.

MR APPLEGARTH: No.

COMMISSIONER: For example, I learnt for the first time

yesterday afternoon from the current witness, Dr Wakefield, that he was specifically requested by Dr Buckland to go through the personnel files in Bundaberg of not only overseas-trained doctors but other doctors, including, for example, Dr Miach, which resulted in a set of circumstances which obviously caused and it may be thought were intended to cause considerable embarrassment to Dr Miach.

MR APPLEGARTH: Well, well-----

COMMISSIONER: That's the sort of thing that had Dr Buckland been represented throughout the proceedings, it would have been useful to hear his version put to the witnesses.

MR APPLEGARTH: Well, Commissioner, you can appreciate I can't engage with you at the moment about that.

COMMISSIONER: Yes.

MR APPLEGARTH: But it immediately occurs to me that if there was an instruction to the review team to review doctors, there might be an entirely innocent, sensible reason as to why that was done.

COMMISSIONER: Exactly.

MR APPLEGARTH: And one would need good evidence to think it was done with some sinister intention. If there was that evidence, no doubt it will be told to us.

COMMISSIONER: And no doubt Dr Buckland will have his own reasons as to why that wasn't put in the written instructions to the review team but made the subject of separate oral instructions we've heard from Dr Wakefield and there may be perfectly innocent reasons for that as well.

MR APPLEGARTH: We will rest on the presumption of innocence for the moment then and we will return to that matter no doubt.

COMMISSIONER: Thank you.

MR APPLEGARTH: Do I have leave to appear?

COMMISSIONER: Of course. And that leave is not limited to the period when Dr Buckland gives evidence. It is at large.

MR APPLEGARTH: Your Honour - sorry, presumptuous, premature perhaps. It may be that due to my other commitments early next week, if other counsel have to appear, it won't be me, but Ms Klease, K-L-E-A-S-E, may appear for Dr Buckland.

COMMISSIONER: We will try, if at all possible, to accommodate your convenience, Mr Applegarth.

MR APPLEGARTH: My convenience isn't that important because I know the time pressure the Commission is operating under.

COMMISSIONER: Thank you. Thank you, Mr Morzone.

MR MORZONE: Thank you, Mr Commissioner.

JOHN GREGORY WAKEFIELD, CONTINUING EXAMINATION-IN-CHIEF:

MR MORZONE: Dr Wakefield, yesterday we discussed the policies-----

COMMISSIONER: I'm sorry, Mr Morzone, there is one other preliminary matter I should raise. Ms Feeney, on Tuesday you mentioned that there may be developments concerning Mr Leck. I am not going to put you on the spot by asking you to tell us anything that you're not ready to tell us but can I say that we've reached a juncture where it is very important to focus on the timing of the inquiry and particularly whether any extensions of time will be necessary and if you have information that may be or if you receive information that may be relevant to that, can I urge on you the importance of letting us know as soon as possible.

MS FEENEY: Yes. Yes, Commissioner, thank you.

COMMISSIONER: Thank you.

MR MORZONE: Thank you, Commissioner. Dr Wakefield, yesterday we discussed the Incident Management Policy?-- Mmm.

Which is attached to your statements. There are two other policies that I wanted to put on to the record for completeness and can I ask you to look at, first of all, the Queensland Health Complaints Management Policy?-- Thank you.

That's a policy which accompanies or is accompanied by a work instruction and it sets out the roles and responsibilities in a general way of various persons within Queensland Health relating to complaints by consumers; is that correct?-- Yes, I understand so.

I think on page 1 of the instruction it expressly excludes complaints made by staff. It's aimed primarily at consumers?-- Yes.

I'll tender that, Mr Commissioner, if it please. It's a complaints management policy and I think the date, Dr Wakefield, on the top of that, the top left-----?-- I'm searching.

COMMISSIONER: I have a document in front of me called "Queensland Health Complaints Management Policy" with policy identifier 15184 approved the 23rd of July 2002. Is that the relevant one?

MR MORZONE: That's it, thank you, Mr Commissioner, yes.

COMMISSIONER: I hope that that doesn't mean that there are another 1,000 - sorry, 15,183 Queensland Health policies documented in this way?-- It's quite possible I would suggest.

Yes. The Health Complaints Management Policy will be Exhibit 292.

ADMITTED AND MARKED "EXHIBIT 292"

MR MORZONE: Can I also show you the Queensland Health Integrated Risk Management Policy. A copy that I give to you is dated June 2004 but attached to it is the superseded policy of February 2002 and I think they're substantially similar except there's some more detail in the work instruction; is that right?-- I would have to-----

Check?-- -----check.

But, anyway, they speak for themselves?-- Yes.

Perhaps I can ask you some general things though about that?-- Sure.

Again, we can see in that policy and, Commissioners, the copies that you have may have some extraneous pages in there in the middle of it which are pages from the Incident Management Policy. That's the appendix 1. They, strictly, should not belong in there but they're pages 17, 18 and 19 and they should be extracted from the Commissioners' copies.

COMMISSIONER: So that's the last three pages before the superseded section?

MR MORZONE: That's correct Commissioner, yes.

COMMISSIONER: We will remove that so we don't confuse ourselves.

MR MORZONE: Dr Wakefield, I think the copy I have given to you has had those extracted?-- Right.

That policy nevertheless repeats, does it not, the consequences of degree by severity of incidences that we saw in the integrated - sorry, yes, the integrated - the Incident Management Policy?-- Incident Management Policy.

And it seems in all detail the same, including in those respects to which the learned Commissioner took you yesterday and which I took you yesterday about the explanation for the degree of severity; is that right?-- Yes, my understanding is that, in fact, this is the source of that risk matrix that we saw in the Incident Management Policy.

But this document came first?-- Yes.

That document on its face seems a relatively bland document in terms of detail and, again, it would seem the expectation is that local districts will implement their own integrated risk management policy; is that correct, do you know?-- That is my understanding of this policy, yes.

Then obviously there are roles and responsibilities which speak for themselves set out in that policy but I don't see where there is any requirement for audits to be done of hospitals about the implementation of that policy or further feedback - sorry, not further feedback, further input coming from Queensland Health about the details of that policy. Are you able to help us further with that or is that something that you can't?-- Look, I think I would like to make a couple of comments about this. First of all, the risk management policy, the integrated risk management policy, my understanding is that this is consistent with the Australian Standard for risk management 4360 and this is widely used across industry generally. So this is consistent with Australian standards. In terms of its development, I really cannot comment. This is not something that - that I have authored or had a part in authoring. I'm not here to defend this particular policy or, indeed, the policies we have already discussed. My role in the Patient Safety Centre is specifically to address the issues of particularly in relation to the policy that relates to the Patient Safety Centre, which is the Incident Management Policy, and to make sure that that indeed is changed to have greater relevance to clinicians.

Yes?-- I think, as I mentioned yesterday, the Incident Management Policy is a generic incident management policy. It covers events that affect patients as well as events that affect non-clinical areas such as breakdowns or whatever the case may be. So I think it's been clear to me, and this is one of the drivers for me wanting to progress this clinical patient safety agenda, is that we need to take a clinical focus on to these matters.

Okay. Now, can I ask you about possible steps that could be taken and tell me whether or not you agree with them?-- Yes.

The first it would seem to me, with all these policies, that some sort of compliance review or compliance audit done by a centralised organisation would be appropriate; do you agree with that?-- Absolutely agree with that. I think Queensland Health has a strong focus on auditing the non-clinical components of its work and it's my - it's my opinion that there had been very little focus on compliance with clinical aspects of work.

That leads me to my next question. All three policies don't seem to have a focus upon clinical competence; am I right about that-----?-- Correct.

Or not specifically enough anyway?-- Individual clinician

competence, I agree.

Yes. I think we have heard evidence already that the problem of clinical competence, first of all, should be a jurisdictional Queensland-wide responsibility rather than just a local responsibility; do you agree with that?-- Absolutely.

And it's not enough to simply assume that a body like the Medical Board, which is a formal body, will deal with it within its own legal framework; do you agree with that?-- Within the current environment I would have to say that I don't believe that that's - that's the case. I think - it appears that there is - that the function of assessing individual clinician performance is not being done well by anybody. The question is who should do that. Should it be the Medical Board of Queensland; should it be Queensland Health; or should it be - should there be aspects of both, an internal and an external regulator, and I'm happy to elaborate on my thoughts about that.

I would be happy to hear them, that's what I was going to ask. First of all, you agree there should be some sort of body which deals with clinical competence and deals with it presumably in an open way. I guess you'd agree with me generally that, and I think you've said this in the team review report, that there needs to be a system which encourages a culture of reporting openly and honestly, and that presently there's a culture of non-reporting, because I think you said in the report, "Many staff thought there was no point in reporting incidences as nothing happens." Plainly, that sort of culture has got to change?-- Yes.

And there has got to be an ability to, I'm sure you'll agree, raise genuinely held concerns about clinical competence, know that they'd be dealt with and dealt with confidentially and that any culture of - or any barriers to non-reporting caused by fear of reprisal or a culture of dobbing on fellow clinicians has to be discouraged as best as one can. You'd agree with all that, they're pretty simple propositions?-- Agree with all - yes.

So what's your thought about how we can go about establishing that sort of clinical competence review so to speak within Queensland Health or elsewhere-----?-- Mmm-hmm.

-----or by an independent body?-- Right. Okay. I'm led to believe that New South Wales has done a fair bit of work in this area but I would like - and I think that we can learn - we don't have to re-invent the wheel. I would like to raise two issues in relation to your question that I would like the opportunity to put on the table. The reason, as I have already said, the evidence is that people don't report because they don't see anything happening and because they are scared, they fear it. And I think - the analogy that I would use is how many of us would self-report that we broke the speeding limit when we know that, in doing so, we'll get a ticket. We have to make it such that there is - there is justice, that there is a just system around reporting when

things go wrong, which means that we have to clarify - so it is not a no blame system. Everybody keeps quoting there is no blame but that's not the case. Everybody knows that there are blame worthy behaviours. So I think it is, in both legislation and in policy, we clearly have to outline what is blame worthy. Now, again, other jurisdictions have done this, and blame worthy events would be deliberate harm which would include, I believe, misrepresentation of one's self and oneself's credentials, and criminal acts, acting under the influence of illicit drugs or alcohol whilst providing care, or deliberate patient abuse.

These, I think nobody would argue, that in those cases, those are blameworthy. In the rest of the cases where things go wrong, where there's been no deliberate attempt to harm, that the just approach to that is to, is to take a system's view, to not blame the individual, to say well, this could have happened to any well intentioned person and our job is to acknowledge that it's happened to the patient and find a way of see whether we can learn and prevent that from happening again. So that's the systems issue. What you're talking about is the individual issue. Now, when this, this is crucial at the interface of individual verses system that we get the right - you cannot mix them up and I think that's what we've done to-date. From an individual perspective, the question that one would first ask as a medical superintendent, for example, when something goes wrong, is is there an individual provider, is this an issue of competence? If the answer to that is possibly or yes, then we need a separate system to manage that. Now, that would involve - and we need to go backwards first - that would involve first of all having a system of clinical - clinician performance appraisal and development, so that we can set the standards for what is appropriate clinical competence up-front and we can monitor that prospectively before things go wrong, so if you like, park the ambulance at the top of cliff, not the bottom of the cliff, we don't have that at the moment. We would need to have a decent system for assessing doctors when there is concern raised about their individual clinical performance with a strong focus on patient safety first, but also protecting the doctors's interests, and we don't have that either. So when something - when there is - when there are concerns about a clinician's performance, you might be surprised to know there is no formal process that we can use to assess that at the moment, and-----

And what sort of concerns-----?-- -----and beyond that - can I just finish? Beyond that, having identified that a clinician's performance is below par, there needs to be a system of remediation. Now, Commissioner, I know that you went to the Skills Development Centre and there are systems there to provide remediation for doctors, but you can't do that unless you can identify they're below par to start with, and then we have to have a process of re-certifying the doctor afterwards, so when once they've been through remediation to assess whether they can go back in at the workface at their previous level or whether we have to constrain their practice. Now, I believe that we need to work very quickly on those things to get some structure and that to make it work, I think that requires a strong partnership with the Medical Board and with Queensland Health and also the professional organisations, obviously the colleges particularly to get that right. But it needs to be open, transparent and I think our staff need to understand how they will be treated because they will not report and it will not be open and transparent to help us learn from errors and mistakes if when they report an error, they get beaten up.

COMMISSIONER: Doctor, everything you say is music to my ears, that that's precisely the sort of things I've been waiting to

hear during the evidence that we've heard. I just wonder though if there isn't a fundamental flaw in the whole approach that you're articulating, and that is what I perceive to be a fundamental conflict of interest between Queensland Health as a service provider?-- Mmm.

And Queensland Health as a regulator?-- Mmm-hmm.

If you are re-writing the system of administration of hospitals, you wouldn't, for example, give Mayne Health or one of the other private health service providers control over the administration of the system and yet we've got for historical reasons a situation where the department is the biggest supplier of health services and also one of the major bodies involved in oversight and regulation?-- Mmm.

From what you've just said, I think a lot can be drawn towards the model of having an independent authority which is responsible for things like patient and public complaints, complaints from within the system both public and private and also proactive oversight and monitoring-----?-- Mmm-hmm.

-----or auditing, if you like, so that Queensland Health isn't put in a position where, for example, if a nurse at Bundaberg wishes to make a complaint about a clinical issue, she can or he can only really complain to their employer, to the people who hire and fire them, decide whether they get promoted and so on and so forth, so that it's quite outside that line of control, that silo, if you like?-- Mmm.

Of management of operating hospitals and the complaints go off to someone who will scrutinise it independently?-- Mmm.

How do you feel about that?-- Commissioner, I agree with you. I think that the external monitoring and regulation has been lucky.

Yes?-- And that there needs to be that function - that function needs to be in place, but as I emphasised yesterday, that's crucial.

Yes?-- But what - but the question is whether that independent group would be able to develop the sort of processes that will be necessary to actually have something to comply with, if you see what I mean. So the question is does the Commission or that organisation set all the standards, develop all the frameworks or is that done internally but it's externally monitored?

Well, you make a very valid point, but at present, if we contrast public with private at the moment, you have, as I understand it, the chief health officer's office, Dr Fitzgerald's office, which is in a rather unusual position, it's part of Queensland Health developmentally but it has a certain autonomy?-- Mmm.

And that office has a significant role in fixing operational requirements for institutions like nursing homes and I think

even private hospitals?-- Mmm.

One of the things I would like to see is that office removed from even the appearance of being under departmental control and having a set of standards which are transparent across all sectors of the health community so that if Dr Fitzgerald's office says this is the minimum standard for auditing, then everyone has that minimum standard for auditing?-- Mmm.

And patients at the Mater or the Wesley or St Andrews don't - aren't in a position where they get a better standard of risk management and clinical care than public patients at the PA or the RBH?-- Mmm.

That's my objective anyway?-- Mmm-hmm. Commissioner, I think that sounds like a worthy objective, that the same standards would apply, and perhaps again drawing the aviation analogy, if we look at how aviation has managed this over the past 30 years, they have a regulator, CASA is the regulator.

Yes?-- They set the standards and regulations and monitor them, then you have the independent accident investigation authority, commission or transport-----

Yes?-- It's a Federal body, which is independent, has no teeth, it just makes recommendations when things go wrong and then the business is required to comply and develop and implement those regulations and the recommendations from the accident investigation, and I think the model that you're proposing is far more reflective of that separation of powers.

And in fact, it's a perfect example, because for many years the system you talk about operated whilst organisations like Qantas and TAA were government owned?-- Yes.

But it was recognised that you couldn't have Qantas and TAA, even though government owned, setting their own standards, they had to come under some independent autonomous standards or regulations authority. I know it's different in other parts of the world, and part of the reason for that is that, for example, in the United States, airlines are privately owned and always have been?-- Mmm.

But nonetheless wherever you go in the world, there is an independent regulatory authority that says firstly, these are the standards you have to comply with, and secondly, has the resources to investigate noncompliance, generally speaking, not so much in a punitive way of finding someone to blame, but in a sense of making sure that it doesn't happen again?-- Yes, and in fact, I'm aware of legislation that specifically protects individuals against action by their employer.

Yes?-- When they report particularly near misses when things nearly go wrong because they - so they're focussed on improvement, not on the punishment.

The difficulty I have - and I must have forgotten to take my happy pill yesterday or something, I apologise if I caused you

any discomfort whilst you were in the witness box yesterday afternoon - but the difficulty I have is that there seems to be this attitude within the Queensland Health administration that producing papers setting out policies is a substitute for actually doing something to ensure they're implemented, and Mr Morzone has made the point that - well, I made the point yesterday afternoon that there aren't the resources provided to do these things, and Mr Morzone points out there isn't the compliance or the auditing necessary to make sure that they're dealt with?-- Mmm.

And that's why I think we need to take these sort of issues out of the hands of the service provider so Queensland Health can concentrate on what it does best?-- Mmm.

And that is providing health services and let someone with their own budget decide their own priorities in ensuring patient safety standards and risk management?-- Mmm-hmm. It seems to me that that would probably be a resourcing issue in terms of who makes the decisions about where the resources are spent, and I think we discussed yesterday that how do you trade off the very important work of reducing patient - unintentional patient harm with not having enough doctors and nurses on the floor to deliver care? And I think you're suggesting, Commissioner, that that will be made by an external body.

I think that's right?-- Yes.

And I think also it's necessary to not to lose sight of the wood for the trees?-- Yes.

A lot of what we see generated from Charlotte Street is consistent with world's best practice, and I wouldn't dispute that for a moment, but there's no point having world's best practice in theory if doctors are being forced to work 30 hour shifts and patients are being forced to wait three and four and five years to see a specialist. So any sensible analysis of the allocation of resources has to take into account that preventing a one in 10 year risk from materialising may not be as important as ensuring that people who are referred by their GP to see a cardiac specialist see that specialist within six months, and that's where there needs to be some prioritisation that involves providing the best possible health care to the largest number of people within existing budget frameworks rather than aiming at world's best practice but having people waiting for years to get a service which, when they get it, will be world class?-- Mmm-hmm. I don't think I can argue with anything that you've said there, except perhaps to say that my evidence-in-chief, I believe, outlines the degree of harm that we inadvertently caused to patients.

Yes?-- So I think again it's a question of what is the best use of the resources, the limited resources that we have and I take it that's what you mean. I feel very strongly about patient safety and I'm very prepared to argue very strongly for it. The decision as to whether dollars are put towards that - that activity is not my decision and nor should it be.

You see, one of the other problems I have with all of the paperwork that seems to get generated from Charlotte Street is that, to be candid, most of it is just basic commonsense?-- Mmm.

You can have the most sophisticated systems and networks in the world, but unless a hospital's run by someone with commonsense, it's just a waste of time and effort. On the other hand, if you have someone with commonsense running a hospital, they don't really need detailed handbooks and specifications to tell them how to avoid risks. One of the - one of the dramatic changes in hospital management in Queensland over the last 10 or 15 years has been moving away from having clinicians with hands-on experience with patients running hospitals to having people who may be the world's most competent administrators but are not practicing clinicians and don't have that patient focus, and to be fair to them, are often put in a very difficult position because they're under constant pressure to achieve budget targets and that sort of thing, so they really don't have the opportunity to exercise the sort of commonsense that an old fashioned medical superintendent might walking around the ward and saying, "Look, someone should clean up that spill over there because otherwise a patient's going to slip over."?-- Mmm.

Now, you know that sort of commonsense is, in my view, worth literally hundreds of millions of dollars worth of research and documentation and programs and so on; how do you feel about that?-- Oh - how do I feel about that? A couple of things: I think the role of competent administrators is incredibly undervalued, medical administrators I speak particularly about, and it almost seems to me, and I agree with what you say about commonsense, the bottom line is this is a - this is about people, it's not a business about dollars, it's about if you look after people, both staff and patients, you'll go a long way towards having a good server. Having said that, health care has moved on from even in the time in the 17 years that I have been working in the Queensland Health environment, and has become significantly more complex. What we haven't - what I don't think comes by way of commonsense is the fact that if you just have well trained people and stick them in a ward or an operating theatre, that they will deliver good outcomes, that you actually need systems, for the same reason, I think, that when you get on an aeroplane, you expect that that pilot is going to go through a standard series of operating procedures before you fly.

Yes?-- And I can tell you that we have many cases across the country of wrong limbs, wrong organs being operated on, not deliberately, by accident, because we don't have those standard basic checks in place, and that's one of the programs that we are currently progressing with the College of Surgeons and the College of Surgeons have been very supportive of that, but that's just an example of the fact that I think that if we ignore the complexity of the world that we live in, just trying our best and having commonsense is probably not going

to get us there, it will get us part the way there but we will not - it will not be the best, it will not be world class, and we strive for the best that we can deliver and the safest that we can deliver.

Doctor, whilst I acknowledge and respect your passion for your patient safety angle?-- Mmm.

The counter argument to that is what the sort of things that I'm sure the other two Commissioners along with myself keep getting told?-- Mmm.

Socially and hearing anecdotally: I was told recently by a friend who's a psychiatrist that there are as many psychiatric beds at the New Farm clinic as there are at the Royal Brisbane Hospital?-- Mmm.

But the New Farm's clinic run by three administrators, the Royal Brisbane Hospital psychiatric department's run by 23. That may or may not be statistically accurate, but it suggests that it's not merely the increased complexity of modern medicine that causes Queensland Health to have such a large proportion of its staff devoted to essentially administrative tasks?-- Mmm.

Is that unfair?-- I can't comment about the psychiatry situation, I don't know that. If you're asking me whether I believe that the bureaucracy has become too big and that we need to stop producing policy that has no - that's not implemented or is not - unnecessary, then the answer is a resounding yes. I think that there is a need to critically appraise bureaucracy and really consider what value that adds to patient care, and if the answer is that that adds significant value, then it needs to continue, and if it doesn't add significant value, then the question has to be raised about whether it should be there. So that's the long-winded answer, but the short answer is yes, I think we have too much bureaucracy, yes, I believe we have too much policy, we could do away with a lot of it and just have the important policy that really leads to improving patient care and let our intelligent, well-trained staff have the leeway to make decisions about things that are not necessary to have policy about.

Another piece of information provided in one of the submissions we've received indicates statistics that Queensland Health has a staff of some 63 or 64,000 people?-- Mmm.

That out of those 63 or 64,000, 1,300 are doctors and that includes not only doctors who are practicing clinicians but doctors like yourself and Dr Lennox and Dr Keating and Dr Buckland and Dr Scott who are not either immediately or primarily involved in patient care, another between 13 and 15,000 are nurses; that means that four out of every five of those employees are non-clinicians. Now, I accept without hesitation that a lot of those people are essential to a good health care system, a lot of those people do important work

like Dr Keating in running a hospital, a lot of them do important work, whether it's cooking food in the hospital kitchen or making beds or tending the gardens or whatever, but it still seems, to my way of thinking, at least, extraordinary that our health care system needs four people behind the scenes to support every one person providing immediate care to patients?-- Mmm. Commissioner, I'm not an expert in knowing what the appropriate ratios are, and I accept what you say. I'd like to reiterate the fact that I think that as a clinician - for most of my professional career I've served the Queensland community as a clinician, I'm aware of the significant barriers that clinicians have in getting through their daily work, and I believe that it is worthwhile having a good hard look, and I'm pleased that this is occurring, at what - at the functions of our bureaucracy, not focussed on personalities and people, but on the functions, and to make sure that the majority of the resources that we have that do not need to be applied behind the scenes are actually provided to clinicians to help them do their job more safely and more effectively, and I think that that requires a real commitment to providing clinicians at the front line with those - with those resources. So we need to go through the place with a fine tooth comb.

Yes. Thank you.

MR MORZONE: You referred to systems for remediation or rehabilitation and systems for re-assessment?-- Mmm.

Do you want to be more particular about that or is that something to be thought of more closely?-- I think from my involvement in the review team, you know, and my experience previously as a medical superintendent, I think there's very little support for you in that situation when you're facing these sort of issues. So, having said that, it is not the patient safety - it's not the area of work of the Patient Safety Centre, it needs to be a body of work by perhaps this external regulator that would set those standards. So I can't speak with expertise on that. All I'm saying is that those - those systems don't exist at the moment, and it's not just that Queensland is a long way behind the rest of the world, in fact most jurisdictions have struggled with this, so we need to - it's not going to be easy but we need to actually get on and do it.

Okay. A couple of other quick things: first, is there a positive duty on staff at present to report clinical incompetence of obviously a serious enough nature to justify reporting, do you know?-- Not to report clinical incompetence, I mean, that's a value judgment, so I'm not aware of any duty. The duty that, under the incident management policy that we've already spoken of, is that staff should report sentinel events.

Yes?-- So that the policy mandates the reporting of sentinel events.

Yes.

COMMISSIONER: It's a bit like going back to what you said before, that they have to report when someone's dropped off the cliff if they're at the bottom of the cliff but there's no obligation to report that someone's teetering on the brink of the cliff?-- Mmm, so if - that's not the only way we can pick - we can get that information, there are other ways that we can get that information through a range of mechanisms: working with the Coroner, for example, we've worked very hard with the Coroner to get liaison with their - to make sure that we get the reports and feedback on recommendations from the Coroner; we have a range of other systems in place; chart reviews and so on; every patient in hospital is coded by a coder, their care - sorry it's coded so we've got various ways of looking at where these things occur, but the question you asked me is is there - is it mandated? Not that I'm aware of.

MR MORZONE: There are a couple of other very quick things I wanted to ask you. You mentioned in your statement - or you have provided in your statement your responses to Dr Anderson and also Dr Stumer's testimony?-- Yes.

And I don't want to go over the details of that, or necessarily to define who was correct and who wasn't. There are a couple of things I wanted to ask, though-----

COMMISSIONER: In fact, Mr Morzone, I am not sure there is any merit in taking those issues any further. We have heard Dr Anderson's version of what occurred. We have now got the benefit of Dr Wakefield's version. This Commission is not going to resolve those issues.

MR MORZONE: I won't take them-----

COMMISSIONER: I think they are just a part of the history to what happened in Bundaberg rather than part of this inquiry.

MR MORZONE: I accept that, Mr Commissioner. Perhaps one question that arises out of them, in those instances obviously you - that is Dr Anderson, Dr Stumer instances - you saw merit in immediate suspension of those practitioners. And we know, of course, in the Dr Patel case that didn't occur. And you weren't involved of course in the Dr Patel case but as a general guide to suspension, what in your opinion should motivate suspension of a practitioner?-- Those two cases were very different, they just happened to occur around the same time. Perhaps if I can deal with - in the case of Dr Anderson, the issue was one of-----

COMMISSIONER: I am sorry to interrupt you.

MR FARR: I know what evidence my friend is trying to lead and I have no objection to him actually asking the very leading question. He has discussed it with my client.

COMMISSIONER: Can I put it this way, Dr Wakefield: you said earlier that we should look at things devoid of focussing on the personalities involved. I wonder if you can leave Dr Anderson and Dr Stumer out of it and just tell us in a general sense what you think are the important considerations in deciding whether to suspend a person pending investigation or whether to allow them to keep working as a clinician whilst under investigation?-- Okay, I would be happy to do that. I can only speak for myself. I have already indicated to you that there is very little in the way of formal process to assist you. If being faced with a range of complaints about a clinician's performance by staff, clearly one has to assess first of all the - verify those issues that have been raised. My own perspective on that is that if a member of staff takes an issue seriously enough to put something in writing about another member of staff, then that really does require my attention - and we're not talking about the specific cases that you referred to, but where that's from multiple sources, then the process that I use, the first question that I ask myself is if these allegations are proven to be correct, would

there be significant risk to patient safety. And if the answer to that question is yes, then I see that I have a duty to act in some way. Now, it depends upon what the specific allegations are as to whether that might be reducing the scope of practice or removing privileges altogether pending the formal investigation by a third party of that - of the allegations which cannot be conducted by me. But as the decision-maker, I would want to be provided with that information so that I could make a final decision on what to do. Now, all that has to be done with natural justice and without prejudice to the individual. It is a very, very difficult situation to be in for the doctor, for the person who is making that decision, incredibly difficult decision to make, but I think you either - there are cases where you have to primarily look after the patient, and sometimes that provides a conflict with looking after the doctor. So that was my process for managing it.

MR MORZONE: Okay, Mr Commissioner, I should tender that second policy I referred to, the integrated risk management policy.

COMMISSIONER: The integrated risk management policy, policy number 13355 with the operative date of June 2004 will be exhibit 293.

ADMITTED AND MARKED "EXHIBIT 293"

COMMISSIONER: And I should note that that 293 also includes the superceded version of the same policy which had the operative date of 20 February 2002.

MR MORZONE: Thank you, Mr Commissioner. That's the evidence-in-chief, if it please.

COMMISSIONER: Doctor, a few matters that I wanted to raise with you regarding Bundaberg more specifically, from what we have heard, the period when you were particularly in charge at Bundaberg as Director of Medical Services is viewed by many as the golden era of Bundaberg Base Hospital. You had some exceptionally good surgeons and no doubt very good clinical staff in other parts of the hospital. Would you agree with that much in the least?-- Yes.

I have-----?-- Perhaps I could qualify. I wasn't aware that it was viewed as the golden era, but we certainly did have some very capable staff.

It is also apparent from the evidence we have heard that Dr Brian Thiele had a very strong following amongst both patients and staff at the hospital and, as I commented previously, succeeding in his position would be a bit like succeeding Don Bradman as captain of the Australian cricket team. He did have that sort of following, didn't he?-- Yes,

Brian is a very well respected senior clinician and there is also - originated from Bundaberg, so has family there. So I think that Brian had a great deal of respect, deservedly.

And he also came across, at least in the witness-box, as a very charismatic man that would attract that sort of loyalty and support?-- Uh-huh.

At the time you were there, no-one could regard it as an Area of Need for surgical purposes?-- It was still a challenge.

Yes. It strikes me that one of the fundamental problems, specifically with reference to Patel, is that Bundaberg, with some extremely good and some competent Australian-trained surgeons, lost the benefit of the services of those surgeons as VMOs. I am talking about Dr Thiele, Dr Anderson, Dr Baker who was there as a Director of Surgery, Dr Nankivell who was there as a Director of Surgery, Dr-----

MR MORZONE: de Lacy later.

COMMISSIONER: Well, de Lacy came later, Dr Kingston who filled in. It seemed a remarkable degree of talent for a town the size of Bundaberg. Is that an overly generous view?-- I think that there was a good spectrum of surgical practitioners both in the public and private sector, yes.

You had at the time the two private hospitals running in Bundaberg and obviously running successfully and profitably with the use of those private surgeons?-- I can't comment on whether they were run successfully and profitably. My understanding is that anecdotally there is only room for one private hospital in Bundaberg, but - anyway, there were two private hospitals in Bundaberg, yes.

See, if anyone had applied at the time, the Act says an Area of Need, which is essentially a place that doesn't have enough surgeons, if we're talking about surgery for the moment, it seems to me no-one could sensibly have said Bundaberg needs to have had someone brought in from the United States or anywhere else in the world to make up a complement of surgeons necessary to support the population of that city?-- I don't agree with that statement, in the sense that when - in terms of providing surgical services, the question is what is required in the public sector to provide those services and who is prepared to provide that service, and I think that if private medical practitioners are not willing to provide that level of service in the public hospital, then the public hospital administration has to get - has to go to the market to find the practitioners.

The suggestion we have repeatedly heard, though, is that any unwillingness by private surgeons and other private specialists has been the result of decisions which make it unattractive for them - and I am not talking about how much money they are paid - that seems to be the least concern of any of the VMOs, but inconvenient scheduling arrangements, inconvenient arrangements to allow them to run their own

private practices, even seemingly trivial things like giving them carparks at the hospital so they don't have to park down the road and walk to the clinic, providing doctors common rooms so they can sit with their colleagues and have a cup of coffee and talk over issues. That sort of thing. There has been somewhat suggested a deliberate strategy to squeeze them out by making it unattractive for VMOs to work in the public sector?-- I am not aware of any deliberate strategy to take VMOs away. Certainly I have not - no deliberate strategy to remove VMOs during my time in Bundaberg and subsequently at the Princess Alexandra Hospital. I think it is important to have a mix of visiting staff and full-time staff.

In the case of Dr Patel, we have learnt that he was appointed not only as staff surgeon but as Director of Surgery without going through any credentialing or privileging process. Would you agree that that is unacceptable?-- Certainly if that's the case, then yes, it is unacceptable.

And we have also learnt that on one view of the evidence he was appointed as Director of Surgery even though he was granted registration by the Medical Board on the specific footing that he would be staff medical officer under the supervision of a Director of Surgery. Would you agree that that's unacceptable?-- In those circumstances, I think that's a question that would need to be asked for the decision maker. I think in the absence of a person to manage the surgical service, one would have needed to make a choice, I suppose, about whether - whether to appoint as an acting director and find the relevant supervision. So you are asking me straight whether that's unacceptable and in the case that it contravenes the Medical Board's requirement, then the answer is obviously yes.

The other thing that has come to our attention over the last couple of weeks is that Dr de Lacy, who had been - I think I have got this right - Director of Surgery at QEII and also worked as a surgeon at the PA, and from everything we have heard, a very talented young surgeon, arrived not long after Patel, offered his services to the hospital and was refused the opportunity to work there. Had you still been Director of Medical Services in a situation where you had Patel as acting Director of Surgery in the circumstances I have outlined, would I be right in thinking that you would have been anxious to capitalise on the fact that there was a young, new and highly talented surgeon in town and done what you could to utilise his services at the hospital?-- I could only speak for my approach to those sort of issues. We had a similar situation with the orthopaedic specialist who came back to Bundaberg whilst I was medical super for private practice, and whilst I was very anxious to get - to attract that doctor to the hospital, there was an issue of how I was going to be able to afford to do so, given that one of my significant responsibilities was to manage the financial aspects of medical practice, and it is not so much that medical officer's salary, it is the 10 times - it is the cost of providing the service that supports that doctor. So it is often 10 times the doctor's salary.

Yes?-- So the question is what is my approach to that and my approach is to - if I did not have the financial resources to do that, which I can tell you that I was always significantly overbudget, which caused me a lot of pain, that I would be progressing a business case, as I would be required to do, to justify the additional resources to put that surgeon on. And the only source of funds that was available for that was the elective surgery fund which is what I did. So it took a little bit of time but managed to get the surgeon on. The problem is that that fund could only provide annual funding. So there was an issue of temporary appointments required. So the system actually made it very difficult for me to do that.

Doctor, I hear what you say and it really raises another of my very deep-seated concerns. You talk about putting a business case forward, and so on. I expect your experience would be similar to that of other witnesses we have heard that you put your business case forward, let it go up through the various tiers of administration, and you would either hear nothing back or hear nothing back for many, many months, and often when you did hear something back, you didn't know who had made the decision or what they took into account, or what was wrong. Is that the sort of experience you had?-- That certainly occurred for many business cases. I mean, this was - so the answer is yes.

See, I am inclined to think it would all operate much more efficiently if the decision-makers for Bundaberg - and just using Bundaberg as an example - the decision-makers for Bundaberg were the management and community representatives at Bundaberg, and if the Director of Medical Services or the Director of Surgery wishes to argue a case for a greater allocation of the total budget, either to add an extra doctor to orthopaedics or general surgery, wherever, that person can deal directly with the decision-makers. Obviously the decision-makers would have a finite budget themselves. They would be allocated X million dollars by Queensland Health and they would know that if they put on Dr de Lacy or the new orthopaedic surgeon, money they will have to find from somewhere else, but at least that decision would be made transparently with knowledge of all the local circumstances and the relevant facts rather than by a faceless decision-maker down in Brisbane?-- Again, I think this could be a case of throwing the baby out with the bath water. We talked yesterday about some of the risks of having no central approach. I am a supporter of limited central approach, mainly around supporting rather than controlling.

Yes?-- And the external oversight. So that's the first point. I think the soaked point is that I agree with you that there needs to be a much more transparent process for addressing some of these requests for funds. I have worked for a long time in a provincial setting. In fact in Bundaberg. And also in a metropolitan setting and I can tell you that there are vast differences between the way - in the difficulties faced in providing the service. In a metropolitan sense there is always a hospital a few minutes

down the road, there are still many, many challenges but it is possible to turn elective surgery on and off like a tap in some respects. You pull people in do more surgery, you let them go. Whereas in a place like Bundaberg or any provincial centre, the people capital, the doctors and nurses and other health Allied health staff are actually there 24/7 for the whole community. You can never close the door or send people to another city - to another hospital, sorry. You are it. And it is - the model that was used for funding additional services was only around elective surgery and, yet, our problems in fact were only partly elective surgery. Our problems were providing a sustainable service 24/7. So I think we need to take a much more holistic approach to the ways those issues are addressed to create a more sustainable service.

I certainly agree with that, and let me make it clear I wasn't suggesting for a moment that we go back to the situation which one witness described as each hospital Board being its own bailiwick and having complete autonomous control. But it seems to me that for day-to-day decision-making, it would be in everyone's interests if that occurred at the local level. And I will take a silly example - probably is a silly example - Dr Miach told us how he wanted to participate in a national kidney day, just a sort of publicity event that allowed people on renal dialysis, and so on, to meet with other people in a similar situation, promote community knowledge, and so on, and he put in his submission and he got a reply back after it had gone all the way up and all the way down through administration. The only problem was that by the time he got the reply back, the day had come and gone and it was too late to participate. That sort of decision making, it seems to me, can only sensibly be made locally. Now, that doesn't mean for a moment that you won't have central guidance on things like patient retrieval audit systems, buying systems, accounts programs, all those sort of things that are done more efficiently and better at a statewide level. But when it comes to a Director of Surgery saying - or a Director of Medical Services saying, "There is this bright new orthopod in town, I would like to see if we can give him a couple of sessions a week to keep him in town, to utilise his services to build up our resource of clinicians and so on". Then the local administration should be able to say, "Well, we can squeeze some money out of another section of the hospital and use it to go ahead with that project."?-- I think it depends on what value you place the dollar versus the other aspects of health care, the productivity and the quality. I agree with you there needs to be far more local capacity to make those decisions and to be able to source resources, but it is essential, so that we don't get into great strife, that when we put on doctors, that we have consideration for the knock-on effects of all the costs. So I really can't support the notion that it is just a case of, "Well, let's put the doctor on and allocate a couple of sessions" without looking at the nursing staff, the ICU, the beds, all the other things that are necessary.

I accept that entirely?-- So we have to go through that

process.

But a local administration can do that as well as Charlotte Street. That's the reality, isn't it?-- They are required to do that now. I guess it is a case of what sort of hearing they get about the money and how - how the decision is made about yes or no and what transparency there is around that decision. That's where I think we can improve.

D COMMISSIONER EDWARDS: And what flexibility. It seems to me, hearing this over the last few weeks, has been the inflexibility to local hospitals in budget allocation is a major concern?-- Yes.

COMMISSIONER: One of the examples - again, I know these things are only anecdotal and individually they may not be very important, but we've been told, I think, that any doctor employed by Queensland Health who wants to utilise his or her contractual entitlement to participate in a conference, if the conference happens to be outside Australia, that has to be approved by the Director-General personally. Even though the contract says the doctor has a right to attend that conference, I mean I cannot for the life of me understand why at the very highest the regional manager couldn't make that decision rather than referring it to Brisbane. Those are the sorts of things?-- Yes, Commissioner, I totally agree with that. Whilst I was at the Princess Alexandra Hospital, I - the visiting medical officers get a moratory for funds for conference leave and it seems to me quite ridiculous that subject to a local approval process that they can't book and pay for their own tickets and claim that back to the amount they are owed, why we would have to go through in-hospital - why we have to use in-hospital resources to source those fares where often they can be sourced cheaper anyway by the doctors themselves, and I think the same thing occurs for the full-time specialists. It seems to me quite ridiculous that - in fact, it is not the Director-General now, I understand it is the Premier, so it goes - the request for overseas travel, which is an award entitlement, in fact, for study leave has to go through the district manager, the zonal manager, the general manager, the Director-General, the Minister and the Premier, I think at the moment, or at least the Minister. And the same - and frequently the pressures at that level are such that there is great delays in being able to approve flights and get attendance confirmed.

And in many cases-----?-- I don't think it makes sense.

-----either the conference is over by the time attendance is approved or the conference is so imminent that there is simply not time to make the arrangements for a locum and to get the cheapest airfares and everything else that would flow from an early decision?-- I think the doctors - well, I know that the doctors view that as a huge - as hugely unnecessary and they don't see that as - I mean, the intent is there to obviously maintain accountability. I don't want to question the intent-----

No?-- -----but I think that the doctors see that if that's an entitlement, why waste public resources in organising it when most people, you know, on the internet can organise it themself quite cheaply and reasonably.

Another example - and this came from - I can't recall whether it was Dr Johnson or Mr Whelan, but one of the senior people in Townsville where they have a doctor appointed at the hospital who doesn't want his car, whose package would include a funded car, but that particular doctor doesn't want a car because he or she likes to drive a four-wheel drive, or has their own car, or prefers to ride a bicycle, or whatever. What we were told is that it would cost the hospital $20,000 to provide a car, but because there is a schedule put out by Queensland Health, the only rebate the hospital is allowed to provide to the doctor is $6,000. So the doctor is told, "Well, if you don't take the car you will get $6,000." And the doctor says, "Oh, well, I might as well keep the car, if that's all I am going to get", and it ends up costing the hospital 20,000. That's another illustration of what Sir Llew was saying about not having the flexibility at regional level to respond to local requirements and the same witnesses made the point about salary sacrificing arrangements which wouldn't cost the hospital one cent. But if a doctor, for example, wishes to include repatriation and boarding school fees for his children as part of a package, with fringe benefits tax and other benefits flowing from that, even though it doesn't cost the hospital anything more, the hospital administration isn't allowed to do that because it is not within Queensland Health guidelines?-- There is a requirement to follow all the guidelines, so there is no flexibility for medical administrators in those employment arrangements.

And would you agree with my, at the very moment, very strong view that it's just absurd that if Mr Leck in Bundaberg or Mr Whelan in Townsville knows that he has a 200,000-dollar a year package to pay to a doctor, that person should be able to negotiate a package which is appropriate for the particular doctor rather than following guidelines written in Charlotte Street?-- A qualified yes. I mean, clearly, we don't want chaos where there is no guideline and so on but certainly more flexibility is what employees want and it seems to me that in the current market, where we have a national shortage of medical - medical staff, we're talking about doctors in this case, which is probably worse than any other state in Queensland, that we should be looking at trying to attract people rather than making it difficult for them.

Even to the point, again we were told while we were in Townsville, that every hospital in the state is required to comply with the state government's advertising policy and if you're advertising for a doctor, it has to go in The Courier-Mail, even though you know that the doctor you're looking for isn't available in Queensland?-- Mmm-hmm.

There is again absolutely no flexibility to say, "If we're after a neurosurgeon, there is no point putting it in The Courier-Mail because there aren't any neurosurgeons available in Queensland, but if we put it in the International Society of Neurosurgeon magazines, there is a chance we might actually get someone." Is that, again, consistent with your experience?-- Again, I think it is another example - I'm not arguing we shouldn't have rules, I think we should, but we should have a minimum number of rules that should make a difference and leave again our well trained, intelligent people in our organisation to be able to make those decisions themselves, where we don't need - I mean, the intent, I understand, of that centralist policy is to be more efficient, is to get a better deal with the advertisers.

Yes?-- So that's a laudable intent. The issue is it's restrictive and it doesn't allow you to sell yourself in terms of individualising what you put in the ad. You're just a plain old ad. So I presume that's the evidence that was given in Townsville.

And for the benefit of Mr Thomas, who is sitting in the back row, I'm not trying to take money away from The Courier-Mail but what I am urging is that there should be flexibility?-- Yes, as I said, within the realms of what's good, right and proper.

We might take a 15-minute break if that's convenient.

THE COMMISSION ADJOURNED AT 11.18 A.M.

THE COMMISSION RESUMED AT 11.43 A.M.

JOHN GREGORY WAKEFIELD, CONTINUING EXAMINATION-IN-CHIEF:

D COMMISSIONER VIDER: Doctor, I just wanted to run one thing past you. You've spoken about the isolation that can exist in some of the non-metropolitan areas and you have had experience working in those areas?-- Yep.

As we move forward and attempt to establish some robust clinical review committees, would you see that those partnerships as well as including the doctors that are actively in practice in the district, that that might also include the GPs if they were wanting to come for some of that clinical audit review? I'm thinking of them in isolation as well?-- Yes. Absolutely. I mean, I think particularly in a provincial town or provincial and rural towns-----

Yes?-- -----the more sense of medical - and, again, I just don't want to talk just about doctors, but we are talking doctors. I think it is important-----

In a clinical review context, yes, I am talking about the medical fraternity?-- The more sense of medical community there is and peer review-----

Yes?-- -----the better and I think that it's - I believe it's actually important that we mandate and support-----

Yes?-- -----peer review. That it should not just be left to individuals to decide whether or not they participate. That I think we actually have to now absolutely clarify the expectation of that. So, the answer is yes.

And some of that isolation that's existing too, I'm sure that there would be a role for a time, if they wished to participate, for some retired clinicians in that mentoring sort of thing?-- Yes.

Even if their clinical practice isn't so much up to date, sometimes the very significant part they play is the benefit of their experience?-- Yes.

And certainly I recall that - retired clinicians taking part?-- In fact in those peer review type processes.

Yes. Thank you.

COMMISSIONER: And, indeed, I even wonder whether there mightn't be room to incorporate other allied health care practitioners, particularly in the remote regional areas, dentists, pharmacists, people like that?-- Mmm-hmm.

Who at least have the patient contact experience even if they don't have the direct medical experience?-- Yes. I mean,

health care is a team pursuit and again it is something - we were talking about doctors, and doctors are an - a very important part of the team but there are other team members and the more that we learn to review things as a team, the better. So I absolutely support that.

Doctor, there is also one thing I wanted to pick up on. We were talking earlier about the funding for operative procedures and that was the only sort of additional source of funding available to regional hospitals. It does strike me that there's an error in priorities to the extent that very important diagnostic procedures which have often had prophetic outcomes, such as endoscopies and colonoscopies and mammograms and so on, aren't included in the extra funding for getting through those waiting lists and one of the most basic and simple changes that could be made is to give those sorts of procedures the same incentive as operations?-- Mmm.

How do you feel about that?-- Absolutely 100 per cent support. I think that maybe in my - I'm not sure whether I put it in my statement in fact, but one of the major challenges that I faced in Bundaberg when I started there was a huge waiting list for endoscopy procedures, upper and lower endoscopy procedures, and there was absolutely no way that I could obtain funds from the elective surgery program to address that issue. And yet that - and yet in putting that service on and - actually, the other thing relative to that, in provincial areas it's often general - generalists, physicians and surgeons that perform those procedures and not gastroenterologists. And so, it still utilises operating theatre times and resources and yet one can't actually get compensated for it. So it's a barrier that should not exist.

And it seems to me that it's a sort of win-win situation. If you're looking at it, as I suspect you should, in terms of patient outcomes, hurrying people through those diagnostic procedures promptly is going to give them a better outcome with cancers detected sooner and similar problems but also, if your only priority is money, then it's also going to be a lot cheaper in the long run to detect a cancer early and deal with it rather than potentially have a patient with a much more serious problem 12 or 24 or 36 months down the track?-- Absolutely. I mean, it's false economy and the human cost is the patients bear the brunt - pay the price for it really.

Yes. Sir Llew.

D COMMISSIONER EDWARDS: Can I just go back again to the flexibility of budgets. It seems that that inflexibility appears to be very difficult for practitioners at the front but it seems that's a whole of government thing due to audit procedures, audit programs and I guess that the only way that that inflexibility is going to change is if such groups as us consider that matter from a health point of view particularly. But I just - are you aware that it is a whole of government, whether it is Queensland government, New South Wales government? This total inflexibility in budget is part of our culture in governments that - these days in all the

departments, and I'm just wondering whether you have a view relative to the accountability for the expenditure of money relative to that possible flexibility - what is now inflexibility and could be a more flexible approach if we consider that aspect?-- Mmm-hmm. Yes. Again, I stress I am not an expert in health funding and some of those whole of government policies but I do have a view. It appears to me that we totally over regulated and over comply - and over govern the financial aspects of health and yet, we have - we've done precious little in that regard from the safety and quality perspectives of health. And that, clearly, government has to be more and more accountable, accountability is necessary, but I'm not convinced that producing multiple policies and tying the hands of administrators behind their backs is - is the best way to achieve that. You know, on the one hand we expect senior people to manage budgets of hundreds of millions of dollars and yet on the other hand we ask - we provide a policy for whether they can have lollies on the tables at meetings so that we can be accountable, and it just doesn't make sense. So policy is important for the important things but I think the discretion is essential for everything else.

COMMISSIONER: Mr Farr.

EXAMINATION-IN-CHIEF:

MR FARR: Dr Wakefield, I would like, if I can, very briefly to conduct just a little bit of propaganda in relation to the Patient Safety Centre. I understand from the evidence that you've given that you are of the view that not adequately funding the Patient Safety Centre and whatever initiatives that flow with that is in effect false budget?-- Yes, it is my view, and I think I've made it clear several times, that I believe that we have to have a very strong focus on patient safety. Now, that is not about funding a Patient Safety Centre. Patient safety is actually in the hands of the people who deliver the care at the front line, so it is about resourcing clinicians to be able to provide safer care. One of the vehicles for that is a small but effective Patient Safety Centre with tentacles that stretch into the front line and there is a range of those, so we provide resources to the front line. So it's not about the centre. It's about resourcing patient safety. So, yes.

In paragraphs 8, 9, 10 - or 8, 9 and 10 of your statement regarding patient safety, you have repeated some figures that had been provided from studies. Now, these studies were conducted in South Australia, New South Wales back in 1995 and then, as I understand it, those results were extrapolated if you like across the nation?-- Correct.

And the results of that study then was that 16.6 per cent of patients that are admitted to Australian hospitals are harmed

as a result of the health care that they received and that the harm is often referred to as an adverse event?-- Yes.

The harm that is being spoken of there is inadvertent harm. That's the type of harm that you've been speaking of?-- Yes.

Half of those were considered to be preventable and 75 per cent of them were due to human error?-- Yes.

You then provided what I take it is the estimates of actual figures based on those percentages, being 50,000 patients across the country, across Australia, who suffered some permanent disability and 18,000 preventable deaths?-- Correct.

These are the figures that are your impetus, as I understand it, and the reason for the passion that you have for patient safety?-- Yes, I think they provide the evidence for - for the importance of driving improvements in patient safety in our health care systems. This is not an Australia - Queensland problem. This is not an Australian problem. This is a First World problem, and there has been a lot of money invested in doing this kind of research around the world. The results - the methodologies are slightly different but the results are the same which is that it's accepted that on a worldwide basis, approximately 10 per cent, one in 10 patients that enter one of our hospitals, acute hospitals, suffer some sort of harm. And whilst that means that 90 per cent of health care is delivered very safely, it's still an unacceptably high rate of harm, but I stress that that is not harm caused by the Dr Patels of the world. This is harm caused by good, well-intentioned people who make mistakes.

All right?-- I think it's a really important distinction. So we regard, the health ministers regard, the nation regards and internationally it's regarded as probably the number one health reform agenda for the next couple of decades.

Those figures, I dare say, would be the focus of attention for anyone who has the patient safety issues first and foremost in their mind. To those who like to approach things in a more budgetary way and look at the cost of that type of thing you have referred to in paragraph 10, that the direct cost of those adverse events in Australia is estimated to be $4 billion per annum?-- Yes.

I take it it's that figure that enables you to say in not addressing these issues and funding them adequately, it simply is a false economy?-- Correct.

And I won't take you through all the things because your statement is extremely - well, it details all of the steps that are being undertaken or are in the process of being undertaken but you have listed what you have been found to be the top five causes of inadvertent harm?-- Mmm-hmm.

They being medication, adverse event, pressure ulcers, surgical complications, health care associated infections and falls?-- Yes.

And you and your team, as I understand it, have attempted to address in the short time that you've had thus far those issues predominantly to either set up or to do whatever is required to reduce as best you can adverse events in those areas?-- That's correct. So-----

And that's-----?-- Yes.

Sorry. And my next question was and that's going to be the focus, if you like, of the intention well into the future to try and reduce those figures as best as is humanly possible?-- Absolutely. I think that it's - I would like to stress that there's been nation leading and possibly world leading work already gone on in Queensland well before the Patient Safety Centre was started and two of those units, the medication unit and the infection unit, have done significant work which I can talk about if you wish in the last three to four years. We've brought together the power of those units into - into a combined unit and we see this really as at least a decade reform agenda. That we need to be really progressing forward with some of those key patient safety issues and I spoke yesterday of some of the hard fixes, the - some of the information technology that can be used to help clinicians, not to help the people that manage budgets or human resources but to help clinicians do their job. We need to really progress that and my team are working on influencing that agenda. But we need strong leadership from the top. Safety is - safety is the reason we're in - we have a health care system and, you know, this - thankfully, this was supported by the administration.

And I think-----

D COMMISSIONER EDWARDS: Doctor, following up Mr Farr's point, has there been any other major study similar to the one published in 1995 that has been done in recent times? Sorry to interrupt, Mr Farr?-- More recently to my knowledge there was a large study in Harvard, the Harvard malpractice study, that was in the early '90s. The Australian study was a landmark study in '95. I think that there's been similar studies in Canada and the United Kingdom since then which have confirmed those findings.

Thank you?-- And in the States, again, in the "To Err is Human" report, which received Presidential direction and resource - huge resources, was in 1999.

COMMISSIONER: I don't want to sound nitpicking but I'm not sure I really understand your figures in your paragraph 8?-- Yep.

8(b) says that half the events are considered preventable and (c) says three-quarters of them are due to human error. Surely any adverse event which is due to human error is preventable?-- They're actually subsets. So the point A is 16 per cent of patients suffer harm.

Right?-- Of those 16 per cent, half of those the event is considered to be preventable.

Eight per cent-----?-- And of those that are preventable, three quarters are due to human error. Sorry, that should have been qualified better.

So eight per cent are preventable and six per cent are due to human error?-- Yes, correct.

Roughly.

D COMMISSIONER VIDER: Doctor, when you talk about the need for resourcing at the grassroots level, I presume you're also talking about the need that will represent a big change in culture because we have had evidence at the present time where people are expected to go to a lunchtime meeting for an audit review or whatever, that just doesn't happen, and they're not given any other time to go. So that will be part of the resourcing that you're talking about, release time, setting aside appropriate committee structure, so that people can attend?-- Yes, I think - I'm not sure it's the committee structure. I believe that it's the focus - the last few years have seen an absolute focus on productivity at all costs and the elective surgery program has been part of that. Now, it's addressed a problem, a waiting list problem and a resource problem. I think what we have to do is use other measures as well as productivity to manage our health service. So it's really dollars, productivity, but safety and quality has to have at least an equal and should really be the priority, which means that when we employ doctors and staff - when we set up our system, we have to adequately allow for time for this kind of work. It is work and it should be able to be conducted in work hours but that may mean a loss of productivity. But without it, we're Bankcarding safety.

And it also means that such groups and such activities have to be supported clerically?-- Yes, absolutely.

So that someone does the work.

COMMISSIONER: We've already heard reference to the situation in the United Kingdom and elsewhere in Europe with a common market directive requiring that no-one in a clinical context is to work I think currently it is 48 hours or 50 hours in a week?-- Mmm.

And in Britain alone that has cost the national health service I think I was told something like 40 billion pounds to deal with it?-- Mmm.

And with that additional expenditure has only increased clinical services by four per cent, some tiny fraction like that. Those are the realities of implementing a safer program, aren't they?-- Mmm-hmm. Yes, I think it goes to - I think what's happened, as I said before, I think we've put on the credit card-----

Yes?-- -----this over a number of years and now we really have to get - if we want a system that works into the future, we have to go back and reassess what is appropriate for - in terms of our clinical front line. I mean, they cannot be productive seeing patients for 40 hours, however many hours a week that they're working. They have to have some time for professional development, for being involved in these sort of activities which are essential, and I think Bundaberg has illustrated this, that if you - if these things are not supported, then it can lead to breakdowns in the system.

Interestingly, Dr Nankivell, when he gave his evidence, spoke of himself, and I think probably most of the people in this room has been in the boy scout generation who is always willing to help out and it strikes me, doctor, that you're of that generation as well?-- Yes.

And he made the point that there are people now aged under about 35, all other considerations aside, just aren't prepared to work those long hours, that they have different priorities, and I think I would have to say better priorities of looking after their own health and their families and their personal development and so on?-- Mmm-hmm.

And again, within the present funding structures, that's simply not feasible - achievable?-- I think the referral to the generational changes are well - is well documented and other industry again has taken again significant moves to recognise that. My generation is focussed on as a real commitment to an organisation and a public ethos and so on, I think that the only generation is far less - is far more prepared to move around and seek what they want out of their work and so - and that combined with the baby boom issue and the shrinking workforce is going to be a huge problem for us, so I think we have to look after our workforce but at the same time we are going to have a look at new models of delivering that care that the doctors and nurses just are not out there, the population just isn't out there, so I think we do have to critically appraise who delivers what in health care, we can't bury our heads in the sand.

I think it was Deputy Commissioner Vider that told me that one study showed in the United States that the average age of clinicians in a-----

D COMMISSIONER VIDER: Theatre nurses was 75 which was staggering?-- 75. Well, certainly at the PA Hospital that I can speak of because I was responsible with Dr Thiele there for surgical services for nearly three years, the average age of the anaesthetists was 55. We weren't retaining any of the new trainees that became specialists and PA Hospital was an area of need for anaesthetists. Now, when we're in that situation, we really have to ask ourselves the question why? And what can we do to really address this issue? And I'm not really sure that we have done what we need to do to address that.

COMMISSIONER: We might have to send you back to work.

D COMMISSIONER EDWARDS: It'd be a long training?-- That's one possibility.

COMMISSIONER: Mr Farr.

MR FARR: Thank you Commissioner.

Just on a different topic and the final point I wanted to raise with you doctor: in relation to the Dr Miach issue that's been raised with you already in your evidence, you've

told us yesterday that the briefing you received from Dr Buckland was on the 18th of April-----?-- Yes.

-----2005. We know that Dr Miach's statement was provided on the same day of his evidence, which was 25th of May 2005?-- Yes.

I can't ask you and won't ask you what was in the mind of anyone other than yourself, but at the time of receiving that briefing, did you accept it with the most honourable of intentions?-- Absolutely.

And I know that you physically didn't carry out that side of the task, but at the time of the publishing of the report, did you once again publish it with the most honourable of intentions?-- Absolutely, and I think that, I'd just like to point out that had there been another - had there been anomalies in Bundaberg that existed and we had not made any attempts to review that, I think that that would have - that would have seriously compromised our credibility as a review team. So we acted on a specific instruction and we felt that it was entirely appropriate.

All right. Thank you, that's all I have.

COMMISSIONER: Thank you Mr Farr. I think on that last point it's, Mr Farr, I can fairly say and I think I speak on behalf of the two Deputy Commissioners, that we don't have the slightest concern about Dr Wakefield's integrity and the honourableness of his motives and involvement in that process, so that matter need not be one of any further concern.

MR FARR: Thank you?-- Thank you Commissioner.

MR DIEHM: Commissioner, can I just raise a procedural issue before the cross-examination goes?

COMMISSIONER: Certainly, certainly.

MR DIEHM: Because it may affect how a number of people go about their cross-examination of Dr Wakefield. The doctor is, of course, one of the authors of this review report.

COMMISSIONER: Yes.

MR DIEHM: And it seems to me that hypothetically, a number of us could engage in a long-winded cross-examination of factual conclusions based on their investigations that have been reached.

COMMISSIONER: Yes.

MR DIEHM: It would ultimately be a barren exercise because the Commissioners have heard evidence broad ranging probably covering the evidence that the authors have and more - and are ultimately have to make their own conclusions about those matters, and it seems to me to be of little assistance but a great consumption of time to go into it.

COMMISSIONER: I'm delighted you raised that. Can I say that for my part, I'm inclined to treat those parts of the report - I'm leaving aside Dr Woodruff's part.

MR DIEHM: Yes.

COMMISSIONER: Which consists of his clinical analysis, clinical audit, but those parts essentially as being in the nature of more of a submission more than evidence, in other words, Dr Wakefield and his colleagues have examined evidence as we're examining evidence, they've arrived at certain conclusions, we in turn will arrive at our conclusions. We will no doubt give appropriate weight to the views of the three authors - or the four authors as we will give weight to submissions from anyone else of a similar calibre, but I wouldn't regard them as evidence of facts rather than as views that are put forward from any authoritative source.

MR DIEHM: Thank you Commissioner.

COMMISSIONER: Does that assist?

MR DIEHM: Yes it does, thank you.

MR HARPER: I have no questions.

COMMISSIONER: No questions. Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Doctor, my name's John Allen, I'm appearing for the Queensland Nurses union. In relation to the patient safety aspects you'd spoken about, you stressed how important it is that there be some minimum standards across the public and private hospital systems?-- Yes.

And that consistency you mention in your statement is one which is sought to be statewide or indeed nationwide?-- Yes.

And, of course, there are very good practical reasons why one would want to have consistency across public and private hospitals in relation to matters such as medication management?-- Yes.

Simple matters such as how equipment is identified and handled?-- Yes, under certain circumstances I would imagine, yes.

All right. And well, one of the obvious reasons why you'd want a consistency is that you might have a visiting medical officer who works to a large extent in a private hospital but

then conducts some sessions in a public hospital?-- Yes, that would be one reason.

Another analogous reason is the fact that there is, for various reasons, an increasing use of agency nurses in hospitals?-- And that's a very important reason that we have found, yep.

So you might have a nurse who's working primarily in, say, the Princess Alexandra Hospital but is also conducting some casual sessions as an agency nurse in a private hospital?-- Absolutely.

COMMISSIONER: Or vice versa?-- Mmm.

MR ALLEN: Or vice versa. And so just to take a practical example, if the PA Hospital has a system whereas, say, intrathecal infusions only occur in a certain manner by way of a line with no other access points?-- Yes.

And are clearly labelled "Intrathecal Infusion"?-- Mmm-hmm.

And that nurse is used to that system and then goes to another hospital and encounters an intrathecal infusion which is not labelled as such and has perhaps a side access point, there's a real danger there, isn't there?-- Absolutely.

Even to the extent where a nurse might mistakenly when wanting to give a subcutaneous infusion of a medication goes and puts it into the intrathecal line?-- Yes, and it has happened many times.

Yes. Would that be an example of a situation where you would describe it as the system creating the failure, where an honest and competent clinician has really been set up to fail?-- Absolutely, that's what I've been trying to address, that's what I've addressed in my statement, yes.

Okay. So in that sense, you're saying that a just system is not a to blame system but one which identifies what is blameworthy?-- Correct.

You mentioned in your evidence that that has been done in other jurisdictions, a definition has been sought?-- Yes.

What other jurisdictions were you mentioning?-- I'm most familiar with the Veterans Health Administration in the United States which is a Federal organisation where they specify those four groups that I can repeat if you like?

No, no, I've made a note of them?-- Okay.

So that was from the US?-- That's from the US. They, as far as I'm aware, New South Wales who have based their safety program on the veterans model, have also enshrined that into policy, I'm not yet, I'm not clear whether that's in the legislation, and my understanding is also that the Mater Hospital in - the Mater group in Brisbane have also recently

defined that in policy for their staff.

Okay. Now, in relation to any role the Patient Safety Centre might have in that question of standardisation across both the public and private sphere?-- Yes.

Does the Patient Safety Centre have any role in relation to private hospitals?-- We don't have any jurisdiction over private hospitals, I think it's fair to say that we are trying to work out what governance exists around the Patient Safety Centre, I think that we've had a great deal of change over the last few months within health and that is still occurring and notwithstanding the outcome of this Inquiry and the Forster Review, that will continue, so we - once the future direction is confirmed, we will confirm our connections with the national Council, the national agenda for safety and quality and the private sector within Queensland, and I would suggest that that will probably come through the Chief Health Officer's office, because he has statutory responsibilities across the private and public sector so that we can have an official as well as an unofficial route for sharing lessons learnt.

Mmm?-- Whether we should have jurisdiction and power to address that, that's probably a matter for the external regulator, Commissioner, that you were talking about, and I think there is - I would like to see that, whatever that is, and if it's the Chief Health Officer's office, have jurisdiction to be able to mandate certain key interventions for safety as you mentioned.

Okay.

COMMISSIONER: Given your passion for patient safety issues?-- Mmm.

If there were such an external regulator, would you prefer to see your organisation as part of the external regulation rather than as part of the public health structure?-- Commissioner, we've thought about this a lot and discussed it with many other jurisdictions. I think the answer is a resounding no, that we - that if we are viewed as the policeman.

Yes?-- We will have no trust from our staff and we will not be able to work with them. All the solutions come from the frontline and our working with them so the answer is no.

MR ALLEN: In relation to the aspect of the Patient Safety Centre being a route for sharing lessons learnt?-- Yes.

As you've just put it, you gave an example yesterday of an alert you had actually had in a document?-- Yes.

That's something which was produced because of the information received and analysed which showed a particular risk involved?-- Yes.

And you said that that would then be circulated through the state to the various safety and quality committees?-- Yes.

As the system stands now, would that include any communication of that particular matter to private hospitals?-- Again, that relates to the governance issue that I raised in the previous response. The answer is that it would go out to our current networks through the Chief Health Officer's office and so on, so it would usually go to the private sector, but just how robust that - those communication channels are at the moment I'm afraid that I can not - I can't speak to that, but certainly that needs to be - I need to make sure and my team need to make sure that those channels are well and truly established.

COMMISSIONER: And certainly at the moment you have no power to mandate the standards?-- Correct, so I think that once we've worked - I mean, the medication chart is a good example - once we've got something which is - we know is a very powerful safety initiative and that it's mandated at a national level and has the commitment of all of the health ministers for public hospitals, it seems to me that we need to be looking at the impact of that in the private hospital setting, but mandating things, you know, some things like that should be mandated.

D COMMISSIONER VIDER: Do you think that the patient safety program will become known to the patient population? Is that your intention or the unit's intention?-- Absolutely.

To help educate the staff? I'm thinking in a particular issue where we've got workforce shortages which exist at the moment?-- Mmm.

And we have situations where for patient safety reasons beds are closed because there's inadequate staff to look after them, people get very cross when they see that half a ward's closed or whatever when they have an expectation that they would have been cared for, but they need to understand the consequences that have allowed the beds to be closed and that public information is not out there?-- I think, I mean, is it our plan to engage with the community and the media? Absolutely.

Mmm?-- The scenario that you give is a safety trade-off and I'm not sure that I would regard that as mainline what I see as patient safety, but in other words, a member of the community, I would assume, would say, "Well, I can't access my health care.", that's a safety issue for me, just as much as providing substandard care would be a safety issue, so I think that's one - that's a hard one, I think we've just got to be honest and open with them.

Yes?-- That's the first point. But the second point is let's be open and honest about the fact that we actually do harm patients as a result of hospital care, we don't mean to but we do, so that's why I insisted that we should be called the Patient Safety Centre, not any jargon, so that people

understand that we acknowledge there's a problem with patient safety, the question is not whether there's a problem, it's what we're going to do about it.

Yes?-- So through a range of - through having a community represented on the Safety and Quality Board, through working with the media and community groups around this issue both nationally and at a State level, and educating them about the things they can do to make their health care safer, such as asking their care provider have they washed their hands and getting them involved in the correct surgery process so that they're - they can take, they can make it safer for themselves, to that extent we certainly are working with them and planning to work far more with them.

Yes.

MR ALLEN: Doctor, as things currently stand, is there any flow of communication to the Patient Safety Centre from private hospitals so that their investigation and experience of incidents which could be addressed in the future find its way to the Patient Safety Centre so that that knowledge can be shared across other private hospitals and public hospitals?-- The formal answer to that is yes, there's no formal link. There's plenty of informal links and a range of our programs we're already sharing and working with private hospitals and private sector health care organisations to help them with training in some of those areas and, in fact, we've been involved quite recently with some private hospitals. We have to balance that between the urgent need for us to do our work in the public sector, but we regard ourselves as being able to assist whatever private or public.

Would you see some value in there being some type of obligation upon both public and private hospitals to report matters of significance so that that information can be shared?-- So long as it's done in such a way that it supports learning and prevention and not as performance and punishment, then yes, I would support that.

And would that be, I suppose in the first instance, as things currently stand, the place for such reporting would be to the Patient Safety Centre?-- Yes, yes.

And any other type of body which in the future might take upon that responsibility?-- Yes, we'd be happy to liaise with private sector organisations and provide any mutual assistance.

And just in relation finally to this issue of sharing of information and others benefitting from the experience - sometimes tragic - of others, you mention in one of your statements that the Patient Safety Centre is looking at setting up some type of liaison with the State Coroner?-- Yes, it's already happened, yes.

And is that limited to the public hospital system and the State Coroner or is there some type of communication in

relation to matters that might occur in private hospitals?-- For the most part, that is related to Queensland Health taking a coordinated approach to consideration of all coronial recommendations and responding to those and working with the Coroner to provide feedback as to whether they're realistic and worthwhile or not. So that's for the public - that's for deaths that occur, coronial deaths that occur in the public sector. I'm not aware that we specifically review private sector deaths.

No, because as the system currently stands, if a death occurs in a private hospital?-- Mmm.

A Coroner might investigate that and then make recommendations, but as far as you know, they're not communicated to Queensland Health unless the Coroner specifically directs that they are?-- Correct.

So Queensland Health wouldn't get to hear about that particular experience and the sort of changes that could be made to prevent it happening in the future?-- Correct, and you know, moreover, I think that the work since the new legislation came in, the work of the State Coroner has significantly improved the process generally and I think that we're not there yet for coronial matters dealt with by the State Coroner's office, all those reports come back through the Chief Health Officer. For coronial matters out in provincial Queensland, that's the local magistrate, there's still not good penetration of that, such that those reports may go nowhere and that's what we're trying to address, so the private sector, you know, we haven't had a focus on the private sector, but I think if there are lessons learnt, primarily they need to go back to the hospital where the death occurred, but I think coordination of those to provide that, you know, is there anything we can learn and need to do at a State level would be important. So we - I can look at that, I don't really know the answer to that at the moment, whether we do look at those.

Would one simple step be that not only does the State Coroner refer to the Chief Health Officer all matters concerning public hospitals, but also all matters concerning private hospitals?-- Well, again, that would appear to be a very sensible suggestion and may well be, again, part of an overall external body looking at this, and we'd be happy to work with the CHO's office on that matter.

Right. But at this stage you don't understand there is any system where the State Coroner refers matters involving deaths in private hospitals to either the Patient Safety Centre or the Chief Health Officer?-- No. I mean, I just don't know the answer to that question, I think the Chief Health Officer would be able to respond to that.

And just one final matter: you told the Commissioner in answer to a question this morning that if Dr Patel had been appointed as Director of Surgery without being properly credentialed and privileged, that if that's the case, that would be

unacceptable?-- Yes, well, it's hard to defend.

Yes. As part of your investigation, you investigated whether there'd been any credentialing and privileges of Dr Patel?-- Yes.

You ascertained that there hadn't been?-- Correct.

Okay. And did you draw any conclusions as to whose responsibility it would have been to initially credential and privilege Dr Patel, whether it would have been the district manager or the acting Director of Medical Services, for example?-- Look, I think that's a matter of local procedure. I can only speak to my knowledge of the system that I put in place when I was a medical superintendent, which was that it was the person who was the medical superintendent at the time would refer - would recommend, as a result of process of credentialing, privileges and the District Manager would sign off on those. That's the process that I used.

And the process you developed is an exhibit to one of your statements. Were you able to ascertain whether that procedure, which you refer to as credentialing and appointment procedures for medical practitioners, the Bundaberg Health Service District, whether that was still the applicable procedure at the time of Dr Patel's appointment?-- Well, there was no other procedure taking its place, so.

Okay. And in relation to that procedure, I note that you deal with the membership of a credentialing and clinical privileges committee?-- Yes.

And it stated that a quorum for that committee must be a minimum of three?-- Yes.

With at least one representative from the permanent and variable groups?-- Yes.

And if we look at the membership variable, that includes a relevant learned college representative or a representative of AMA or RDAQ for rural hospital?-- Yes.

And that seems to be perhaps the only - or the most relevant variable member, if one was to set up a committee regarding Dr Patel?-- Yes.

What steps would you have taken if it was impossible to find a college representative that was someone officially endorsed by the college? What alternatives would be open?-- Okay. I mean we're talking hypothetical.

Yes?-- I think that I would still regard, as the medical superintendent, that I was responsible for providing written privileges to this person. I think I'd have to acknowledge if the college could not provide an alternative, I would seek out an alternative. Now, if that's for a Director of Surgery, then one would have to go outside the hospital. So, you know, may have gone to the local community for an external surgeon, or probably more likely I would have gone through Queensland Health channels to find a surgeon from another facility. But in any event I think that, you know, one has to make the decision and make the recommendation.

So you wouldn't have simply failed to go through any credentialing and privileging on the basis that you hadn't yet got an endorsed college representative? You wouldn't simply let the process lie?-- Again, hypothetically I can only speak to my practice and how I would address that. I would see it as my responsibility to provide privileges. If I couldn't get a person - an appropriate person, then I would have to do the best that I could to provide privileges. I think that if it was a temporary appointment, then I would have probably just done it myself and defined the scope of practice in the best way that I could based on the knowledge that I had. For a permanent position I would have been quite uncomfortable and I'd have been knocking on doors in Queensland Health.

When you say a temporary, would that encompass a 12 month appointment with the possibility of renewal?-- If it was a 12 month appointment - again, this is a matter of relatively - for locums, up to two to three months, I would have done it myself, but for longer term appointments, I would have felt uncomfortable without having a bit more of a formal peer oversight of the process.

COMMISSIONER: Doctor, I assume that with modern technology it is not necessary that all members of the credentialing and privileging committee be physically present in Bundaberg; it could be done by telephone link-up or video connection, or whatever?-- Sure. Sure, yes.

MR ALLEN: I take it from what you have explained that where the procedure you have developed states, "The relevant learned college representative must be within the quorum"?-- Yes.

Have you got that page?-- Yes.

Is that really shorthand for saying that the quorum must include one of those persons under dot point one of membership variable, that is "relevant learned college representative or a representative of AMA or RDAQ"?-- For a rural hospital.

Oh, so leave out RDAQ. What about "relevant learned college representative or representative of AMA"?-- Look, this was a few years ago when I drafted this policy, and I think I am pretty clear that there was no statewide or national policy at this stage. And my recollection is that I went to Nambour Hospital and had discussions with the superintendent there and modified their processes to put this in place in Bundaberg. I - my recollection is that I needed to leave enough scope and flexibility in this policy not to tie myself in knots so that ultimately I could grant privileges to a doctor.

COMMISSIONER: But, doctor, the important thing, the bottom line to all of this, is that having some transparent privileging and credentialing system is what's necessary. If - if, for example, the College of Surgeons had said, "Look, for insurance or other reasons we're just not going to nominate anyone", then you would have looked for someone of a similar standing. You would have got on the phone to Brian Thiele or someone and said-----?-- I would have sought out

alternatives. All the surgeons are Fellows of the college anyway, so it is a college representative, really means a Fellow nominated by the college. But I was responsible for the medical staff in the Bundaberg Base Hospital, so I would have gone wherever I had to go to get it.

Yes.

MR ALLEN: Thank you, doctor.

COMMISSIONER: Ms McMillan?

MS McMILLAN: No, thank you.

COMMISSIONER: Mr Diehm, before you have - Mr Tait may have some questions.

MR TAIT: I am happy to wait. It doesn't bother me.

MR DIEHM: I would prefer to go after parties not affected-----

COMMISSIONER: I think that's desirable because Mr Diehm should have the opportunity to anticipate anything that is adverse.

MR TAIT: My questions don't relate to any particular party.

CROSS-EXAMINATION:

MR TAIT: Doctor, my name is David Tait. I act for the Australian Medical Association. There are two areas that I would ask you to clarify, please. The first relates to the peer review-----?-- Yes.

-----deputy Commissioner Vider asked you about. Where does that fit in, the peer review system?-- Where does it fit into what, sorry?

Well, exactly. Is it the Patient Safety Centre?-- As I have said already, the Patient Safety Centre focuses on systems, not on individuals.

Yes?-- So peer review is part of local governance, if you like, at the moment for a hospital. So a hospital has a requirement of - probably not a requirement at this stage, a hospital has an obligation to have peer review processes in place. They are not defined in policy as far as I am aware other than the credentials and privileges process. What - so what we mean by peer review is local clinicians, say in this case the surgical fraternity within the public hospital and hopefully within the private hospital as well, to get together and in an open and transparent way present to their colleagues their work, any mortality or morbidity that has resulted from

their work and be able to respond and discuss issues and learn from that. That - at this point in time that only occurs at a facility level. There is no requirement for that to occur. I think I have already mentioned in the course of proceedings this morning that I think that's a deficit. That's fine for those clinicians that - which is most - that actually wish to do that and see that as part of their responsibility, but if you have an individual that tries to evade that, at the moment it is very possible to do so. So I am recommending that we actually mandate and support and define that peer review process, and I think that smaller facilities like Bundaberg do not currently have enough capacity to be able to manage that. I think there needs to be - it needs to be done on a more zonal level with the metropolitan clinicians and the provincial clinicians at least interacting and I think that would actually provide a better understanding of the challenges faced.

Well, let's pick Toowoomba-----?-- Yeah.

And - so all mortality and morbidity is referred to this peer review committee. Is that right?-- I am not aware of what happens in Toowoomba.

Pick any town you like. I am making it up?-- All right.

Your proposal, I am trying to understand how it works, how it would work. All mortality and morbidity is referred to this peer review committee, is it, in hospitals?-- At the moment.

No, no, what you propose?-- What I am proposing is that - that that is defined. So what peer review actually means is defined.

All right?-- And that I anticipate that there would be - that it would be mandated that clinicians provide in a broader forum than one hospital.

Yes?-- Particularly for small hospitals, get together to present in a safe environment to present their data and be challenged, challenge each other on it and learn in that process.

That's what I am trying to get to?-- Yep.

So Toowoomba?-- Yes.

A few hospitals there?-- Yes.

So all mortality and morbidity is presented to this peer review committee - that's mandated?-- It is not a committee.

What is it?-- It is not a committee.

No, what is it then?-- It is a - usually takes the form of, say, a monthly meeting.

Right?-- Of rank and file.

Rank and file what?-- Doctors. I think that often-----

COMMISSIONER: Call it more a discussion group or a forum, rather than committee?-- It is a forum, that's right. So they get together - and this happens across hospitals across the State.

MR TAIT: I understand that but I am just trying to pick a town at the moment?-- So they get together, they present their work.

Mmm?-- So, "This month I have done 100 cases. This is the case mix that I've done, these are the - these are the patients who had adverse outcomes and these are the patients that died." And then they go through those cases in detail, okay. So that rather than that be left to chance or the enthusiasm of local people, that that's actually a formal structure, again which is then subsequently monitored by perhaps an external accreditor or agency.

All right, so an accreditor, all right. We will come back to the accreditor?-- Yep.

So this is every doctor in Toowoomba, every month, because I heard you say it includes GPs-----?-- Yes.

-----goes to this forum and presents all of their cases where they have had adverse outcomes or deaths? That's what you said?-- Yes. I think that-----

All right?-- -----there is logistics attached to it, though.

Sure are. How many - how long would this meeting take?-- Okay. Let's just step back.

Forum, sorry?-- Let's step back a step, okay. First of all, that it is an ethical and professional responsibility that doctors have to review their work and undertake peer review.

Doctor, I don't doubt that. I am looking at-----?-- Can I-----

-----your model?-- Can I finish? So that at the moment around the State clinical units get together on a monthly basis or two-monthly basis, whatever, and review their work. That should continue. Perhaps it would be more logistically appropriate that, say in a particular specialty, like, say, vascular surgery, where there is a vascular surgeon in Bundaberg, how can the vascular - the one vascular surgeon in Bundaberg undertake peer review in Bundaberg? Can't. So I am suggesting that perhaps the interval - this needs to be worked up but the interval, say, at six months or 12 months, that there is a broader meeting of vascular surgeons that they can review their work. Perhaps on a regional basis. Because without that, there is no-one else - no other peer is reviewing their work.

I understand that. I understand that and I understand the metropolitan versus rural and if there is only one vascular surgeon in, I don't know, Biloela-----?-- Yes.

-----that it is sensible to go elsewhere, but I am looking back at the Toowoomba one?-- Yes.

Where every doctor is going to go to this forum once a month?-- No, no, no, you have-----

Not every doctor?-- No.

Which doctors then?-- By specialty.

It is by specialty now?-- Correct.

COMMISSIONER: I think, Mr Tait, you are being a little unfair.

MR TAIT: Sorry.

COMMISSIONER: Let's start with this: doctor, these sorts of forums exist in all of the metropolitan hospitals, public and private, at the moment?-- Yes.

Is that right?-- Well, the ones that I know about, yes.

The difficulty is that people in provincial parts of the State haven't had the benefit of that protection because there just aren't the numbers to do it?-- Correct.

And all you're really suggesting that is novel is that, as I understand it, two things: one is that if the town is too small to have a clinical forum in a particular specialist discipline, then there might be a multidisciplinary forum involving GPs and other specialist disciplines, and, secondly, that specialists who are isolated from other people of the same specialisation should have the opportunity to participate in forums for larger groups over a larger part of the State, so that vascular surgeons from Bundaberg and Maryborough and Gladstone, Rockhampton might get together for a forum rather than just the one who is in Bundaberg?-- Correct. The latter point absolutely.

Yes?-- The first point is I am not suggesting that, you know, there be a mass town hall meeting for this type of approach. I think that in small places it is still specialty based. So, for example, you know, in Toowoomba the surgical department might hold a monthly meeting for their mortality and morbidity which would be pretty standard, that be that they might invite along some other disciplines, so the radiology department, for example, to talk about some of the radiology aspects and maybe some of the senior nursing staff should be there as well.

And in Bundaberg-----?-- That's what I am talking about.

Bundaberg, since that's the town we've heard most about, you are not going to have a vascular forum because there is only

one vascular surgeon in the whole town?-- Yes.

But you might have a surgical forum which includes general surgeons, the vascular surgeon, perhaps the orthopaedic surgeon, and perhaps other specialists who have an input into the surgery, such as radiology, possibly obstetrics, gynaecology or cardiac where there is a close involvement with surgery?-- Correct. I mean, how that would be managed, you know - I think by and large, you know, specialists really want to be peer reviewed by their specialist colleagues.

Yes?-- But, you know, that works effectively in many departments in small hospitals. It is just - it is just purely transparently and openly displaying your work for your peers to review.

But, doctor, as I understand your evidence, the real message, in answer to Mr Tait's questioning, is that specialists in regional areas shouldn't miss out and patients of specialists in regional areas-----?-- Correct.

-----shouldn't miss out because of isolation. If they can't have the same sort of peer review that exists in Brisbane, there should be some comparable form of peer review, whether that's across a regional basis, or bringing in other related specialties, or finding some practical way on a town-by-town basis of giving those specialists and those patients the same protection as specialists and patients in Brisbane?-- Absolutely. And I strongly - I don't strongly feel, I - it is - I have a strong belief that it is our professional duty and responsibility to, as being professionals, take some responsibility for patient care of our colleagues.

MR TAIT: All right?-- And to be prepared to respond if there are concerns.

Yes, well, let's pick a town where there are 20 GPs?-- Yes.

They would have a peer review system where they get together in a forum once a month. 20 GPs?-- I am not suggesting that we have no jurisdiction over general practitioners.

I am sorry, I thought that's what you said to Deputy Commissioner Vider.

COMMISSIONER: No, I think what he said was GPs would have the opportunity to attend. He can't compel them to.

WITNESS: I can tell you some of the GPs attended some of those sessions in Bundaberg, some of the local GPs.

MR TAIT: So who is mandated to attend under your proposal?-- The mandate is that all doctors must be able to demonstrate that they are involved in peer review process.

So it doesn't include GPs?-- To the extent that Queensland Health - I am talking about a Queensland Health mandate.

So it is Queensland Health employees?-- Queensland Health employees.

COMMISSIONER: Including visiting staff?-- Visiting staff are our employees as well, so absolutely. In fact, it is already - if you look at most of the college requirements, they require their fellows to participate in peer review process. If you look at most of the contractual arrangements, it is a requirement. So to that extent it is already a requirement. Our issue is perhaps to be able to demonstrate that it is occurring.

MR TAIT: All right. The second topic I want to deal with is paragraph 15 of your statement, "Strategies used successfully by HROs". Do you have that?-- Yes.

Subparagraph (b) "human factors", subparagraph (vii) "incident and near miss reporting", and (viii) "legislation to provide protection for staff involved in reporting serious incidents"?-- Yep.

Now, are these - the near miss reporting system and the protected staff reports, do they go to the same body? Who - well, let's make it simpler. The incident and near miss reporting system?-- Mmm.

Who does a practitioner, who suffers a near miss, report himself to?-- He is not reporting himself, he is reporting the near miss or the incident, and he is reporting that through his local - through the hospital, through his management structure. So he is reporting that to his superior in the first instance.

So does all of this only relate to Queensland Health?-- Yes.

I see.

COMMISSIONER: Although in a desirable world you would see the same protections extended statewide?-- Absolutely but our jurisdiction only applies currently to Queensland Health employees.

MR TAIT: But is your proposal that it be extended to all medical practitioners?-- The proposal - the proposal that I believe we have been discussing is having some sort of external regulatory function which has jurisdiction beyond Queensland Health.

Yes, all right, that's what I want to deal with?-- Okay. So all I am saying at the moment is that the Patient Safety Centre only has jurisdiction in Queensland Health.

I understand that?-- But the benefits - I am sure the private sector and the private sector insurers and medical indemnifiers are equally interested in whether harm is occurring in the private sector, and so it seems common sense to me that those things are applied more broadly.

All right. Look-----

COMMISSIONER: To be fair, Mr Tait, you can't blame the witness for this because it is something I raised. The proposal set out in the witness's statement is purely a Queensland Health proposal?-- Yes.

It is simply I have said - and I said this in a discussion paper the best part of three months ago - that we should have an independent health regulatory body, and obviously if we're going to have that, then the sort of initiatives the Patient Safety Centre is undertaking for the public sector hospitals may well have benefits for the private sector hospitals, and there may be some scope to extend it to other institutions, such as nursing homes or GP clinics, or physiotherapist clinics, or dentists' clinics, but you can't pick up a set of proposals designed for public hospitals and apply them to the local GP clinic because you are not going to have clinical forums, you are not going to have adverse event reporting systems, and so on, at the local GP's clinic.

MR TAIT: No, certainly, and day surgeries for surgeons where there is no mechanism.

COMMISSIONER: Yes. So I am sure you didn't intend it but I think it is a little unfair to blame the witness for something - for a sidetrack that I took him down.

MR TAIT: I wasn't blaming anyone for that sidetrack.

COMMISSIONER: Thank you.

MR TAIT: I was concerned, from my client's point of view, how such a system would work and I was going to ask - I am conscious of the time - whether, for instance, someone who appears before this outside review body - your standards body, would that be an appropriate name, professional standards body, clinical standards?

COMMISSIONER: Mr Tait, let me outline the sort of proposal I have.

MR TAIT: Certainly.

COMMISSIONER: If you wish to debate it with the witness, you are welcome to. I see a standalone organisation that is not part of Queensland Health. I think that's vital, and numerous witnesses have agreed with that.

MR TAIT: Yes.

COMMISSIONER: I see it as having a number of functions which would probably be best dealt with in divisions or departments or directorates, whatever you want to call it. One is registration and accreditation, which is already handled by the Medical Board and would, I imagine, be subsumed into the organisation. The second is something we've discussed with many witnesses and that's a health sector ombudsman who will

deal with complaints from the public and ensure that they get appropriate feedback - not necessarily investigate the complaints but at least record them, refer them to the appropriate authority and ensure they are dealt with. The third would be something I am tentatively referring to as a clinical audit and inspectorate division, similar to some of the roles currently done by the Chief Health Officer. So that there is, if you like, a firing squad that can do the sort of audit that Dr Woodruff did in the present case. If there is a problem, there is a purpose-built body of people ready to deal with that problem at a moment's notice.

The fourth would be a research and statistical division, and I was going to follow up with Dr Wakefield whether maybe the Patient Safety Centre should be part of or should contribute to that, because I think, you know, there is no point having things like an audit and inspectorate division unless you have got the research going on to provide the information that allows things to be fixed up. There would be something similar to the present Human Rights Commission - again, my tentative thought is to call it a mediation and dispute resolution area to resolve mainly patient complaints, potentially other issues as well, in a non-adversarial, cooperative sort of environment. There would be an institutional standards division, which again takes over some of the role of the present Chief Health Officer of directing standard for both public and private institutions and, again, Dr Wakefield's inputs I think might be very relevant to that, and, finally, the professional standards and discipline area which is currently part of the Medical Board and I would see it continuing under that sort of structure.

MR TAIT: Yes.

COMMISSIONER: So that's the sort of independent body I have in mind, and I don't think anyone is suggesting that we could or should determine now what standards an institutional standards directorate would apply. I think the important thing is we have a system in place where the best people can determine what those standards are, and if Dr Wakefield's organisation says it is essential that you have peer-to-peer review, at least at hospital level, then that's one of the standards which would be adopted. We know that ACHS already has many of these standards in place and I would expect any such organisation to say, "Well, we just adopt all of the ACHS platform, plus any of the other regional requirements that seem appropriate for Queensland."

MR TAIT: Commissioner, I don't think I can usefully contribute to the debate more now that you have explained it in that background. I might deal with it in submissions. One thing you said, Commissioner, the Human Rights Commission, you probably meant Health Rights Commission.

COMMISSIONER: Health Rights Commissioner, yes, I did mean.

MR TAIT: The AMA supports the idea of peer review, so long as it is workable in terms of not taking people away from practices for long, frequent meetings which will just exacerbate the problem of the shortage of doctors.

COMMISSIONER: And, indeed, as Deputy Commissioner Vider said, one of the problems at the moment is that whilst clinicians, not only doctors but nurses, and other allied health professionals are expected often as a term of their employment to participate in these things, they're not given any time to do it.

MR TAIT: No.

COMMISSIONER: And they end up missing out on their lunch because they have to sit through meetings.

MR TAIT: Thank you, Commissioner, I won't take any more time with this witness.

COMMISSIONER: Doctor, having heard that, and I will probably get myself into trouble again for speaking my mind so frankly, but do you have any views about that sort of structure, particularly as regards the Patient Safety Centre?-- I would regard the Patient Safety Centre as providing information-----

Yes?-- -----to such a commission - such a body and, in fact, we're already committed to - to providing - to contributing to a national public report and also a statewide report on sentinel events and their management and what we have learned and what we have done about it. So, I would see that exchange of information would be important.

I was a little concerned when you said that you wouldn't want the Patient Safety Centre to be seen as part of a police organisation and that's part of the reason why I emphasised that in any such standards and regulation commission there would have to be police functions but one would hope that they would be very clearly segregated from things like research and statistics?-- Yes.

And development of standards and so on?-- I think there are a range - currently within Queensland Health there are a range of bodies that collect data.

Yes?-- Sometimes in duplicate data in different areas.

Yes?-- And I think that it - an analysis of where the data currently sits in relation to what you've proposed would be sensible. I think there could be some re-alignment for data that's used for performance and compliance versus data that's used for improvement and connect the two. So I don't see - I don't have any objections to the sort of proposals that you've just mentioned.

And just on a related subject, you have referred both in your statement and in some of your evidence to the need to provide legislative protections for these processes. I was just making some notes for my own future reference and the sorts of legislative protections that I would regard as worth consideration in any event are, firstly, exemption from freedom of information legislation so that what goes on at a

clinical forum can't be accessed?-- Yes.

Would you agree with that?-- Yes.

Secondly, indemnity from civil liability so that if I go along to a committee and say, "Dr X performed that operation negligently", or was drunk or something, then I'm not going to be sued for defamation?-- Yes.

The third would be privilege from the use of information given at such a forum in any subsequent criminal proceedings?-- Mmm.

So a person who puts their hand up for doing something wrong isn't going to then be on a charge as a result of that?-- Yes, I think with the blame worthy caveats that we mentioned before.

Yes. Well, even so, I mean, it wouldn't prevent a person being charged but it would - it would encourage honesty by saying, "What you say within the confines of a clinical forum can't then be used against you in criminal proceedings"?-- Yes, yes.

The fourth would be whistleblower protection?-- Mmm.

So that anyone who makes a report to the appropriate forum will have all of the protections of the whistleblower legislation. And the fifth, which I'm a little bit doubtful about, is compulsive powers, the power to require a person to provide information?-- Mmm.

But it does seem to me that there are certainly circumstances in which, for example, if there is a concern over whether a clinician is mentally competent, then there may be a need to be able to compel that person's psychiatrist or a treating institution on the clear understanding that it will only be used to determine that person's competence to continue practising?-- Mmm-hmm, mmm-hmm. I think the matters to which you refer are - really focus around those peer review process and the protections around peer review.

Yes?-- And, certainly, other jurisdictions have gone down that path. The legislative amendments that I would propose around the specific analysis of events at a hospital level is - is slightly different to that.

Mr Diehm, how long are you likely to be?

MR DIEHM: Only about 10 minutes I would have thought, Commissioner.

COMMISSIONER: Look, I'm sorry, Dr Wakefield, I actually have some - a group of doctors from the country have come down to see me at 1 o'clock and I am already keeping them late. Do you mind very much coming back at shall we say 2.15?

MR DIEHM: Certainly?-- That would be fine.

Is that a problem?-- No, no, that should be okay.

COMMISSIONER: Does that suit everyone else?

MR MORZONE: Thank you.

THE COMMISSION ADJOURNED AT 1.06 P.M. TILL 2.15 P.M.

THE COMMISSION RESUMED AT 2.21 P.M.

JAMES GREGORY WAKEFIELD, CONTINUING:

COMMISSIONER: Mr Diehm.

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Dr Wakefield, my name is Geoffrey Diehm and I represent Mr Keating. Just a couple of matters firstly about the credentialing and privileging committee structure that you've given some evidence about just before lunch. You mentioned some of your experience in your time at Bundaberg as Director of Medical Services and you've told us about the policy which is appended to one of your statements which you were responsible for drawing - or adopting the Nambour policy as it were?-- Yes.

Was I right in understanding your evidence that at the time you implemented that policy there was no state based policy from Queensland Health with respect to credentialing and privileging?-- That's my understanding or my recollection.

Certainly, the state of mind you had at the time of preparing your policy?-- Yes.

That you were, in effect, free to devise an appropriate policy as you saw fit to implement at Bundaberg?-- That's my recollection.

It follows from that, does it, that if you were then confronted with the situation where the policy that you had with all good intent drawn up as being appropriate proved to be unworkable in some particular respect, temporarily or permanently, it was a matter for you then to adapt that policy or abandon it as necessary to get the job done?-- Yes, I think I said that.

Now, you were taken by Mr Allen to a part of the policy or he referred to part of the policy which talked about college representatives?-- Mmm.

Did you have college representatives on your credentialing and privileges committee at the time?-- As I recall, the committee was convened - I'll just go back a step. When I commenced as Director of Medical Services, it's my recollection that there had been no formal process. So when - in setting this up and then subsequently credentialing

and privileging all the current practitioners. It was done as a - almost a one-off if you like, so there was a number of committees convened at the same time, or concurrently.

Yes?-- And that, at the time that there were college representatives for - I can't recall in fact whether there was a formal nominated college rep for the various specialities at the time.

Yes?-- Or whether I appointed local college fellows to do that job. I don't recall. I'd have to refer to the minutes of the meetings.

Okay. Now, you say that there was no formal system in place when you started as director and you've obviously implemented a system, you've drawn up a policy, put in place some committees and, as you say, you went across the spectrum in terms of the difference specialities that you were dealing with. That process, how long did it take from the time that you commenced working on this project to the time that you'd finished credentialing all of the different specialities?-- I would have to refer back to those specific committee notes. I just don't have that information to hand.

All right?-- What I can say is that it would have been - from woe to go, it probably would have been a matter of some months, I don't know, three or four months, but that's just a guesstimate.

Thank you?-- Those documents would exist still, I presume, to confirm that.

Now, Doctor, we have in evidence before the Commission a state based credentialing and privileges policy that came into force I think was in about mid-2002 but that's after your time at Bundaberg, isn't it?-- Yes.

The committee system that you established, was it still in operation at the time you ceased as Director of Medical Services at Bundaberg?-- Again, I'd have to point to how that committee system worked. By and large, that was not a committee that met once a month to determine those privileges. Because of the staffing arrangements at the time, everything was done at the same time, which meant that that group of doctors would be recredentialed in three years. So that, unless there were problems in the meantime and a need to review those privileges, those people - the committee would not reconvene during that period. It would only reconvene to consider any new appointments. So it wasn't a committee that met all the time. It just - it came together to do a job at the point in time that it was necessary to do that.

Thank you?-- So - so the answer is there was no standing committee when I left.

Yes. Now, one of the matters in your - or in the review team's report that I wanted to take you to, and for reasons we referred to before lunch I'm not going to go through the

details of your report at all, your team's report, but if I can just take you to page 32 of your report?-- Yes.

You see a para about two-thirds of the way down the page starting with "Dr Keating"?-- Yes.

I would just invite you to read that so I can then clarify some things. Just read it to yourself?-- Yes.

Now, there are some various items of chronology that I need not go into with you about this particular paragraph but there is one matter that I should ask you about. Were you part of the interview panel as it were within the team who had the discussion with Dr Keating that is mentioned in that paragraph?-- I believe so.

You will see that there's a sentence starting on the fourth line. It says, "Dr Carter had also indicated that the patient", which is a reference to Phillips we can see from further up the page. "Dr Carter had also indicated that the patient had not been a good candidate for surgery and had been refused surgery in Brisbane"?-- Yes.

I just wanted to ask you if you have a recollection and based on what's written in that paragraph, is that being intended to suggest that Dr Keating related that information to you, that is, that Dr Carter had indicated to Dr Keating those matters?-- The way that I read this is that that had been indicated by Dr Carter in his - in interviews with him. So I would - but I would have to return to the specific file notes that were made of the interview as to confirm that.

COMMISSIONER: Is it fair to say that to the best of your recollection it's information you got directly from Dr Carter rather than through Dr Keating?-- Yes.

MR DIEHM: Thank you. Whilst you've got your report there, if I can also take you then to page 37?-- Yes.

What I want to direct your attention to is the concluding paragraph on that page and, importantly, the matter that it then leads into over the page on to page 38, which concerns the offer of employment as a locum or on a salary of $1,550 a day, which the review team then goes on to say they're not aware of any provision under the district health services, et cetera, award 2003 which allows for locums to be employed in this way. Now, my question for you is do you accept that there would be nothing unusual about employing - a hospital like Bundaberg employing a doctor on a locum basis on those sorts of terms, save that there shouldn't be a reference to the award?-- Sorry, can you repeat that question again?

That there would be nothing per se unusual about a hospital like Bundaberg employing a doctor as a locum on those general terms, save that it wouldn't be employment under the award?-- My recollection of the - the policies and rules around that, if I can use that terminology, is that if - if the hospital was engaging a locum as it were as a company or a registered

partnership, that that sort of arrangement does occur. In other words, a locum agency or a registered company, medical company, which employs a doctor specifically can engage in a commercial arrangement with a - with a hospital. But as an individual provider, I'm not aware that that - that that occurs.

My suggestion to you is that the - a common practice for hospitals employing individuals as well as doctors as locums is to engage them on market rates, which commonly fall in a range between about a thousand and $1500 per day?-- Mmm. I mean, I'm happy to respond to that in terms of saying, "Well, I can only respond in my own experience."

Yes?-- Certainly, I - whilst I was in Bundaberg, I employed locums at so-called market rates through a commercial arrangement with a registered company. In fact, I recall seeking advice corporately about that. If it were a company or a locum agency, that that was just a commercial arrangement. That there was an issue with employing an individual on a payroll, if you like, outside of award rates, that that was an industrial issue. So I can't really - so, two parts to the answer to that question: firstly, yes, locums are employed at market rates, I would imagine, throughout Queensland outside of award rates if they're employed as a medical proprietary limited or partnership, but I'm not personally aware of doctors being appointed as individuals as employees outside of the award.

Thank you, Doctor. Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Diehm. Is there anyone else who hasn't yet cross-examined who wishes to do so?

MS FEENEY: No, thank you, Commissioner.

COMMISSIONER: No? No-one else. Mr Farr any re-examination?

MR FARR: No, further questions.

COMMISSIONER: Mr Morzone?

MR MORZONE: No, thank you, Mr Commissioner.

COMMISSIONER: Doctor, thank you. I would like just to apologise again for any unpleasantness yesterday afternoon. Your evidence has been extremely helpful to us. We've taken particular note of what you've said about the Patient Safety Centre and I'd like to congratulate you on the good work that's taken place there and I would like to see that continue as part of any changes that subsequently occur in Queensland Health. We do appreciate your time and we're sorry for any inconvenience. I know you were scheduled to come earlier in the week but, unfortunately, things don't always run to schedule in these proceedings. Thank you again, Doctor. You're excused from further attendance?-- Thank you, Commissioners, and thank you for your apology.

Thank you. I think on the shelf there was the original copy or our copy of Exhibit 102, the report; if that can be returned.

WITNESS EXCUSED

MR MORZONE: If it please, Mr Commissioner, I call James William Gaffield.

JAMES WILLIAM GAFFIELD, SWORN AND EXAMINED:

COMMISSIONER: Dr Gaffield, please take a seat and make yourself comfortable. Do you have any objection to your evidence being filmed or photographed?-- No, it's fine.

Thank you. I am going to have to ask you to keep your voice up too because it is important that everyone hears you clearly?-- Yes.

Thank you.

MR MORZONE: Your full name is James William Gaffield?-- Yes.

You are a member of the Royal Australian College of Surgeons?-- Yes.

You're presently in private practice in Bundaberg?-- Yes.

You were the staff surgeon at the Bundaberg Base Hospital between April 2003 and June 2005?-- Yes.

You've prepared a statement in these proceedings which has attached to it your curriculum vitae?-- Yes.

Are the facts contained in your statement true and correct to the best of your knowledge and belief?-- With one minor exception.

What is that?-- Sorry.

Do you have a copy handy?-- It's on page 5.

Yes?-- Paragraph 35.

Yes?-- It says there, "I reviewed the patient on a daily basis with Dr David Risson."

Yes?-- It should say following "David Risson", "and other junior doctors".

Okay. Thank you. But for that change, is the balance true and correct to the best of your knowledge and belief?-- Yes.

And are the opinions which you expressed in that statement opinions which you hold?-- Yes.

I tender the statement, if it please.

COMMISSIONER: Yes, the statement of Dr Gaffield will be Exhibit 294.

ADMITTED AND MARKED "EXHIBIT 294"

MR MORZONE: Doctor, I don't propose to take you through your statement in detail but there are a number of issues that arise both in relation to the Mr Bramich case and the P26 case, the 15-year-old boy, that I want to ask you about. The Mr Bramich case first of all that you deal with in paragraph 17 onwards, there are a few issues that arise there that I wanted to ask you about. Initially when Mr Bramich was examined in the emergency department by I think yourself and also your surgical PHO; is that correct?-- Yes

It was thought, and I think you've said this in your record of interview to the CMC, that there was nothing more significant than a couple of fractured ribs at that time. Is that a fair statement?-- Yes, that's how it appeared then.

And you did not at that time predict what ultimately eventuated?-- Correct.

There has been some evidence that, in general, heavy crush injuries to the chest make it difficult to estimate by exterior examination how serious such injuries could be; would you agree with that?-- I would tend to use the word "opinion" rather than-----

Opinion?-- Could you state the question again?

Yes, I'll start it again. In general, a serious crushing injury may not manifest - I'll rephrase that. The seriousness of a serious crushing injury may not manifest itself merely by external signs; would you agree with that?-- Yes.

And that there's a likelihood of severe soft tissue internal damage occurring which doesn't manifest itself by immediate external signs?-- I would say there is a possibility. I wouldn't necessarily use the word "likelihood".

Okay. In ageing adults, where their response to bleeding and trauma is not so marked as in a younger person, that might make the external signs even less likely to show the seriousness of the injury; would you agree with that?-- No.

You don't agree with that?-- Maybe I don't understand the question. I-----

In a person of Mr Bramich's age?-- Which I - was middle age.

Which is middle age. He is unlikely to exhibit externally the kinds of symptoms that a younger person might exhibit for a similar size - sort of injury?-- I think the external signs would be similar based without regard to age.

D COMMISSIONER VIDER: Doctor, could I just check something with you. The original X-ray indicated fracture of the ribs?-- Yes.

It didn't indicate fracture of the sternum; is that correct?-- That's correct. And chest X-rays are very good at detecting fractured ribs - or it's still not that easy to detect fractured ribs but it's doable. External fractures are something that are notoriously difficult to pick up on X-rays. They basically, in general, unless it's a super - severely displaced fracture, do not show up on X-rays. It is one of those you would think that it would but they in fact don't.

MR MORZONE: An intercostal drain was inserted initially in ICU - I beg your pardon, in the emergency department?-- Yes.

And subsequently you've relayed in your statement noting on the 27th of July, which is two days after Mr Bramich's admission, that that intercostal drain was not working properly; is that correct? Or at least you had a concern that it wasn't working properly?-- I had a concern that it was not adequately treating potential bleeding that he had on the inside but it still seemed to actually be working to some extent.

You say in paragraph 23 it had only a limited amount of drainage?-- Which would suggest to me that it was still working to some extent.

And a second drain was inserted in ICU and that revealed a further drainage of a significant amount of blood?-- Yes.

Which also suggests the initial drain wasn't properly working?-- It was not adequately draining the blood that was collecting.

Okay. And we know, of course, from the autopsy report that ultimately when Mr Bramich died, there was three litres of blood found in his thoracic cavity, and would you agree with what Professor Woodruff has told the Commission, that in the absence of any major vascular injury which the autopsy report also excluded, that must necessarily have meant that the drain, whether it be the first drain or the second drain, was not draining adequately fully?-- There's a lot of issues that you just said there, sorry. There's a couple of different issues there.

Okay?-- My reading of the autopsy result is - does not correlate with what you just said there.

There was no major vascular injury?-- There - the autopsy result demonstrated multiple torn intercostal vessels. I think that's to some extent a major vascular injury, it's certainly not a transected vena cava, but torn intercostal vessels are a vascular injury.

Okay. Okay, I understand what you're saying. Nevertheless, the presence of that blood would indicate that the drainage was not working properly; wouldn't you agree with that?-- There was blood, internal bleeding that found its way out through the tubes and internal bleeding that did not find its way out through the tubes.

And ordinarily, one would hope that these drains working properly would drain all the blood?-- Yes.

Okay. And we see there's - in a adverse event report which I can perhaps pick up quickly, and I think is part of Exhibit 163, and perhaps it's easiest to put it on the screen. This is a report that you probably recognise having been put in by Nurse Karen Fox after the incident, and she reports as the incident the intercostal drain having no water in the underwater seal section, and the place she reports that is in ICU; do you have a copy of that?-- No, but I - no, I don't have a copy.

If you go down the page, you'll see a highlighted yellow section on the screen; can you see that adequately?-- Yes.

That's the part that I'm referring to and if you go over the page, you can also see at the top of the page, which may - which has been highlighted there's a reference to, "On doing checks, noted no water in the underwater seal drain section of the ICC drain.", and underneath that again in terms of prevention, "More time checking.", and then the shift supervisor has made a note of, "Action taken or needed to be taken.", and there's a note there, "Awareness for the need of water in the underwater sealed section of the drain." All those - that tends to indicate, obviously, that the drain was recognised as not working by at least the nursing staff; is that something you can comment on, do you agree with that?-- I guess it's something that I became aware of this morning, and my - so it wasn't something that I was aware of at the time. I think it would be very important to know when exactly the time was that this was noted on the - it looks like it was filled out the day after his death, but where in the course of events during his hospital stay was this noted? Presumably it was in the ICU.

Okay?-- How long was the cannister incorrectly, you know, not - that it didn't have the water in it? How long before it was noticed was it? When they did notice there was no water in it, what did they do about it? All of those sorts of things would be helpful to know.

I accept that. Focussing on your knowledge of matters, you attended the surgical ward when called urgently by Dr Younis?-- Yes.

That's on the afternoon, early afternoon, I think, of the 27th?-- Yes.

About 2 p.m. or thereabouts?-- It was earlier than that.

Earlier, okay. And presumably, by your language, which you mention in paragraph 23 and 24, you at least have a concern immediately arising about the patency of the drug, otherwise you would have stated that you did?-- Yes.

Do you - is that the first time you obtained or learned of a concern about the patency of the drain or had a concern about it?-- My concern really wasn't about the patency of the drain, my concern about was with the patient having a, as a acute of a deterioration as I've ever seen somebody have, so you start looking for reasons why that deterioration's happened and we adjusted the drain at that point as one of the things to do in that situation, so.

But doctor, you say in paragraph 24, "Attempts were made to re-adjust the ICC and given concerns as to the patency of the chest tube, a second one was inserted.", so plainly, you had some concerns about it?-- Yes, because when we did make the manipulations to the tube that already was in him, it didn't result in a dramatic improvement in his clinical status.

Sorry, I'm not sure I understood that answer. Before you put in a second tube, you obviously had concerns about the patency of the drain or the tube; correct? Otherwise, presumably, you wouldn't have put in a second one and presumably you wouldn't state as you did that you had concerns?-- I had concerns about the adequacy of it functioning to drain the blood.

Okay. Now, was that the first you learnt, yourself personally, of there being a potential problem?-- Yes.

Had you visited the patient in the surgical ward before then?-- Yes.

Do you recall how many times and whether you reviewed the drain?-- I don't remember precisely, either of those things.

D COMMISSIONER VIDER: Was the underwater seal patent in intensive care when the second ICC went in?-- I would assume so but I can't recall seeing it with my eyes, I would certainly assume so.

Yes.

MR MORZONE: While Mr Bramich was in the surgical ward, we've heard that he undertook some physiotherapy exercises. Were they exercises that were ordered by you or prescribed by you or is that-----?-- They wouldn't have been directly prescribed by me, they would have been - I'm not sure if they

were a standard protocol for rib fracture patients or if it was something that was specifically ordered by junior doctors working underneath me for this particular patient, one or the other.

And we've heard those exercises involved walking and - some distance, I think it might have been 15 metres or thereabouts, and I think some opinions's been expressed that those exercises may have been too vigorous, at least in hindsight, for the circumstances; do you have a view about that?-- Yes, I have a fairly strong view that I think I read the testimony that you're talking about.

Yes?-- Which was about a month or six weeks ago.

Yes, that's correct?-- That indicated that you sort of keep people in bed and do nothing to them for a prolonged period of time when they have rib fractures. That's 1950s level treatment.

I think-----?-- That's been shown to be grossly inadequate at preventing the complications of rib fractures.

But in the circumstances where - in circumstances where there has been a crush injury, then potentially over-exercising could exacerbate any internal injury; would you agree with that, and one must be wary of that?-- You certainly tell people in those sort of situations to avoid things like contact sports, to avoid flying in aeroplanes, I mean, situations where major injuries could happen to the patient, but you do not keep patients in bed following trauma or elective surgery.

Okay. Up until this time, had transfer of the patient to Brisbane been an issue or consideration?-- No.

And again, we've had some different views expressed about this, but one view was that once a patient who suffers an injury of that sort stabilises, which would have been the time perhaps when Mr Bramich was transferred to the surgical ward at the latest, he should have been transferred to Brisbane; what's your response to that?-- My response to that is you would need to build a whole lot of new hospitals in Brisbane to absorb the patients coming from all over the State if you were going to expect patients with routine injuries like rib fractures to be transferred to hospitals here.

Now, we've also heard some evidence about Dr Patel's involvement. Can you tell me when you recall Dr Patel first becoming involved in the patient, approximately?-- I think it was roughly 4 p.m. on the final day, the 27th.

Okay. And we've also heard evidence, and I think the report of Dr Carter that you may have seen to the Coroner, records a request for the retrieval team having been logged at 4.20 in the afternoon, and there's been some - or can I ask you to comment on - I think you in your statement state that you were of the opinion the patient was simply too unstable to transfer

and that that was an opinion that you held throughout the period; is that right?-- Yes.

It's been suggested that, we know, of course, someone must have made a decision to transfer the patient because the log has been made, but it wasn't you?-- Definitely not.

Okay?-- And it was not under anybody working underneath me on my direction.

Okay. Now, a suggestion's been made that after the arrangements for the transfer were made, whether they were made by you or someone else it doesn't matter, but after the transfers were made, Dr Patel was responsible for the cancellation of that transfer?-- That - I have no knowledge at all about that.

Okay. Whilst you were present then, and I think you say that you were present until about six; is that right?-- Yes.

Were you present constantly during that time?-- No. I was present for approximately, I would say half of the time between 1 o'clock and 6 o'clock, if you added all of those minutes up, about 50 per cent of them I would have been there for.

What about between 4.20, which is when the retrieval was logged, until about six?-- I couldn't give you a specific answer about that.

Okay?-- But I do know that that was the period in time in there when - where he had the CT scan done.

And Dr Carter went with him then?-- Yes.

And presumably you were doing other things during that period?-- I don't exactly remember what I was doing, other than eventually looking at the CAT scan myself.

After Mr Bramich had sustained the downturn in his condition from about one or two that afternoon, approximately, was consideration given to transfer him at any time by you?-- No, he, as you said before, it was my opinion that he was way way way too unstable to be transferred.

And did you have any discussions with Dr Carter about those issues that you recall?-- Not that I recall.

Okay?-- There - I think is somebody - as people have told you, there were a lot of people involved in this patient's care late in that afternoon and there were a lot of conversations between lots of different people.

Okay. Now, can I ask you about the patient P26, and you deal with that in your statement from paragraph 30 onwards. That was a patient that initially was under the care of Dr Patel and then you've stated that Dr Patel went on holidays and you took over the care on the 26th of December 2004 which was

three days after he was admitted to hospital, and you've set out what Dr Patel informed you about the patient at the outset, and he - at that time did you review the patient records?-- I don't recall reviewing the patient records, I recall having a fairly extensive discussion in person with Dr Patel on the morning of the 26th about the patient and his other patients that he was leaving me to look after.

COMMISSIONER: And doctor, are the attachments to your statement the notes you made during that discussion?-- No, those are Dr Patel's - let me just make sure.

Sorry?-- Something that looks like-----

Yes, two page document with handwritten notes in relation to this patient?-- That's Patel's handwriting.

And he gave that to you during the handover?-- Yes.

And well, I'm just wondering whether that's then a useful device to refresh your memory as to precisely what was said?-- Yes.

MR MORZONE: Do you want to expand on that in terms of refreshing your memory from those notes what Dr Patel had said?-- He informed me of the - how the patient presented. He was quite proud of himself for saving this person's life. He was - he obviously felt very good about this case in general. He did explain how they had to go back to surgery the three different times but he very strongly emphasised to me that the patient was fixed up. There was, you know, "He was all taken care of, don't worry, everything's fine and a couple days from now when the swelling goes down, you're going to have to put some skin grafts on his wounds." He had really no concerns about the patient

We've seen in evidence a urine pathology test which was taken at 7.20 p.m. on the 23rd of December which was the night that this patient was admitted, and we'll put that on the screen, and Dr Woodruff has referred to this document, as you'll see, that the document shows that the myoglobin is 721,000 when it should be less than 10, and he said that that showed that or was indicative of there being dead and dying muscle and the products of that in the blood - in the urine and that that should have been an early warning sign that something was wrong. Do you remember seeing that or it being brought to your attention?-- Neither.

COMMISSIONER: Doctor, had it been brought to your attention, what if any changes would you have adopted to the patient's management?-- I think the best thing would have been to repeat the test level and see if it was - had resolved or not, because after he appears to have had no blood flow into his leg for six hours, eight hours, something along those lines and any time you have that situation - it can happen in the arms or legs - you get some degree of muscle dying and you get this myoglobin in the urine. The - if the problem is adequately treated and blood flow's restored and you haven't

gone beyond a critical period of time, that level will eventually go back down.

You - I see from your statement you've thought this patient would probably lose his toes?-- Yes.

Or have some part of his foot amputated and that would be consistent with that level of myoglobin, would it?-- I don't think - they really don't have much to do with each other.

It's not quantitative in that sense you can't judge in the myoglobin level how much of the foot or how much of the limb might have died?-- No, I've never seen that sort of correlation reported.

I understand. Had the myoglobin level had been found still to be elevated on re-testing, what would the next step have been?-- Then it would have been to seriously consider that there was ongoing muscle necrosis going on.

Yes?-- And to investigate that.

Right. Thank you Mr Morzone.

D COMMISSIONER VIDER: Doctor, what's the turn-around time for pathology reports? I notice that the place of origin in this is Intensive Care?-- It's incredibly variable. I mean, some things are back in 40 minutes, some things are back in days. So-----

For the Intensive Care Unit?-- Yeah, it matters what the test is, not who the patient is. That speeds things up a little bit but a test that takes a long time to do anyway is not going to be any faster because of a patient being in an ICU.

And did I understand you to say you've only just seen this test here?-- Yes.

You were not aware of it at the time in Bundaberg?-- Correct.

Would the laboratory not ring you and alert you to such an abnormally high result, be it a false positive or not?-- I've never been rung by the lab in Bundaberg about an abnormal blood test, but I notice this is on the 23rd.

Yes?-- When I'm off on vacation at that point.

COMMISSIONER: If they'd rung-----

D COMMISSIONER VIDER: But that wasn't brought to your attention?-- No.

COMMISSIONER: Had they rung anyone, it would have been Dr Patel?-- It probably would have been the junior doctor working underneath him.

Right, but in your experience that just never happened in Bundaberg?-- Never seen it happen.

D COMMISSIONER EDWARDS: What I was going to ask is how - have you a view how this most important document was not available? It was - the time was collected 1920 on the 23rd, the day of the injury, and yet it was this high in level. I'm just wondering - and I know you say you didn't see this - but how could such a document, such a level of myoglobin in the urine not go undetected?-- Well-----

Sorry, go undetected?-- I assume it was detected by the people who were treating him at that time.

But wouldn't it send a shiver down your spine?-- Absolutely, but it was a different group of people treating him at that time.

But those people, wouldn't it send a shiver down their spine to see that level of myoglobin?-- Yes, definitely.

D COMMISSIONER VIDER: And there's no mention, no notation of that on the handover report that's attached?-- No, he - I recall him telling me that the patient had some transient renal dysfunction, presumably from exactly from this, but he told me it had cleared.

Yes.

COMMISSIONER: Mr Morzone, this is, so far as we know, the only haematology result which would shed any light on this? There wasn't a later myoglobin test?

MR MORZONE: Not that we're aware of, that's correct.

Doctor, can I ask you to look at the progress notes which I've opened for you, and-----

COMMISSIONER: Mr Morzone, has the doctor had an opportunity to go through these notes?

MR MORZONE: He should have.

MR FARR: I'm not acting for - I think it's Mr Tait.

MR TAIT: We asked that the notes be available today so that - he's only just come back from overseas.

COMMISSIONER: Perhaps we might then have the afternoon break so that the doctor has a chance to consider the notes as a whole rather than just being taken to isolated passages which he may feel are out of context.

MR MORZONE: Certainly, Commissioner.

COMMISSIONER: We'll break for 15 minutes.

THE COMMISSION ADJOURNED AT 3.08 P.M.

THE COMMISSION RESUMED AT 3.32 P.M.

JAMES WILLIAM GAFFIELD, CONTINUING EXAMINATION-IN-CHIEF:

MR MORZONE: Dr Gaffield, in paragraph 35 of your statement, you make reference to initially observing that the leg had a mottled appearance and that the colour you then say seemed to improve over the next few days. But you said you formed the view that it was likely the patient would require transmetatarsal amputation at some point. Do you recall when it was that you formed that opinion?-- When I talked to Dr Patel.

When you talked to Dr Patel?-- Yes.

Right at the beginning?-- Yes.

Is that not something that by itself would have required transfer to Brisbane?-- No.

Is that something that would have been done at Bundaberg?-- Yes, and has been done relatively commonly.

Okay. You have had a look at the progress notes - and I don't want to take you to them in any particular detail, but can I put these couple of propositions to you: that the progress notes don't show an improvement in the leg over the period from about the 26th through to the 30th. They might be equivocal in some parts but they don't show an improvement. Would you agree with that?-- Not exactly. I would say I think equivocal is a good word to describe the overall progress of his leg, but in some ways there were signs of slight improvement in the appearance of this leg, although not dramatic improvement.

Okay. Well, for example, the limb observation chart - which we can perhaps put on the screen - I have got one copy there - that certainly seems to reflect consistently patchy sensation and motley coloured leg throughout the period and also swelling throughout the period. There is no improvements in those, is there?-- There is a - pretty-----

They go over the page as well?-- Pretty vague terms. There is a lot of - there is various degrees there of swelling and mottling, those sort of things, so it is not an all or nothing phenomenon.

Okay. Well, okay, certainly observations wise, looking through the range that one can write down in that sheet, there is no - certainly no dramatic improvement during that period. In fact, there is no movement from those sorts of descriptions throughout the period, as far as I can see?-- There were - the words are the same there but, again, there is no - you would really need to have a photographic documentation. I

don't think this piece of paper shows the whole picture.

COMMISSIONER: Doctor, do you have a recollection yourself as to whether there was any observable improvement in the limb?-- Yes, a fairly vague recollection that there was again mild improvement in the appearance of the leg for the first three or four days. Basically no change for better or worse for the next day or so and then a sudden decline in the last 24 hours he was there.

And was the mild improvement you speak of in relation to colour or swelling or-----?-- Mostly swelling was one of them, certainly. The swelling did go down a bit, not as much as I wanted it to go down to do the anticipated skin graft.

Yes?-- The mottled appearance of the leg, it was initially, I believe, just a little bit above the ankle where the demarkation from normal looking skin to mottled skin was, and over the first two or three days that definitely improved so that the skin looked normal further down. So that was definitely something that we saw, the mottling - there was less skin that was mottled. Those are the two things that I remember.

With the second thing you referred to, the level to which there was mottling, when it started it was similar, I think someone may have described this as looking as if he had socks on because there was a change in colouration?-- Yes.

And that reduced down towards the level of perhaps the achilles tendon, or thereabouts?-- Yes, again, it got to a smaller sock than that.

Right.

MR MORZONE: In those - that particular document, the leg observation sheet, there is an absence of records for the 29th of December. Do you know why that is? They seem to follow each other but-----?-- No, I don't know.

Okay?-- I was also going to suggest whoever filled out this form, I don't think it is entirely reliable because they have used the word "motley" to describe the colour of the leg, and motley is indicative to me that a person doesn't really know what they are talking about. It is mottled, not motley.

D COMMISSIONER EDWARDS: They also could feel a pulse, according to this, all the way through except for the first three times readings at 20 past 12?-- Sorry, can you repeat the question?

I note that they had also said there was a pulse strong in the leg from the third reading at 7.25 on the 27th. Does that surprise you, in retrospect?-- No. The issue with the pulses was that there was a great variability in the information that you see on the chart. It really depends on the person - a lot of it depends on the person who is checking the pulse, what they were using, how good - some people are better than others

at checking for pulses. Some people would get out the Doppler and use that, some people feel their own pulse when they are checking for a pulse. It is one of those things that I don't think it is really all that reliable unless it is the same person doing it over an entire period of time.

Are you really saying that feeling or not feeling a pulse is unreliable?-- Yes, definitely depending on who is doing it.

I think - I am surprised?-- Some people are very good at doing it. It also has to do with the sensitivity in your fingers. There is great variability in the ability to detect pulses.

COMMISSIONER: I suppose it makes a difference that this is looking for a pulse in the foot rather than in a wrist or-----?-- We can almost all feel that pulse. Pulses in the feet are notoriously more difficult to feel, and, again, this patient's foot was roughly twice a normal foot, so that makes it more difficult, too.

MR MORZONE: Okay. Dr Woodruff has said that it was quite apparent from the features of loss of sensation and spasm of muscles that are described in the progress notes that there was dead muscle in the leg. Would you agree with that?-- I think in retrospect, yes.

At the time that wasn't so obvious?-- No.

I will ask you to have a look also on the screen at this haematology report, which has also been referred to by Dr Woodruff, so I can ask you for your comments on that. I think you make mention in your statement of the white blood cell count increasing dramatically on the 30th and 31st. Certainly on the 30th, from 10.5 to nearly 18, and then to 19.5 on the 31st. Dr Woodruff also referred the Commission to the neutrophil count, which I have highlighted, and he said that they're becoming elevated on the 28th, which is another indication that the patient is septic, and clearly septic at around that time. Do you have a comment about that?-- Yes, I think those - I think those dates should be moved forward by two.

By two?-- I don't think that those numbers support the development of overwhelming sepsis, or however it was stated, with a normal white blood cell count and a normal neutrophil count on the 28th of December.

I understand that, okay. Now, so that you can comment completely on Dr Woodruff's opinion, his opinion is that with the blood - I beg your pardon, the urine test which I first took you to, the blood test that we have now seen and also the progress notes showing the loss of sensation and spasm in the muscles and the lack of progress, that all of those showed that there were difficulties and that the patient ought to have been transferred earlier than the 31st. Would you agree with that in hindsight, at least?-- Just to be - he was transferred on the 1st.

I beg your pardon, yes?-- In hindsight, yes.

And in hindsight, how much earlier do you think he should have been transferred?-- I think 24 hours earlier would have - I think I should have picked it up 24 hours earlier. I think going previous to that is something that can really only be done in retrospect.

COMMISSIONER: Doctor, I think it is fair to say that no-one has suggested that a failure to transfer the patient 24 hours earlier has had any long-term impact on him. He didn't lose his leg in the last 24 hours.

MR MORZONE: Exactly, Commissioner, yes. Finally-----

COMMISSIONER: Doctor, reading your statement, and based on a great deal of other evidence we have heard in relation to this patient, it seems to me that the big problem is that you were effectively assured by Patel that he had corrected the vascular problems and if you had been in any doubt about that, not being a general surgeon and particularly not being a vascular surgeon yourself, I take it you would have referred the patient to Brisbane for appropriate vascular care?-- Definitely.

MR MORZONE: Okay. Can I ask you to have a quick look at this document, which is a briefing note which was given to the zonal manager after the incident by Dr Keating? I am instructed it is attached to the Rashford statement, Mr Commissioner, which for the record-----

COMMISSIONER: Yes.

MR MORZONE: -----I can't turn it up quickly. Doctor, there is only one question I wish to ask you about that, not so much the detail of it, but you will see there there is reference to Dr Keating consulting you before writing that report, is that correct?-- I believe so. I don't-----

Before you gave any information to Dr Keating, did you make any contact with Brisbane or doctors in Brisbane about the consequences?-- No.

Transfer or what operations occurred afterwards?-- No, I heard that through the grapevine.

Okay.

COMMISSIONER: For the record, the statement of Dr Rashford is exhibit 210.

MR MORZONE: Thank you, Mr Commissioner.

COMMISSIONER: So an attachment to that.

MR MORZONE: I have nothing further, thank you, Commissioner.

COMMISSIONER: Thank you, Mr Morzone. Mr Tait, do you have any questions?

MR TAIT: No, thank you, not at this stage.

COMMISSIONER: Mr Harper?

CROSS-EXAMINATION:

MR HARPER: Dr Gaffield, my name is Justin Harper and I appear on behalf of the Bundaberg Patients Support Group. I would like to talk to you about the care of the patient Mr Bramich. You mentioned in your evidence-in-chief that routine rib fractures would not normally be referred to Brisbane. Would it be fair to say, though, that the circumstances of this accident would not have constituted routine rib fractures?-- I think I meant to say rib fractures would not routinely be transferred to Brisbane.

Right. Would a factor, though, in determining whether to transfer to Brisbane, not be the seriousness of the trauma involved?-- Yes, that would be considered.

Right. And so then in this circumstance where you have a patient who is admitted having had a caravan fall on his chest for a period of about 15 minutes, would that not be a factor which you may consider in determining whether to transfer that patient?-- Yes, it would be a factor that you would consider.

Okay. Was it a factor which you considered in determining whether to transfer Mr Bramich?-- It was one of many factors considered.

Right. Obviously, then, there must have been counterweighing factors against that?-- Yes.

Right, and what were they?-- His overwhelming clinical stability.

Right. You mentioned as well that the sternal fracture can be difficult to pick up. Now, would that include where there is a complete fracture right through of the sternum?-- It would depend on whether it was a displaced fracture or not.

Right?-- The fact that - as I saw in the autopsy result, the pathologist says there was a complete - I think her words were "complete transection of the sternum".

Yeah?-- That still doesn't tell you whether or not it was a displaced fracture and the degree of displacement of the fracture.

But obviously a complete fracture is more likely to be

displaced? The basic physics of it - I assume if it is not a complete fracture-----?-- There are not really textbooks written about sternal fractures. It is a rare injury so I would assume the answer to your question is yes, but I don't know.

Again, if you had been aware of a sternal fracture, would that have influenced your decision whether to transfer?-- I would have considered it with everything else that's going on with the patient, but sternal fractures are something that are very - are - it is not a common injury, but when it happens it is usually an injury that has no significance.

It would cause a degree of pain, though, I assume?-- Pain, yes, and he did not mention pain in that area.

Right. Can I take you then to the notes, to the clinical notes? I might get this put up on the screen, if I can. Now, if we could just scroll up the page a little bit, we can see the date of this one. Perhaps that doesn't have the relevant date. I will have this put up. You see there that's the 25th of July, which is - these are the notes which are taken on admission.

COMMISSIONER: Doctor, these aren't your notes, these are your-----?-- This is from Sange - this is Sange's handwriting.

MR HARPER: Dr Kariyawasam?-- Yeah.

You will see there - if we can just scroll up a little bit, you will see there it is identified on admission he has fractured ribs and there was a CT of his chest and abdomen done. If I can go now to the next page - you will see this is the next day now, on the 26th of July, and I have highlighted there what I read to be "Patient complaining of" - something?-- "Mild".

"Mild", is it, "pain in chest". Okay, if we can go further down the page then, "chest X-ray". So he was at least then reporting some pain in the chest?-- Yes, as anybody would with rib fractures.

Right. But was it not beyond what he'd suffered - what he had been reporting the day before?-- I am sorry, can you say that again?

Sorry, would you accept then there was something further in addition to what he had reported the day before by the fact that a chest X-ray was then conducted the next day?-- No, that's a normal thing to do every day the patient is in the hospital with a chest tube in place.

Can I ask when were you made aware there was a sternal fracture?-- I don't exactly recall but I think it was somewhere way down the road.

Okay.

COMMISSIONER: After the patient was transferred to Brisbane - attempt to transfer him to Brisbane, sorry, yes?-- Not - after he had died.

Yes.

MR HARPER: Can I ask in relation to the decision to have some physiotherapy treatment by mobilising him, do you know who made that decision?-- No, as I said before, I don't know who exactly made that decision, whether it is a standing order for trauma patients, or whether it was an order put in by junior doctors working underneath me.

Okay, but were you the surgeon in charge of Dr Bramich at the time the decision was made?-- Yes, I was in charge of Mr Bramich.

But you didn't authorise that physiotherapy?-- Not directly.

Okay. Would it be normal that you would have at least been consulted about a decision like that?-- No.

Right?-- Physiotherapy is a normal thing to do for patients who have had rib fractures.

Can I ask again, if you had known about the sternal fracture, would it have been normal as well, for a sternal fracture as well?-- Yes, we would have had some - potentially some modifications in what was done but physiotherapy still would have been started.

You answered some questions earlier from my learned friend Mr Morzone and he put to you an assertion that the autopsy report did not reveal any major vascular injury. Could I possibly get you to - I have got the autopsy report here of Dr Ashby, which is dated the 1st of August 2004. Can I get you to have a look at it, please? If I can just indicate where in there she identifies any major vascular injury?-- I will need to read through the whole thing.

Yes?-- And I would need to actually read through what's in the patient's chart, which is her handwritten - there is a second report from her. It may have been in there that I read it.

COMMISSIONER: Mr Harper, is there any point? I mean, we can actually read the report for ourselves.

MR HARPER: Okay. Well, if I suggest to you that in fact, as Mr Morzone put to you earlier, that that report says - and you can go to the bottom of page 2, it refers - the only reference I could find, "The major great blood vessels are intact, the aorta has minimal atheroma." Other than that, I was unable to find any other reference to major vascular-----?-- It is in there. It is definitely in. I haven't found it in here yet. It may be in her handwritten record. I read it about three nights ago.

Okay. Can I put then, though, were it to be that there is no finding by Dr Ashby of any major vascular injury, would you accept Dr Woodruff's evidence that the conclusion can therefore only be that the drain was not working appropriately?-- I don't think - I don't want to say yes to something when I don't agree with the first part of your sentence.

Okay?-- Because you say "Given there is no vascular injury", but my reading of the autopsy report is there is a vascular injury.

MS McMILLAN: If I could just have my file back, I know where the handwritten report is. That might be fairer to the doctor to show him.

COMMISSIONER: Yes.

WITNESS: I don't see it in this report. Do you want me to read?

MR HARPER: If you can.

COMMISSIONER: That would be useful, thank you, doctor?-- It says - we're here on "internal", it says, "Comment: The blood in the right chest appears to have originated from intracostal blood vessels, not only at the fracture sites but bruising crushing damage to soft tissues. The right internal mammary vessels may have been damaged by the sternum fracture but could not be identified." It goes on to talk about the pericardium. That is where I think he bled from, his intracostal vessels.

MR HARPER: Is that categorised, though, as a major vascular injury, would you think?-- Yes, when it leads to death, yes.

But I think Dr Woodruff's point is that clearly there is some bleeding and that is the purpose of the drain, in the absence of a major vascular injury for which the drain could not cope, therefore the drain must not have been working appropriately?-- I am sorry, can you-----

COMMISSIONER: I don't understand either.

MR HARPER: Sorry-----

COMMISSIONER: The patient bled to death internally, three litres of blood in his chest.

MR HARPER: And Dr Woodruff says that the two possible causes of that are (a) that there was a major vascular injury, or (b) that there was obviously some other bleeding and the drain failed.

COMMISSIONER: Well, Mr Harper, aren't we just playing with words? There was a sufficient vascular injury to produce enough blood that if the drain wasn't working the patient

died.

MR HARPER: Yes.

COMMISSIONER: We didn't have three litres of blood come out through the drain, we had three litres of blood accumulating in his chest.

MR HARPER: Yes.

COMMISSIONER: That's the end of the story, isn't it?

MR HARPER: Well, as I understood it, Commissioner - the witness doesn't accept that the drain wasn't working.

WITNESS: I accept the statement that you just said.

COMMISSIONER: Yes?-- I would say yes to that.

MR HARPER: If the witness accepts that the drain is unlikely to have been working, then I don't need to take it any further.

COMMISSIONER: Well, the fact is that there were three litres of blood in the chest that didn't come out through the drain. Whether it was the drain was mechanically malfunctioning, or inserted in the wrong place, or obstructed internally, whatever the reason that was the cause of death?-- It didn't drain out the three litres of blood.

MR HARPER: I won't take it any further, Commissioner. Just one other area. You talk about at page 8 of your statement, the insertion of PermCaths and at paragraph 64 and 65 you talk about Dr Miach getting to transfer his renal patients to you rather than to Dr Patel?-- Yes.

Okay?-- Specifically his patients who needed this procedure done. It wasn't necessarily patients who needed a wide variety of procedures but this specific one.

How long had you been working there at the time when Dr Miach imposed that practice?-- Roughly one year.

Right. So you knew Dr Miach pretty well by then?-- No, I didn't know him well then and I don't know him well now.

You'd worked for him for a considerable period of time though?-- We worked in the same hospital and we said hi to each other in the hallways.

You never had the same patient that you needed to work together on?-- Maybe once or twice a year.

You maintain that Dr Miach didn't say anything to you why this occurred?-- Correct.

Did you think it was a little unusual though?-- I thought it was a little bit - the whole thing was a little bit immature.

Right. So by that, what was immature about it?-- There seemed to be a conflict between the two of them that seemed to me to be personality based.

Right. And Dr Miach-----

COMMISSIONER: That's without knowing either party's side of it as it were?-- Yep.

Had you known that Dr Miach had ongoing experience of Dr Patel fitting these drains, you wouldn't have thought it was at all immature for Dr Miach to keep his patients away from Dr Patel?-- No, but back then, what I heard was Dr Patel's side of the story, is Patel was very - he took this as a slap in the face.

MR HARPER: Okay?-- So he was actually very angry with me, Patel that is, that I started doing these procedures. He wanted me to, you know, basically tell Dr Miach to go find somebody else to do them somewhere else.

And how did you respond to Dr Patel when he said that to you?-- Like I normally did to him, which was to try to get away from him as soon as I could because he just - he had - he was somebody who had lots of bad things to say about everybody around, including people standing right next to him, so I really didn't want to be any part in that sort of behaviour.

But it didn't make you pause for thought about whether you

should go back to Dr Miach and say, "Look, it is just a personality difference. Can't you just sort it out and get Dr Patel to deal with it"?-- No.

And Dr Miach never mentioned to you anything about his concerns about the quality of the work which had been done by Dr Patel?-- Never.

Okay. I have nothing further, Commissioner. Thank you.

COMMISSIONER: Just following up on that last point, I guess one of the mysteries that the three of us have been contemplating over the past three months is what drove the personality of Dr Patel. I take it, Doctor, that you've been as shocked as anyone with the revelations of the level of problems associated with Dr Patel's surgery?-- Yes.

But from what you've said, you didn't find him a particularly attractive person in a personality sense?-- Correct.

Do you feel, from having dealt with him as essentially co-equal professionals in the same hospital, that you can shed any light on the personality issues that may have resulted in this situation?-- It would be sort of my speculation.

Yes?-- I think, you know, like a lot of people, he wanted to be well liked and - well, maybe not so much well liked but well respected.

Yes?-- He definitely craved professional acknowledgment of his good work. He wanted people to think he was really, you know, better than average, whether that be through the complexity of the operations he could do, the volume of them, the speed at which he could do them. He wanted - he was not content with being average; wanted to stand out. Bundaberg Hospital wasn't a place that that was appropriate or - for that kind of person. I mean, there's lots of surgeons like that but I don't think they'd seen one like him there for a long time, if ever. And the place wasn't set up to keep pace with him or to police him either way.

All right. I take it you'd never heard of him before you arrived at the hospital?-- Correct.

D COMMISSIONER VIDER: As the Director of Surgery then, did the surgical unit ever have meetings, unit meetings?-- Yes, every Thursday at lunchtime.

And who went to those?-- Who was supposed to go were the full-time surgeons, Patel and myself, all of the junior doctors rotating on surgery and any of the VMOs in town. Although the meeting was - and any medical students on surgical rotations. The meeting was all - open to anybody though. It was not a closed meeting. And we would get a few junior doctors on other services and one of the gynaecologists came to the meetings quite a bit.

Were they fairly well attended?-- Yeah, there would be

between five and 15 people there, I think, in general.

And was the nature of the meeting used as a teaching forum or was it mainly talking about the surgical program for the coming week?-- We never had those sort of talks about the operations that we're about to do. We had three week - it was basically ran on a four-weekly cycle. Three of the weeks were educational and then the fourth week was the morbidity and mortality meeting, which was also basically - became a - more of an educational conference than a strictly spill your guts about your complications kind of meeting.

We've had some evidence presented by people that that certainly never went on, that full and frank presentation of clinical case studies?-- In retrospect it certainly didn't. It seemed - at the time, it seemed that we did - I mean, certainly - I have a problem in that I wasn't at those meetings very often or usually I'd get there with about 15 minutes in the meeting left and Patel would already - he would start off by doing his complications or his junior doctor would do his and then I would show up, because my theatres were always running over time on Thursday morning, and I would get there, he would be done and then my junior doctor would present my complications. So probably 80, 85 per cent of the time I wasn't there when his complications were being presented.

Mmm?-- But the - the junior doctors, I asked them retrospectively if he asked them to withhold information or not to present cases and they always said no, that he never - he never, you know, told them not to bring cases up. But certainly I - if we did discuss all of the cases that rightly should have been discussed there, I don't think there was adequate introspection on his part.

Certainly we have had some of that evidence presented to us that could allow one to form an opinion that there is the commission and omission part. Junior doctors necessarily may not be experienced enough to know what they should have included. They might just present something that they consider adequate that by comparison for, say, someone like yourself would be a superficial presentation of the case?-- And sometimes that - what also happened at the time was if you started presenting the same complaint over and over, everybody gets a bit bored with hearing about it, so it sort of - you know, for example-----

Try an anastomotic leak?-- It shouldn't be something serious, but say an extra day in hospital after a laparoscopic gall bladder operation because of more pain, or something like that, which is relatively insignificant - not actually common but just, for example, say that was common, and you kept having that happen, things like that would tend not to get presented because we - "Okay, we've talked about that enough already, let's leave it behind." But it could be an ongoing problem that you're actually just ignoring. That's just a made up example.

Were those meetings informal or if there were outcomes raised with those, were they taken anywhere else?-- I don't believe they were taken anywhere else.

D COMMISSIONER EDWARDS: Did he chair that meeting?-- Yes.

COMMISSIONER: Doctor, we've heard it suggested by Dr Woodruff that from his examination of the files, there wasn't any indication of Dr Patel ever corresponding with another specialist taking advice or assistance or anything of that nature. Is that consistent with your experience at the hospital?-- Partially. It's my impression that he never sent letters to the GP - you know, when a patient was referred to him he never sent the letter to the GP which most - I think basically everybody else in the hospital did, to let them know what his evaluation was and what he was going to do. I think the - the one case where I thought that he did consult a fair amount was with our visiting oncologist, although I think I've heard from - you know, in Geoff de Lacy's testimony or somewhere along the line that he even didn't talk to oncologists, but my impression - my impression was that he did quite a bit and that he enjoyed talking to the oncologist, who visits every third week. But that's information I just have from talking to Dr Patel, not first-hand knowledge.

It's also been suggested that he was unfamiliar with at least the practice that operates in Australia and I can't comment on whether it is similar in the United States, that when one specialist or consultant asks another for advice in relation to a patient, the patient remains the patient of the first consultant, it wasn't Dr Patel's right then to take over care of the patient and proceed with operative treatment as if it was his patient. Did you experience anything like that?-- I, again, read about that and the last time I sort of heard that kind of an issue was when I was a third year medical student when there were very rigid rules in the teaching hospitals where if a consultation was requested, you were only supposed to give an opinion, not actually do anything. But in the reality of practising medicine, I found that not to be the case at all; that if somebody asks you - if somebody asks a surgeon for a consultation, they expect the surgeon to do the surgery that is needed without running it past them. That's always been my observation and I've never got - you know, had anybody come back to me and say afterwards, "But, you know, I just wanted an opinion. I didn't want you to do something." So I think, really, if somebody just wants an opinion, they should make it clear to the surgeon that they just want an opinion.

The other thing that's been suggested, and perhaps the way it's come out is slightly exaggerated but it's implied at least that Dr Patel would stalk the wards looking for patients to the point that patients had to be hidden from him to prevent him performing surgery. Can you shed any insight on that?-- Yes, I never heard of patients being hid from him, that's something I read in the newspaper. He certainly - and I think this was to his credit to a large degree, if he was on his - you know, almost ready to leave to go home and he heard

about somebody with a ruptured spleen in the emergency room, he certainly, you know, took a right-hand turn and went to the emergency room rather than pretending he didn't hear about it and duck out as quick as possible. So in a lot of ways I think that was a good trait that he had but I do also think that he saw surgery as the cure for everything.

Thank you, Doctor. Mr Allen?

MR ALLEN: Ms McMillan was going to go first, Commissioner.

MS McMILLAN: I got the prize.

CROSS-EXAMINATION:

MS McMILLAN: Doctor, my name is McMillan. I appear for the Medical Board. I just want to ask you a few questions. Doctor, you've been asked a number of questions in relation to the Bramich case and I don't want to go over that ground again but I just want to clarify one or two issues. Now, you were asked in relation to it and I think you must be referring to Dr Ashby, the pathologist's evidence. I think you said you read that; is that correct?-- Yes.

One of the statements she made is a statement, firstly, about the degree of the arterial disease because it is difficult often to tell that and you have given some evidence about that today. The second issue is she commented about the age of Mr Bramich and she said, "You couldn't call him an old person by any degree but he was ageing and in ageing adults and certainly in older people" - she was effectively saying that it can be masked in - the bleeding, rather, in a fit, healthy person. What do you say about that?-- It's actually the opposite is true. It's the fit, healthy people who can mask bleeding more than people who are getting older.

All right. Okay. Doctor, in relation-----

COMMISSIONER: Sorry, just to interrupt on that. I think the suggestion though was that people - take, for example, a person with a poor circulatory system, either through age or through vascular disease or through smoking or through any of the usual courses, that that person will in fact have defence mechanisms in their system that will address the poor circulation. So if that person then has a circulatory problem, it doesn't become apparent as quickly as a young, fit healthy person, who will immediately show the signs of interference with circulation?-- Partially-----

Yes?-- -----true. The older person with vascular disease or circulatory - in fact, specifically in arterial disease-----

Yes?-- -----is more able to tolerate an acute arterial event than - because of they've already developed collateral

arterial vessels to effectively bypass diseased blood vessels. So in that specific case, the less well person is - can tolerate that event better than a young person. But in terms of haemorrhage, a young person can tolerate that - that's not haemorrhage that I'm talking about in that situation but for haemorrhage, the - between about age 15 and 25 is your - your best period to survive that.

For most things?-- Yes, yes.

MS McMILLAN: Doctor, if I can just finish that quote. That they sometimes - "Their response to bleeding and trauma may not be so marked and evident as in a young, fit, healthy person. So certainly in geriatric medicine, masks of bleeding and infection is very common, so that his signs may have been misleading. They may not have been so serious as one would expect normally." What do you say to that?-- I think there's lots I wouldn't agree with. I think we need to go back piece by piece.

Okay. We'll start, "Their response to bleeding and trauma"-----

COMMISSIONER: Ms McMillan, I'm not sure there is any point taking these generalities any further. The doctor has made his position fairly clear.

MS McMILLAN: Well-----

COMMISSIONER: No, you go ahead if you think it is useful. I don't for the moment see how it can possibly be but you proceed your way.

MS McMILLAN: All right. Well, I just wanted to - perhaps if I can encapsulate it, Doctor, as I understand what you're saying. You're saying you don't necessarily agree with that. You would think it would be the other way around, would you, if you've got a young, fit, healthy person, you think it's the other way around in effect, the masking of the bleeding in a trauma?-- Yes, the young, fit, healthy person can mask it much more effectively than others.

Right. Thank you. Now, in relation - when the drain was-----?-- Excuse me. Actually, I should say the young, fit, healthy person can compensate for it better than older people. "mask" may not be the perfect word to use.

More adept at coping you mean?-- Yes.

Now, in relation to when the drain - the first drain was placed into Mr Bramich, it was done under your supervision you've said in your statement?-- Yes.

Doctor, are checks done at that time to see that it's functional?-- Yes, both-----

What sort of things are done?-- You basically look at the result of what's happened when you put the chest tube in

and - which is blood coming out.

Yes?-- You connect it to the cannister and make sure that there is - to make sure there is a variation in the level of water. The water should go up and down with respiration. And then the final thing you should do is a chest X-ray to make sure the catheter is in an appropriate position.

Do you recollect whether those things were done with Mr Bramich?-- They were all done.

And once it's in place, are there checks or how do you check that it's actually continuing to function properly?-- One thing you do is look at the output to see if there's any additional blood coming into the drain. The other thing you do is again look at that water level and see if it's going up and down.

Doctor, in relation to the notes, and I can show you these if you wish, it records about swinging the - the drain swinging but no bubble and is that something important in relation to whether the drain is functioning properly?-- No, that would be a note written by somebody who is not well-informed. The only reason you would ever have bubbling or ongoing bubbling is if you had a suction device connected to it.

And-----?-- So you've got the tube coming out into the box, you've got another little tube that you can either leave exposed to air or you can connect it to a suction device at the wall to actually pull out. In that case, you have ongoing rapid bubbling in the tube.

Right?-- Or the other way you would have bubbling is if the patient caught - if they had a pneumothorax and if they caught a little bit of that air, would come out into the tube and give you a little bubble.

It's noted, "ICC in situ. Swinging only", and that's noted a number of times in the chart. Is there any significance of that?-- That tells me it's working.

Right. So that, plus what you actually observe in the cannister as you've indicated, do they tell you it's working?-- That's the same thing. The swinging is just a one word explanation for that.

Did you see Mr Bramich on the 26th? He went in on the 25th-----?-- Yes.

-----we know, late afternoon. Did you visit him?-- Yes.

And to your observation was the drain working still?-- I don't remember specifically.

Would it be something you would look at?-- Yes.

Mmm-hmm. In relation to when that second drain went in and five to 700 mls of blood drained out, that obviously indicated

to you that there had been blood accumulating I take it?-- Yes.

In terms of the fractured sternum, you say you became aware later it was fractured. Was that after the CT scan?-- No, after he died.

After he died. All right. Now, in relation to the P26 case, when you take over a patient's care, Doctor, is it your practice to read the chart?-- No.

No?-- No.

Is there-----

COMMISSIONER: You rely on the doctor giving you the verbal handover to tell you what you need to know?-- Exactly. And in the case of that holiday period, Dr Patel and I met in person in our office on Sunday morning the 26th right after I got off the plane, he had a plane like an hour later, so we picked a time to meet there, he gave me the handwritten summary and spent about 15 minutes going over everything.

Yes.

MS McMILLAN: Whilst you may not review the chart totally do you look at things like a patient's blood tests, pathology results?-- Not routinely. I would do it if there was a concern or there seemed to be some particular reason to do it but I wouldn't do it as a routine thing.

Did anything in the P26 case move you to think that you should look at the test results or pathology results for him when you took over the case?-- No, unfortunately not.

Doctor, you describe in paragraph 31, obviously he's a young patient that had had a great deal of surgery within a fairly short of period of time, hadn't he?-- Yes.

You know he had three operations, as you've mentioned there. Given also your observation on the 26th, when you took over his care, that he would most likely lose some toes at some point, do you ever recollect whether a transfer for him was discussed at that time?-- There was no transfer discussed.

Did Dr Patel say anything to you to discourage any issues about transfer for him?-- I don't remember him saying anything specifically. There was also an undercurrent with him that was sort of anti transfer but I don't remember in this particular case him saying anything one way or the other.

With P26's care, you indicate that you would go daily with Dr Risson and other junior doctors; correct?-- Yes.

Dr Risson in fact wrote the referral letter to Brisbane for P26, didn't he?-- Yes.

Have you seen a copy of that letter?-- Yes.

Do you want to have another view of it? I just want to ask you some questions about it.

COMMISSIONER: Ms McMillan, why are you doing this? It doesn't have anything to do with your client. It is not a Medical Board issue. Counsel assisting have done their job of calling the evidence that's relevant.

MS McMILLAN: Well, I just wanted to explore with this doctor again because of the other Term of Reference of - previously I've mentioned in relation to other matters that the whole case is obviously a matter that might be one that might merit further action in relation to P26's care.

COMMISSIONER: I'm not going to do anything precipitive until you can speak with your leader but if - we are on a short time schedule, the Medical Board has been given leave to appear to protect its own interests. If this sort of thing continues, I am inclined to withdraw that leave save for issues directly affecting the Medical Board.

MS McMILLAN: Well, I won't continue with the line of questioning. Could I be permitted to ask the doctor one more question in relation to-----

COMMISSIONER: Ask whatever questions you like. I'm not going to stop you now.

MS McMILLAN: And could I reserve the position and in time make some further submissions about that. Doctor, would you just look at that letter, please. Have you read that through?-- You mean right now?

Well, what I'm asking you, I particularly want to take you to page 2 of the letter. The word starting "he started to develop temperatures from the 27th" - "27/12/04". Can you see that there, that paragraph? Are you able to recollect whether you accept the factual information set out there?-- I don't think - well, I think it is slightly inaccurate. He had temperatures all along from the moment he hit the hospital.

COMMISSIONER: Doctor, the medical chart will be much more reliable than that, won't it? In fact, nothing in that letter is going to give us better information than what you've already been taken through by counsel assisting in the medical chart.

MS McMILLAN: If I might have that back, thank you, Doctor.

COMMISSIONER: Mr Allen.

CROSS-EXAMINATION:

MR ALLEN: Doctor, you said in answer to my learned friend Ms McMillan, and I should mention that I'm appearing for the Queensland Nurses Union, you said that observations in relation to Mr Bramich's drain where it was recorded by staff swinging not bubbling is indicative of such observations being made by someone who is not well-informed. Can I suggest to you that such observations are indicative of observations by someone who are both well-informed and astute to the condition of the patient and, in particular, the presence of bubbling would have given an indication perhaps of a pneumothorax?-- I'm sorry, what's the question?

Well, I'm suggesting that it's quite consistent for nursing staff, for example, to note that a drain is swinging and not bubbling. That doesn't indicate any ignorance. It indicates competence and diligence?-- I would accept that noting swinging and presence or absence of bubbling are valid things to record.

Thank you.

COMMISSIONER: Why did you say earlier that you thought that note was made by someone who was ignorant of the situation?-- Well, when we were talking about that before, wasn't there the - I thought there was an implication - how do we know what we were talking about before?

I thought it was just something in the medical chart that was shown to you by counsel assisting?-- It was something-----

MR ALLEN: My learned friend asked you a question about some observations that had been made in relation to the drain which included references to swinging and bubbling not-----?-- I wish I could - there was some reason I had for saying that but the observing swinging, yes or no, the bubbling, yes or no, are very valid things to record. I think what I'm - I wish I could remember it perfectly but the observation that it was swinging but not bubbling meant that it wasn't working and that's what I was - I think I was trying to respond to.

You were probably at cross-purposes. It doesn't mean that at all. It means that it's working perfectly well and it's valid to observe that it's swinging and not bubbling?-- Yes, and that-----

Thank you?-- That doesn't mean that it's not - exactly, it does not mean it's not working.

Okay, thank you. Indeed, if there are observations made at 11.20 a.m. in relation to the drain of Mr Bramich that it was swinging, that would tend to indicate that it was working at least to some extent?-- Yes.

And it would also be quite inconsistent with the scenario you were taken to on an incident report where at some stage it was noted there was no water in the underwater seal section?-- Right. The - I think where that may come from is that the chest tube and the cannister at 11.20 in the morning were with - from a tube that he had that was put in in the emergency room, it may be that the tube, the cannister that was found to have no water in it was from the second, from either the second tube put in on the right side or even possibly the final tube put in on his left unaffected side sometime later that night, who knows.

Exactly. And put in and obviously not observed until sometime later in ICU after he'd been transferred there at about 2.30 p.m.?-- Right.

Okay. And as you mentioned in answers to my learned friend Mr Morzone, you can't comment as to the significance of the finding recorded in that adverse event report form because you don't know when it was noted, for how long it might have been empty of water, things such as that?-- Yes.

But what we do know in relation to what's recorded in that adverse event report form, it had absolutely nothing to do with Mr Bramich's deterioration in the surgical ward back at 1 p.m.?-- Right.

Thank you. In relation to Mr Bramich, you mention in your statement that Toni Hoffman, the Nurse Unit Manager in ICU, felt that the patient needed to be transferred to Brisbane?-- Yes, that was the impression I had.

And there's been some evidence from Miss Hoffman that in fact arrangements had been made so that a bed had been located at the PA Hospital around about 2.30 p.m.; you can't say either way?-- I had nothing to do with that - sorry, what's the question?

Okay. In your opinion, was there any realistic prospect at any time from 2.30 p.m. of transferring Mr Bramich?-- Not safely.

Okay. And finally-----?-- And I just think I can add a little bit to that. I've been on the aeroplane that transfers very critically ill people from Bundaberg to Brisbane, it's about as wide as from here to here, there's no way you can have a really sick patient as Mr Bramich was on that aeroplane for 45 - it's about - it's not much lower than the Qantas flight, but in the time getting to the airport, loading the patient on to the plane, getting him off, he was not a patient who could survive being on that aeroplane for five minutes, in my opinion.

COMMISSIONER: For the sake of the transcript, when you say "here to here" you were indicating what, about six feet or five feet?-- It's probably five feet, yeah.

All right. Whatever that is, 1.6 or 7 metres?-- Yeah.

MR ALLEN: And finally, in relation to patient P26, you were asked to look at a limb observation chart?-- Mmm-hmm.

And you made some comment in relation to entries made under the column which is headed "Colour"?-- Yes.

And you suggested that the fact that someone had written "motley", suggested that they didn't know what they were doing; is that your evidence?-- I guess that's a - yes, I said that, yes.

All right. Well, I'll ask you to have a look at the document again. So, for instance, at the top in relation to colour we've got, what, "purple, motley"; are you saying that that would cause you some confusion as to what's being conveyed, would it, if you read that?-- Yeah, I see that, I think what I was responding to there earlier is that it is it's a bit difficult to be asked to making such a important opinion when the data entry is - when the person writing this is not using the correct word.

Did you ever look at this document when you were considering the care of patient P26?-- No.

So what, as the surgeon in charge, you wouldn't look at the limb observation chart?-- No, I would look at the limb.

I see. All right. So you never had cause to look at the document and think well, what's that supposed to mean? "Motley" or where it says "mottled"?-- No.

COMMISSIONER: Mr Allen, I think you're being unfair. The witness was put in the position of being asked whether looking at the document now eight months or so after the time, he would agree that it shows a condition which doesn't improve and doesn't get any worse, and he was simply saying that the level of precision of the data shown in this document is not sufficient that he could make a call one way or the other on that, which struck me as a perfectly fair and sensible and reasonable answer. I don't think it was intended in any sense as criticism of the nurse or whoever it was that is given a couple of square centimetres to fill in a casual observation regarding colour. It's simply - he was simply making the point that this process is not designed to make the type of clinical judgment which he was being asked to make as to whether the patient's condition had got better or worse.

MR ALLEN: That's so, doctor? There wasn't any criticism made of the person recording the information?-- No, and I would actually assume that the person recording the information is able to judge whether or not a limb is mottled or not and has just recorded it using the wrong word.

Okay. And would you look at progress notes, for example, if a note was made on the 30th of December 2004 by a nurse containing detailed observations of as plus plus plus, detailed on observations of what pulses are audible and what

are not, colour of the limb, capillary refill, is that something you would look at?-- Again, I would look at the leg and not at the nursing-----

Not at the notes?-- No, I go straight to the source.

Is that the general practice, that these notes are made by nurses and physiotherapists and the doctors don't look at them?-- Correct.

Thank you.

COMMISSIONER: Mr Diehm?

MR DIEHM: Thank you Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Doctor, my name's Jeffrey Diehm and I represent Dr Keating. You mentioned in your evidence that - and it's in your statement as well, that you performed procedures, particularly the insertion of PermCaths on a number of Dr Miach's patients. Do you have any or are you able to estimate at all the number of Dr Miach's patients you treated in the time since he stopped referring them to Dr Patel?-- Somewhere between 10 and 15, I think.

Thank you. Spread out, generally speaking, over the time?-- Yeah, I mean, you get two of them in a week and then not another one for three months, so-----

Thank you. There's been considerable discussion during the course of these proceedings as well as touched upon in your evidence about transfers of patients, and sometimes we're talking about patients who are critically ill and at other times patients who perhaps have been made stable, but as a general proposition, can you tell us something about your experience of the ease with which you were able to arrange for transfers of patients out of Bundaberg to Brisbane?-- I would say it's something that became easier, in my experience it became easier to do once the whole crisis hit.

COMMISSIONER: We're glad to hear it had some benefit?-- Yeah. I had very good success with getting patients accepted and it all happening quite quickly really from about February 2005 on. Before that time, it was not as good as that.

So you think if we arranged for Jayant Patel to travel to hospitals around the State, we could improve services in every part of Queensland?-- Could happen.

MR DIEHM: Doctor, what sort of obstacles would you strike?-- The situation that I remember experiencing on several occasions, and I think these were back in 2003 for the most

part is getting head injured patients in usually at night, usually intoxicated, that sort of thing, they would have CAT scans done and they would be shown to have bleeding inside of their head so that a patient in that situation needs to be in a ICU or needs to be in a facility that has a neurosurgeon, which there is nobody in Bundaberg who does that. On more than one occasion, we got the report back from somebody in Brisbane, I don't have any idea who, that, "Well, you can't send that patient down now because we don't have any ICU beds available.", and just handing the problem back to us, that, "There's no ICU beds available, can't send them here.", and I just, I remember really thinking that's just so completely inappropriate, that the patient would be put in that position, that, you know, that we would be put in that position, it just shouldn't have happened. So that really stuck with me seeing that happen a couple of times. Now, ultimately in those cases, you know, you'd get a call back, you know, two hours later, a bed's been found at some other hospital so we'll send a helicopter - an aeroplane, not a helicopter, but just somebody's got bleeding inside of their - in their head doesn't need to wait for an ICU bed to become available somewhere, they need to - I've worked in hospitals previously where when the ICU fills up, they just create the either postoperative recovery room for surgery, which is basically an ICU waiting to be used, they would stop using surgical theatres and start using the recovery room as a overflow ICU, so I mean there are - that doesn't put the nurses there to take care of the patients, but I mean, there are some other options there I think in those critical situations rather than saying, "No, you can't send the patient there".

D COMMISSIONER EDWARDS: When that occurred, did you report that to, say, Dr Keating or senior people in the hospital or do - were you having difficulty with transfers to Brisbane for emergency cases?-- No, I think I talked to Dr Patel about it actually, I didn't talk to Dr Keating about it.

COMMISSIONER: Doctor, one of the suggestions we've heard, and I don't know how valid it is, is that the majority of doctors in Queensland hospitals have trained locally, done their - been in Brisbane hospitals as students, as interns, as registrars and so on, and so they've got the contacts and it makes it a lot harder for someone like yourself coming from overseas?-- Yes.

That's right, isn't it?-- Definitely. I mean, eventually you persist and I'll never, you know, 30 years from now I won't be a local with all of the connections, but I mean, you can make small strides over time, but-----

I guess what makes it worse though is that when you go to conferences and meetings and college events and so on, you're dealing with other plastic surgeons like yourself and they're the one category of specialists who're not going to be needing help from because that's your field?-- Mmm-hmm.

There's really no system of getting to know who the neurosurgeons are or getting to know who the vascular surgeons

are or the colorectal surgeons are or any other specialists you may need to know; do you think you would have benefitted from the opportunity to work for three months in one of the metropolitan hospitals before going to Bundaberg?-- Absolutely, it would have been good for me, it would have been good for the patients.

Yes?-- It would be really, it would be helpful - the only way I could see it being sort of not so great is if you just sort of were, you know, for three months you showed up for half an hour a day and, you know, had lunch with people, you just didn't - if it were something that weren't taken seriously.

Yes?-- But if it were taken seriously, it would be fantastic.

D COMMISSIONER VIDER: I wanted to ask you about that so I might ask it now, and that was about the orientation that you did receive and the particular bits that I was interested in was your opportunity to gain some familiarisation with elements of the Australian health care system, like the funding arrangement, the Medicare arrangements, Workers' Compensation, the Pharmaceutical Benefits Scheme, those sorts of things?-- There was none, absolutely none of any of that, there was - there was no orientation of any type whatsoever.

None?-- None, I was told - I made sort of a bad joke about it to, you know, friends of mine, I've said, you know, they've told me, "Your clinics are on Mondays and Fridays, here's the keys to your car", that's it. I think there was something - there was one other thing they told me in there but it was - that was my orientation.

COMMISSIONER: Doctor, speaking with other witnesses that we've heard, it struck me that orientation - if that's the appropriate word - has to have a number of levels to it: one is communication, because even though you come from an English speaking country, the fact is that Australians tend to use the English language differently, and more particularly in country rural areas of the State. Have you found that ever to be problematic?-- Not - a tiny little bit. I think that's something I was able to sort out pretty - within a month or two.

Right. The second area is what sociologists at least would call a culturation, just understanding cultural differences. It's said, for example, that Australian males are very reluctant to complain about medical problems and to express feelings of pain and particularly express psychiatric problems to medical practitioners and so on. Do you see that as a useful area for orientation or some sort of training before you're let loose on-----?-- Maybe a little bit, that's probably more relevant for general practitioners, I would think more so.

And again, probably more so for people coming from very different cultures, from Asian or African cultures, for example?-- Correct. Yes, I wouldn't want to sit through too too many of those type of sessions.

All right. The third thing, as Deputy Commissioner Vider has mentioned, the administration of health care, the funding arrangements, Workers' Compensation, Medicare, Pharmaceutical Benefits, all of those sorts of things, and obviously from what you've said, you would have wished to have received more information on that?-- Yes, that would have been nice to learn about, although maybe not - it would have been very helpful to know, but for somebody working solely in the public system, you can sort of get by without too much knowledge about it, it would be better to be better informed. What would be really helpful, especially coming from a country where there is no public health care system, and I suppose those - there are a few other countries around besides the US that doesn't have a public health care system is to be informed how a public health system runs. What - I mean, the whole concept of waiting lists was as foreign to me as Vegemite.

Yes?-- It's just I've never heard of a waiting list - I mean, in the US we hear of Canadian waiting lists and just management of waiting lists and how can, when somebody needs a medical procedure, how can they wait? It's - and how do you decide, you know, how long it's appropriate to wait for a colonoscopy when somebody's bleeding? Verses how long they should wait for their, you know, the varicose veins, these other things that they sit on waiting lists for years and years for.

I suppose the Australian response to that American question was how can the wealthiest country in the world not have a public health system in the first place? It might be better to have a waiting list than no waiting list at all?-- Right, that - that may be very true, but it just would be helpful to know out of coming from a different system.

The fourth area of a culturation or inductions that has been suggested is technology, because there is the likelihood that the technology you work with at the hospital, from the desktop computer to the most sophisticated medical equipment may be different from what which you're used to at home?-- In my case they're virtually identical.

Right?-- So that may be more relevant to other places.

Right, and fifthly and finally, it's been suggested that there are unique medical issues that a doctor coming to Australia should know about: anecdotally, I received a telephone call last night from a lady who was treated by an Asian doctor at Caboolture for a dog bite and he wanted to give her a Rabies shot. It's probably not the world's best example, but it's an illustration of how, unless you're given some introduction to the differences between Australian medicine and medical issues overseas, there can be confusion?-- Yes. I think that just would fall under a good introductory system into Australian health care.

Thank you. Sorry Mr Diehm.

MR DIEHM: Thank you Commissioner.

Doctor, you say in your statement that you obtained your Fellowship of the College, I think it was in November of last year?-- Yes.

Did you, at around that time, form an intention to leave full time employment at the Bundaberg Hospital?-- My intention to leave full time employment at the Bundaberg Hospital started before I started working at the Bundaberg Hospital.

Sorry, indeed. Did you at the time or leading up to the time of finally obtaining your Fellowship, have a plan that you would very soon thereafter cease employment at Bundaberg Hospital?-- Yes, it was not a plan - it wasn't a plan with a date attached to it.

No?-- And it wasn't a plan that I had articulated to people at the hospital.

All right. You intended to enter into private practice, didn't you?-- My initial intention was to do a combination of public and private.

Yes. When did you say that you first articulated that plan to anybody at the Bundaberg Hospital?-- I remember meeting with Dr Keating roughly in January of this year saying, you know, this is what I would like to do. At that point I think I told him I wanted - we were going back and forth with a couple of different options of working a day in the hospital, maybe two days at various potential times of being on-call. So in January of the year I - it may have been February, but I think probably January, we met informally to talk about options.

Do you think that it's possible that you'd in fact had some discussions with Dr Keating about this even late last year?-- Yes, that's certainly possible.

All right. Now, with respect to your experiences of Dr Patel, and without the benefit of hindsight by looking at things retrospectively, but in the almost two years that you worked with him, and I appreciate from your statement that you didn't, for instance, spend much time in the surgery, in the operating theatre with him, for instance, but you did have interaction with him at a variety of levels, didn't you?-- Yes.

That included some limited experiences in the operating theatre?-- Yes.

It included some attendances at these weekly meetings on Thursday lunchtime, subject to the limitations on your ability to get to them at all or on time?-- Yes.

And they included every month a Morbidity & Mortality Meeting?-- Yes.

You presumably discussed professional matters with him at the time, did you? Medical matters?-- Yes.

And so you would get some insight into what was his apparent level of expertise?-- Not really, I - I would get his side of things.

Yes, I accept your qualification entirely on that. You would get a view of what he appeared to know?-- Right, he liked to talk.

Yes, and so he would have taken plenty of opportunities to tell you what he did know?-- Yes, you had to sort of walk backwards to get to wherever you needed to go-----

Yes?-- -----as he was talking.

You would also at times, I suggest, care for some of his patients?-- Pretty rarely. He - which I thought was really to his credit at the time - he, if he was - he was in, say, a 12 month period, he would be in Bundaberg for 11 of those months, say, roughly, he would take maybe a two, two week holidays or one four week holiday or something, but otherwise he was in Bundaberg a lot of all of the time he didn't go out of town on weekends. The point that I'm making is that he saw his own patients in the hospital on the weekend when - even when I was on-call.

Yes?-- So I didn't - the only time I would see his patients were when he, for example, in the case of the Christmas last year we talked about earlier.

Yes?-- When he was actually left the country is when I would see his patients. I saw a very small number of his patients in my clinic over the course of two years, but maybe five or so patients, maybe a couple more than that, maybe seven or eight but not many.

When he would go on holidays, as you say, you would tend to see more of - you would have occasion to see his patients at those times because you would be looking after them in the interim?-- Yes.

Now, again, and appreciating the opportunity that you've had through hearing about evidence subsequent to all of these events, leaving aside what you may have learned since, from what you saw and experienced over those two years, did you have any cause yourself to suspect that there was something wrong with his competence?-- Not until the time that it really struck me that there was things weren't right was in the aftermath of the young man who we've talked about-----

P26?-- -----earlier today - yes, where he basically had given me false - like, false information, maybe he knew that he was giving false information, maybe he wasn't, but it was a pretty significant piece of false information, whether it was intentional or unintentional, but prior to that, I didn't have exposure to an event of a patient interaction or anything that

made me think things are not the way they should be.

Prior to that time, and we'll return to that issue in a moment regarding Patient 26, as far as you were concerned, did he appear to be a competent surgeon?-- He certainly appeared to have the knowledge base and could talk the talk. The very limited number of times I was in theatre with him that I can - I think I can recount all of them in all of the cases that his behaviour, his techniques seemed reasonable to me, so in those two ways - sorry, your question was did he seem competent?

Did he seem competent?-- Yes, in those interactions, yes.

COMMISSIONER: Doctor, can I ask, do you have a flight to catch this evening or-----?-- At 7 o'clock.

All right. It's obviously desirable to finish your evidence this afternoon, but I think we might just take a five minute comfort stop and resume shortly after 5 o'clock.

MR DIEHM: Thank you, your Honour.

THE COMMISSION ADJOURNED AT 4.58 P.M.

THE COMMISSION RESUMED AT 5.08 P.M.

JAMES WILLIAM GAFFIELD, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Mr Diehm?

MR DIEHM: Thank you. If I can just hold it together.

D COMMISSIONER EDWARDS: You need a doctor, Mr Diehm.

COMMISSIONER: Actually, since the crowd is reemerging, perhaps I will make some announcements now so we don't get it at the end. Firstly, on Monday morning there is going to be the swearing-in of I think two new Magistrates in this room. So regrettably you will have to take your papers from the Bar table and we'll commence sittings on Monday morning not before 10 a.m., obviously as soon as the courtroom is free, either at 10 a.m. or shortly thereafter. Secondly, as I announced on Tuesday, we will not be sitting the week after next, that is the week of the 29th of August without at this stage foreshadowing that we will definitely use all the fortnight commencing 5th of September, I think it would be sensible for counsel to have their diaries free for that fortnight. That's certainly not to encourage anyone to fill up that fortnight if we can avoid it, but based on present expectations with the amount of evidence to be covered, I think it is sensible to allow that entire fortnight if necessary. So that's the week of the 5th of September and the week of the 12th of September.

As regards Mr Leck and Dr Keating, of course we still don't have a decision from the Supreme Court. I noted, of course, what you said, Mr Diehm, when you raised that on Tuesday, but my own sense of it is that it would be disrespectful to the Supreme Court to proceed with their evidence whilst that matter is still outstanding in that Court. It would be potentially unfair to Mr Leck and Dr Keating. And it would also be potentially wasteful of the resources of this inquiry if following a decision from Justice Moynihan there is some change to the status of either of gentlemen in these proceedings. So our attitude is not to require either Mr Leck or Dr Keating to give evidence next week. We are still very anxious to have statements from both gentlemen. I will leave it for their counsel to discuss with counsel assisting but I would be quite happy to approve an arrangement under which any statements provided are on entirely without prejudice basis or confidential draft so that should things turn out in a certain way in the Supreme Court, they will be returned without any use made of them. But I will let counsel work that out amongst themselves.

What I have said about sittings in September also will nullify the intimations I gave on Tuesday about the timing for submissions. Can I say, however, that on systemic issues, to put it another way, big picture issues as to what's going to

happen in the future of Queensland Health, it would be useful if we could have any submissions as early as possible during September so that we can concentrate on the preparation of that part of our report. Obviously issues in relation to incidents at Bundaberg, and particularly issues affecting individuals like Mr Leck and Dr Keating can't be dealt with until their evidence is over. If systemic points - if anyone is wishing to make submissions about systemic type issues then the sooner we could have such submissions, the better. That's what I propose to raise.

Mr Diehm, does that all make sense as far as you are concerned?

MR DIEHM: Yes, and perfectly acceptable, Commissioner.

COMMISSIONER: Ms Feeney?

MS FEENEY: Yes, thank you, Commissioner.

COMMISSIONER: I take it there is nothing yet to.

MS FEENEY: You will be the first to know when I am able to say something, Commissioner.

COMMISSIONER: Thank you. We might then proceed with the evidence, Mr Diehm.

MR DIEHM: Thank you. Doctor, I had just asked you and you had answered the question about Dr Patel's apparent competence, as you were able to see things at that time. Did he also seem to you to be a very hard working Director of Surgery?-- Extremely.

And one who was very supportive of his staff members?-- Yes.

He did not seem to have an abrasive personality that caused offence to a number of people?-- Yes.

COMMISSIONER: When you mention about support for staff members, there seems to be a hint in some of what we have heard in any event that he preferred to not have around him people who challenged his views or technique, and that even when it came to junior doctors, and so on, he gave preference to those who went along with his own view as to how things should be done. Is that unfair?-- No, I think that's fair. Actually, I think I spit out the yes before I let you finish on that point, because I thought you were going to say to his junior staff, because basically when you say - when you say his staff, basically that would be me.

MR DIEHM: Yes?-- Who do you mean?

Well, certainly junior doctors?-- Yeah, you know what, there were one or two junior doctors whose names haven't come up much in all of this, and I won't mention, who didn't get along with him all that well because they tended to be a bit - they weren't critical, I wouldn't say of him, but they were - I

think he got the feeling that they didn't like the way he worked.

Yes?-- Yeah. But that's more answering your question.

COMMISSIONER: Yes?-- There were a couple of people who he didn't get along with well who were junior doctors. There were others that he seemed to get along with quite well. I think they all lived in fear of him a bit.

Doctor, I don't want to interrupt Mr Diehm's cross-examination, but I guess, cutting to the chase, you were in as good a position as anyone at the hospital to have detected the problems with Dr Patel. That would be fair, wouldn't it, in the sense if you couldn't pick something up, it was unlikely anyone else would?-- Yeah, I think that's fair.

So you certainly wouldn't criticise, for example, Dr Keating for having failed to identify problems that you yourself were unable to-----?-- Right, I would not.

D COMMISSIONER VIDER: Mr Diehm, can I just ask another question? We have had it presented to us in evidence by those who have had the opportunity to see some of Dr Patel's patients following treatment that they have received from Dr Patel, and one such person has indicated quite strongly that he would now believe the records, very often the operative record is actually false, that it is not a bad theoretical presentation of the surgery, but having seen the patients now to do some follow-up work, he seriously doubts that that was what was done at the original time. You mentioned the word before, too, that you thought something had been falsely presented to you in relationship to P26. Is that a fair comment?-- Yes. I haven't seen large volumes of his patients to make that kind of comment that I think Dr de Lacy made.

That's all right?-- So I can't - I really haven't - I mean, I have seen a handful of patients, not 150. He certainly - you know, reviewing for this appearance, I - he certainly did paint a - not always but often a fairly rosy picture on the chart and the patients obviously I reviewed were ones that didn't go well.

MR DIEHM: Thank you. On that topic of P26 and your evidence that you realised that Dr Patel had given you false information about a patient, and that was the first occasion upon which you began to doubt matters regarding his clinical performance. When did you come to that realisation?-- I don't remember exactly when. Gradually over the next month or two, really. I think it is not something that just dawned on me, like, right away when I heard that he had tied off his femoral vein instead of repairing it, but I think eventually I sort of felt duped into - I would say it wasn't something again that I immediately thought, "Damn it, he has lied to me." It took a while.

So that certainly wasn't something that you related to Dr Keating when he spoke to you shortly after P26's discharge from Bundaberg?-- No, definitely not.

Or indeed at any other time?-- No.

Just to return to something I was asking you before the break, I was asking about your plan to leave Bundaberg Base Hospital as a full-time employee. You told us about your plan to do some work in public and private hospitals at that stage. Was this plan that you had something that you had been discussing before the end of last year with Dr Patel?-- Yes.

When you did come to discuss the matter with Dr Keating and you were talking about your desire to do some work in the public system, did you have discussions with Dr Keating about your - or the opportunities that there might be for you to do some VMO work at the hospital?-- Yes.

And he was supportive of your plans in that regard?-- Very.

Thank you. I have nothing further.

COMMISSIONER: Thank you, Mr Diehm. Ms Feeney?

MS FEENEY: No, thank you, Commissioner.

COMMISSIONER: Is there anyone who hasn't yet - oh, Mr Farr.

MR FARR: I don't have any questions, thank you, Commissioner.

COMMISSIONER: No-one else yet who hasn't cross-examined who wished to? Mr Tait, any re-examination?

MR TAIT: No, thank you, Commissioner.

COMMISSIONER: Mr Morzone, any re-examination?

MR MORZONE: Perhaps just one question arising from the last question.

RE-EXAMINATION:

MR MORZONE: I see from your CV that you're not presently a VMO at the Bundaberg Base Hospital?-- Correct.

But is it your desire that you would like to in the future be a VMO?-- I think I would - I would like to consider it. I don't want to commit myself to something. It's something I would strongly like to consider though.

Is any part of that change of view related to any systemic problem that you wanted to tell us about or is it for other reasons?-- The change meaning to not work there?

Yes. By that I mean something that could be improved that would encourage you to work there rather than some other reason that's personal?-- Yeah, it's not a personal reason. It's a sad reason. Is basically it came around the middle of May this year there - and I was going to - you know, come July

1st, was my leave date, and I was still going to work day a week at the Base Hospital but about the middle of May I suddenly really realised that I just did not feel safe working in that hospital anymore.

Can you elaborate on that?-- Yeah, that - I felt that my long-term career longevity was at risk working there. That there are so many factors working against an individual surgeon in that hospital that, at present, I really don't want to take the chance that I feel is very high by working there. That you get the sickest patients with the most acute - either, you know, horrible acute problems or neglected long-term chronic problems. You're expected with fairly limited resources, without much backup to have a perfect success rate with these patients and when things don't go well, there are people who file complaints about you and your reputation is potentially ruined and even potential worse things than just having your reputation ruined, such as having - being deregistered or, you know, those sorts of troubles. It's a risky environment to work in and I don't know how to turn that around, really.

Are the problems you referring to problems of sufficient resources in terms of equipment and staff or more than that?-- More than that. It's sort - it's an over used word, but cultural - I mean, the culture within the hospital. I guess probably the best thing to do is to give you the example that pushed me over the edge with - without all - tonnes of details. I think it was about April of this year there was a patient under my - under my care there who had - the details are sketchy. He had a dead toe when he came in. He was an elderly diabetic - he had all of those factors and he had a dead toe and we allowed it to demarcate, to put him in the hospital for - actually, we watched him in the outpatients clinic for a while to let it - you know, where the sock stopped and finished, we wanted to know where that was to do the amputation at the right level above, not to high, not too low. He then had a - we admitted him to the hospital. He developed a little bit of an infection so we had to try him with some antibiotics. He was in the hospital for quite a while. Then he - we ended up doing the amputation and it didn't heal well, is a common thing, and then he - ultimately, he ended up being sent to Brisbane to the vascular surgery unit where he underwent a bypass operation and amputation of the - half of his foot. So he - ultimately, things turned out fairly well for him but it took quite a while and it wasn't a perfect sequence. Nobody ever raised any - from, you know, nursing or ancillary staff never raised any concerns about this patient with either myself or the junior doctors working underneath with me, which was Anthony at the time. About a few weeks after this patient's event transpired I was called into the director of - the temporary director of - it was the temporary-----

District Manager-----?-- I forget. Whichever it was, Darren Keating's or Peter Leck's, but one of them to discuss a complaint letter that a nurse had filed about our management of that patient and she had basically filled out a three-page

letter detailing all of what she perceived were the deficiencies in our management of that patient. Basically, a formal complaint letter. Yet the person had never ever brought to the attention of me or anybody treating the patient that she had any concerns with this particular patient but instead she elected to file a complaint about me. And I just don't want to work in a hospital where that's the way people do business, where people won't tell you up to your face, "Hey, you know, maybe you want to consider doing this a little bit differently", or - instead, they file complaint letters that lead to potential - I mean, not in this particular case but in a case it could lead to serious problems for an individual practitioner.

COMMISSIONER: Doctor, do you think this is re-active to the Patel situation, that people are now so nervous that they feel they've got to document complaints rather than inform-----?-- I think probably a bit of that. I think probably a bit of the individual in question here is a - somebody who probably individually is prone to do this sort of thing. But, yes, I think - it's part of that.

MR MORZONE: Okay. Are there other systemic differences between the private hospital you work with and the public hospital that is also acting as a deterrent for you working as a VMO that you'd want to point out?-- The attitude in the private sector is, "Let's get the work done." That's not the attitude in the public sector. There is a lot of great, talented, skilled, intelligent people working in the public sector but somehow collectively the attitude is - and where you see it most in surgery is, you know, that we have to be done by 4.30, so, you know, there is no running over 4.30. Just - yeah, you've got these waiting lists full of people who need operations, so it's - I don't see it as a - it's a good place to work if you don't want to get a lot of work done.

COMMISSIONER: Doctor, Mr Morzone has really anticipated something I was going to ask you but in a slightly different way. Reading your statement and the circumstances in which you came to Queensland in the first place, it seems to me that you are a perfect example of the overseas trained doctors that we do want to attract to Australia, if you would forgive me for saying so, excellent qualifications from highly respected American institutions, the sort of - if we're going to have significant numbers of overseas trained doctors in Queensland, we need more James Gaffields to come here. What as a public health system can we do to attract people like yourself and to make it easier for people like yourself to come here?-- I think, sir, the - making the pay quite a bit higher would be one thing.

Yes?-- It would need to be substantially higher if - to recruit people. And I guess just a - a work environment where there is still some recognition that surgeons are the most qualified people to comment on surgical patients, not necessarily - we're not necessarily all equal at work. The individual surgeons, anaesthetists, I really can't comment about on the rest of the doctors, just don't really seem to be

valued much by the hospitals themselves.

Yes?-- We're exchangeable parts, very much.

MR MORZONE: Briefly, you mentioned pay?-- Mmm-hmm.

I've been told that your pay during the early stages of your arrival was something like $20 an hour; is that correct?-- Something like that, yeah, it was - I think it was $90,000 a year or something about that.

I have nothing further, thank you, Mr Commissioner.

COMMISSIONER: Thank you, Mr Morzone. Doctor, obviously it's a matter of concern for anyone to come and give evidence about matters of this nature. I'm very conscious of the fact that of all of the witnesses we've heard, you probably worked most closely with Jayant Patel. For that reason in particular I want to make it very clear before you leave here that I have seen absolutely nothing in any of the evidence that we have seen or heard that would in any way suggest that you have the slightest responsibility, whether legal or moral or otherwise, for anything that went wrong. We do appreciate your coming and giving evidence. Your evidence will be of great assistance to our deliberations. We thank you for your time and you are excused with that thanks?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Ladies and gentlemen, not before 10 o'clock on Monday. Oh, Mr Andrews?

MR ANDREWS: May I notify the parties that it's proposed for Monday to call Dr Mark Waters for 10 a.m., Dr David Farlow for the afternoon and, with some optimism, there is in reserve a Dr McNeal. Dr McNeal's statement I suspect has not been forwarded to the parties. It's just been received within the last few minutes by Mr Groth. Depending on its size, it might be able to be e-mailed to the parties. Mr Groth is giving me an indication that he thinks it can be, but I'd ask the parties to be aware that Dr McNeal might be called for Monday.

COMMISSIONER: All right. Can you just tell us very briefly what their evidence relates to, Dr Farlow and Dr McNeal.

MR ANDREWS: If you'd asked me that half an hour ago, Commissioner, I could have answered that. I know that the first two are in fact to do with systemic improvement issues.

COMMISSIONER: Yes.

MR ANDREWS: Things that Queensland Health does well and some suggestions on how to encourage more practitioners to rural areas.

COMMISSIONER: Yes.

MR ANDREWS: I don't imagine there'll be a lot of cross-examination.

COMMISSIONER: Right. Thank you, ladies and gentlemen. It's been a very big week and I appreciate the assistance of all of you. 10 o'clock on Monday.

THE COMMISSION ADJOURNED AT 5.33 P.M. TILL 10.00 A.M. ON MONDAY THE 22ND OF AUGUST 2005