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SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 23/08/200

..DAY 47

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

THE COMMISSION RESUMED AT 10.36 A.M.

COMMISSIONER: Before the evidence resumes, may I inform everyone of the outcome of my meeting this morning with the Premier. Perhaps I'll preface my remarks by explaining that the Premier shares our view that the systemic issues in relation to the administration of public health which are being examined at this inquiry are matters of the utmost public urgency and the sooner a start can be made on addressing those issues, the better for everyone concerned, for doctors, nurses, other clinicians, administrators and, most importantly of all, for patients.

With that in mind the Premier has made it very clear that he is anxious to have a report from us in relation to systemic issues by the original deadline of the 30th of September and we propose to do that. The difficulty which that presents is that there are some individuals whose conduct has come under consideration by this inquiry who would not, within that time table, have time to give their evidence and to make proper submissions in relation to those issues. Taking that into account, the Premier has approved an extra two weeks of evidence during September with any final report relating specifically to issues where parties are entitled to have the opportunity to address issues which affect them by the 14th of October 2005.

The effective result of all of that is that we will finish what we perceive to be the main part of our task within the original deadline of the 30th of September but taking into account the very proper entitlements of individuals who may be affected by the contents of our final report, there will be a delay of no more than two weeks in finalising our report in respect of those issues.

I'm pleased to say that my meeting with the Premier was an extremely cordial one. I was accompanied by Mr Atkinson, one of the counsel assisting. We met with the Premier, Deputy Premier and Minister for Health as well as the Directors-General of both the health and Premier's departments. I can, I think, fairly say that the progress of this inquiry is being extremely closely monitored at all of those levels and there is a degree of satisfaction in the rate of progress which we have made to date. Indeed, without wishing to sound immodest, I don't think there has been an inquiry in history that has covered quite as much ground quite as quickly as we have and, of course, the credit for that goes primarily to the inquiry's team, Mr Andrews and his fellow counsel assisting and their exceptional staff, both legal and investigative, who have made this possible, and the Premier has asked me or authorised me to pass on their congratulations to everyone concerned for the extraordinary and dramatic progress which we've made. Thank you. Mr Andrews.

MR ANDREWS: I call Dr Keith David McNeil.

MR BODDICE: Commissioner, we seek leave to appear on his behalf.

COMMISSIONER: Such leave is granted.

KEITH DAVID McNEIL, SWORN AND EXAMINED:

COMMISSIONER: Dr McNeil, please make yourself comfortable. Do you have any objection to your evidence being video or audio recorded?-- No.

Thank you. Or photographed?-- No.

Thank you.

MR ANDREWS: Dr McNeil, do you have a copy of your statement?-- I do, thank you.

You are Keith David McNeil?-- I am.

You're the head of the Transplant Services at Prince Charles Hospital?-- Yes, that's correct.

And your statement now is signed and dated the 22nd of August 2005?-- That's correct.

Doctor, can you tell me, the facts recited within it, are they correct to the best of your knowledge?-- To the best of my knowledge they are correct.

Where you express opinions within it, are they opinions you honestly hold?-- Yes, they are.

I tender Dr McNeil's statement.

COMMISSIONER: Thank you, Mr Andrews. Just apropos the matter I mentioned earlier, I should mark as an exhibit so that it's on the public record a letter from the Premier to myself of today's date confirming the arrangement in relation to the progress of the inquiry which will be Exhibit 299.

ADMITTED AND MARKED "EXHIBIT 299

COMMISSIONER: Dr McNeil's statement will then be Exhibit 300.

ADMITTED AND MARKED "EXHIBIT 300"

MR ANDREWS: Commissioner, I have a spare copy of Dr McNeil's statement. I'm not sure if you have one.

COMMISSIONER: I have one and I have the signed original which I assume will become the exhibit.

MR ANDREWS: Thank you. Doctor, you are a member of the Royal Australian College of Physicians, of the Thoracic Society of Australia and New Zealand, the Thoracic Society of Queensland, the Royal Society of Medicine, the European Society for Heart and Lung Transplantation and the International Society For Heart and Lung Transplantation?-- That's correct.

You're a full-time staff specialist at the Prince Charles Hospital?-- Yes.

Within your statement you have observations to make about your opinion that, ideally, there should be a mix of visiting medical officers and full-time staff specialists, but in respect of each of those essential elements, you observe that there are some advantages to staff specialists and some disadvantages which attend the employment of visiting medical officers?-- That's correct. Yes.

Can you explain, please, what the disadvantages are if one is confined to having visiting medical officers?-- The system that we have in Queensland covers a very wide variety of medical needs for patients, in particular different specialities in different geographical areas. There are some specialities which require large amounts of flexibility in terms of availability in emergency situations, availability after hours. When that can't be predicted and for VMOs to be available at all occasions in those sorts of scenarios can be very difficult given that they have other commitments outside of the public system, namely, their own private practices. So in some instances in some specialities, that can be a disadvantage in being able to provide the reactive service that is needed by the patients.

Doctor, you mentioned, for instance, transplant operations as a type of surgery which can occur after hours?-- That's right. Transplantation occurs almost always after hours in the middle of the night and it incurs usually quite a long length of time, eight to 10 to 12 hours, that the doctors are involved in the procedures. By that very nature, come the following morning, having worked the day before, there are safety concerns which would mitigate that they don't provide patient services the following day. Now, if, for instance, a VMO has a fully booked operating list or clinic, then it is very hard for them to then carry on and do that which means that they either compromise their ability to do the transplant, their availability to do the transplant, or perhaps their availability to do the list the following day. And so, there's a trade-off.

So that I understand better the transplant example, these transplants which usually take place during the night-time

hours-----?-- Yes.

-----are they not scheduled for that time?-- No, they're always unpredictable. We don't know when a transplant will be done in terms of any day or any night and we are unable to tell at what time the transplant will occur. So we get a phone call at some time in the night and things then happen from that - from that period. The phone call may arrive at 8 o'clock at night, it may arrive at midnight. And so, we have to have a team that's reactive to be able to come in and work around those sorts of flexible hours.

And the team that is available, is it always a team comprised of full-time staff?-- It hasn't always been and is not always now but predominantly solid organ transplantation in Queensland is performed by full-time staff.

Where you speak of the safety concerns which arise where a VMO might be called to work after hours, you raise an interesting point. Do you have a policy at the Prince Charles as to the number of hours which can safely be worked?-- Yes, there are clear, and I can't remember the exact wording of the policy, but there are clear guidelines handed down through safe working directives from both I think the Department of Health and through the hospital as to what would constitute safe working hours and the amount of time that should be taken between - between working overnight and what would happen the following day. Now, there are some times when that, obviously, can't be always adhered to but there are principles which guide us along those lines.

You don't happen to remember what the safe guidelines say those hours are?-- I don't. I can't recall that.

But they are clear?-- They are clear.

COMMISSIONER: Doctor, I think, from your statement, you've worked in the UK?-- I have, yes.

Are you familiar with the European Union directive which has come into force limiting safe work hours in the medical profession?-- I know of it, yes. In fact, it started to be brought in whilst I was in the UK.

All right. Do you see some merit in those sort of limitations being given statutory or regulatory force in Queensland?-- Yes, I do. Safety is obviously a major concern for all of us and there is no doubt and all the evidence would suggest that long working hours certainly compromise people's ability to make decisions and perform manual tasks to the best of their abilities, so the answer is yes.

MR ANDREWS: At paragraph 9 of your statement you make the observation that doctors in full-time practice provide the bulk of the education and training of junior medical staff, that VMOs do not tend to be able to perform these additional activities because of their private commitments. Is that your experience at the Prince Charles Hospital or in other places

as well?-- It is my experience at the Prince Charles and also at the other tertiary hospitals that I've worked in in Queensland, that specifically being the Mater Hospital. That's not to say that VMOs don't participate in training and education, but given the time constraints that they have in terms of their commitments to the public and private systems, the amount of time they have available to give in terms of training, education, et cetera, and all the other outside clinical activities is limited compared to full-timers, who generally have more flexibility in the time they can put in those areas.

COMMISSIONER: Doctor, in that context, I observe particularly the comment made in the first sentence of paragraph 9 in your statement regarding the comparable standards of VMOs and full-time medical staff. I would like you to be aware, and I have said this a number of times as the inquiry has progressed, our discussion Paper Number 6 was prepared at an early stage of proceedings, based almost entirely on submissions and evidence received from the AMA. Some comments in that discussion paper have been misinterpreted or taken out of context as implying a lack of recognition that full-time medical staff are often as good or better as visiting medical officers. Those comments were in fact directed specifically at the situation with overseas trained doctors coming into the workforce in Queensland without the level of scrutiny that Australian trained doctors would be subjected to and the point intended to be conveyed is that with VMOs who are from the Australian trained market, you're dealing with a known quantity, people who have met the highest standards in our community, whereas overseas trained doctors, of whom Jayant Patel is the obvious example, aren't subject to that scrutiny. I would be very grateful if you would convey to any of your colleagues who are disturbed by that, it was never a reflection on Australian-trained full-time medical staff?-- Thank you.

Thank you?-- May I make a comment on that?

Yes, please do?-- In terms of the overseas trained doctors, we have an enormous number of overseas trained doctors in Queensland, as you know, and some of them are very highly qualified. On Monday night we performed Australia's second heart/lung/liver transplant and the two lead surgeons were both overseas trained doctors, and I would just like to have that put on record. They provide an extremely valuable service to us in many areas.

And, in a sense, that's why we feel that it is tremendously important that the great majority of overseas trained doctors in this state aren't labelled with the black mark of Patel and a couple of others, like Berg and so on. From what we have heard, there are something like 1500 or 1700 overseas trained doctors practising in this state at the moment and the vast majority, over 99 per cent of them, do a wonderful job for our community and we owe to them as much as to the patients to ensure that those who do have the skills are protected from unfair criticism?-- Thank you.

Thank you, Doctor.

MR ANDREWS: You observe at paragraph 12 of your statement that training and education remains significant issues with inadequate resourcing for this vital activity in most areas. Can you suggest any improvements or initiatives?-- The issue here really is the time that it takes to train and educate people properly and that comes back to resourcing in terms of numbers of staff available to provide both an effective clinical service and to provide that valuable area of work. Really, the only way that we do it now is we train at the time that we're doing clinical ward rounds, which make the ward rounds go much longer. We train during outpatients, which make outpatients go longer, patient waits are inevitably longer, and to do that properly takes a lot of time and effort. But it is the most vital thing that we probably do outside of direct patient care within the system, because it is the future of the system. And the only way that we'll get better is having recognition of it as a vital - an area of vital need and concern and by having the adequate resources to be able to do it in terms of both numbers, the time available, to have it recognised as part of our inbuilt clinical work and then to have all the resources that go with it, training facilities, rooms for teaching, et cetera, et cetera, and all of those are somewhat lacking at the moment.

Now, to address that lack, is it something that ought to be recognised in particular hospitals among those who administer the hospital budgets or is it something that ought to be recognised within Queensland Health's head office?-- Well, I think it is something that is recognised in Queensland Health's head office, although I guess that recognition doesn't always filter through in its fullest extent to the districts and to the hospitals themselves. Every hospital that has training registrar positions or medical students should have the facilities and the resources to train and educate those people properly.

You speak of what seems to be an initiative you recommend at paragraph 12 of network training and education services out of major Brisbane hospitals. Can you explain that, please?-- Yes. Essentially, training requires a critical mass of space, of time and of individuals to do it and in peripheral areas, the personnel that are available are limited. Now, in the larger Brisbane metropolitan hospitals and in some of the base hospitals, there is larger number of staff available and it would seem to me that if we were able to network our systems, that we could support a training and education infrastructure utilising the critical mass in south-east Queensland and take that out to peripherals centres. Now, following on from that, one of the problems that we have in attracting people back to peripheral centres is because most of the training that's done is done in Brisbane, so people put their roots down in Brisbane for a long period of time during their training process. And so, when they come to finish their - or when they graduate, finish their speciality training or whatever, essentially, they've set themselves up in Brisbane or

south-east Queensland and to get them then to move out is very difficult. So if we could set up training programs that actually networked out of Brisbane into, say, Townsville Rockhampton, Mackay, Cairns, et cetera, we could get local people training in those areas with a critical mass supported from Brisbane, then they would set up roots in that community and then perhaps they would provide the continuity of care there.

So that I understand, who travels in the network, the student or the teacher?-- Well, it would be - as I would see it, the attraction is to employ - the attraction for employment is in south-east Queensland. So if we were able to employ people in south-east Queensland and then have them move out to the peripheral centres to provide a critical mass in those peripheral centres on a rotational basis or whatever, then that would provide a good training environment for local people, for local registrars, residents, et cetera, medical students, who then may be attracted back to stay in that environment.

Do you mean that somebody such as yourself might be - as part of your duties, might be sent to some regional place for training for a short period or do you mean that a junior medical officer from Brisbane will be sent to the region? I'm-----?-- No, I would envisage someone like myself doing that. As part of my contract of employment, it may be that I would agree to go to a regional centre for however many months a year, provide a clinical service, and it is the clinical service that's the basis for the training, and if we could beef up the clinical services, then we can also beef up the training and attract the local people in that way.

COMMISSIONER: And this you'd see as a win-win situation because patients in those regional centres would have the benefit of the visiting specialists from Brisbane as well as trainees in those centres having the benefit of training?-- Very much so, yes.

MR ANDREWS: When you say that registrars would then be more likely to return to the regional area, the registrar that you're speaking of, is this a registrar who is training under the visiting specialist or series of specialists in the region or is this a registrar who is sent for three months of one particular year to the region?-- Well, it could be either. I mean - and both - both things do happen but if you could - if you have a - for a specialist, you need a certain level of clinical service, a certain level of patient interaction, of procedures. You have to achieve those to qualify for your specialist qualifications. If you can't get that in an area, almost always you have to come to Brisbane because that's where the critical mass is. If we could move that critical mass in some way out to regional centres like Townsville or Cairns or Mackay and provide the training there, then local people could be trained in that local centre and they'll be more likely to set their roots up there. This is only supposition on my part but I have discussed it with my colleagues and, you know, we're all in favour of doing this

sort of thing.

The colleagues with whom you've discussed it, are they at the hospital?-- Yes.

You'd understand that there are other specialists at the hospital who would find it agreeable to be transferred to the regions for short periods for training?-- Yes, and some who wouldn't but that's, again, up to the individuals.

At paragraph 18 you have another observation about VMOs, that one disadvantage being a cost to the system if one compares VMOs with staff specialists. Wouldn't it - perhaps you should explain it, paragraph 18?-- In paragraph 18, what I was trying to convey was that VMOs - the public system runs most efficiently where it can schedule certain things to occur within hours and that way people are working within their rostered hours, they don't incur overtime, et cetera. If you have a system based entirely on VMOs or where VMOs predominate, then the system has to be reactive to the VMO's availability and flexibility. And so, on certain occasions, and this certainly happens on occasions where I work, procedures are delayed or they're rescheduled and that means that other staff have to change their rostered arrangements and come in after hours or out of rostered hours and that means overtime payments for them. So just by shifting that to accommodate the VMOs situation, you can incur additional expenses in terms of overtime paid to other staff members.

COMMISSIONER: I suppose, doctor, you will have to appreciate, I don't come from a medical background, so I have to work this out from what I hear from witnesses, but there are categories of emergency treatment that have to be done when the patient needs treatment, rather than-----?-- That's right.

-----at times that suit the clinicians?-- Mmm.

There are also categories that can't be scheduled because, for example, with transplant work, it has to be done when the organ becomes available. Leaving those two categories to one side, what is classified by Queensland Health as elective surgery - surgery which isn't emergent, which can be done within limits at a time to suit both patient and clinician - should be the category which is most suitable for being performed during regular office hours, as long as the VMO is able to say, "Well, I'm setting Friday aside", or, "Tuesday morning", or whatever. Is that a fair summary?-- Yes, that is.

In the categories of surgery which can't be scheduled - emergency surgery and transplant surgery, and so on - I take it the VMOs are in the same situation as everyone else. You have got to be there when you are needed?-- That's right. If they are rostered on, they have to be there.

The real difficulty you are identifying is with elective surgery where the VMO is scheduled to perform surgery, shall we say on Tuesday morning, but has his own emergency to deal with in his private practice and doesn't get there until lunchtime?-- That's correct, yes.

D COMMISSIONER VIDER: Doctor, are you familiar with the Service Capability Framework that Queensland Health has put out?-- I'm familiar with it, yes.

Would you think that that's got merit to be looked at and further developed into the future so that it can help hospitals - certainly non-metropolitan hospitals - define the scope of practice that they can manage at all levels, not just from the clinicians that might be there, but from the support services that are required as well?-- I would think that it certainly does have merit, along with credentialling and privileging procedures.

Where I'm coming from with that is if that has merit, then that will help determine, if you like, the level of training for specialists that can go on in various places throughout the state. You have mentioned, for example, Townsville. Townsville would be an obvious site for a tertiary referral centre?-- Yes.

But that same level of training wouldn't be able to go on at all hospitals down the coast, because they don't have the infrastructure to support some of the clinical work?-- That's exactly right, and partly, I think, some of the clinical infrastructure support relies on what they are scheduled or

budgeted to do and partly relies on the sort of clinical infrastructure they have that's able to do various things. So, I think they are intermixed.

Given the nature of the work that you do, I would be interested in your comment - we talk about retrievals, but at this stage of the game we are talking about going in to retrieve the patient to bring them out. Do you see any merit in the future from flying in retrieval teams, a bit like M*A*S*H, because you would have to take everything with you, or is that just not feasible?-- It is feasible, but very labour intensive and resource intensive, and I think it would only be applicable to very bespoke areas of medicine. Cardiac emergencies, for instance, where people have to be put on particular types of life support for them to be evacuated to a centre where they can be worked on, it does have limited capability.

Mmm.

D COMMISSIONER EDWARDS: Doctor, could I ask, what about the argument that's put up that in modern transport systems that we have, that we really should have the super specialties - dare I use that word - and yours is one of them, of course - in one or two places only, because of the - first of all, the enormous cost of the setting up and establishment of the units and, secondly, the expertise that somebody like yourself has because of your regular contact with surgeons throughout the world and your experience and your daily operative process, rather than somebody doing these in centres like that perhaps once a fortnight or once every three weeks. The argument has been put up that therefore, in the modern age of transportation, we should put aside some of the political demands for a cardiac unit or surgical - coronary surgical unit almost in three or four centres and really concentrate in one or two centres where the major population is, and still not have any disadvantage to patients if they had a road accident, for example, in Mount Isa?-- You know, this question has been bandied around all over the world, and we are not the only place to struggle with it, and Queensland, of course, with its geographical issues, is almost unique - apart from perhaps Canada - in those sorts of problems, and the trade-off, of course, is local availability, family involvement, moving them all to Brisbane, which we run into all the time with transplants and paediatric cases, et cetera. I don't think there's any doubt that concentrating super specialties or specialty services is, in terms of clinical outcomes, the way forward. There's, you know, a huge amount of evidence which would suggest that doing numbers and maintaining experience gets you better outcomes in a whole lot of areas, but we have to weigh that up against the imposition that we put on people having to travel perhaps long distances, even with transport, because if you are looking at very complicated procedures, you are often looking at lengths of time, relocating families, et cetera, and, of course, it is generally the families who are least able to be relocated, who can least afford to give up local jobs and things that are most imposed upon.

But if we can get the best results in the world, isn't it worth that support - looking at even some support for that?-- I would think so, yes.

Rather than establishing units similar to yours in one or two other centres in Queensland?-- From that point of view - I don't know where you quite draw the line in terms of level of specialty, and again it comes back to who's available to do what, where, and whether you can generate a critical mass, but, in general, the principle would be to try and concentrate those super specialty services to try and maximise outcomes.

COMMISSIONER: If I can go back to Deputy Commissioner Vider's question about retrieval teams. I guess we have seen in the evidence at this Inquiry a good example of the sort of thing that is going through all of our minds. It involved a young male patient in Bundaberg who had a serious injury to his leg, and it seems perfectly apparent now that what he needed was the attention of a vascular surgeon, but there was no vascular surgeon available in Bundaberg, nor was there - nor was the patient sufficiently stable, at least at the early stage, to transfer him to Brisbane. I guess that's the sort of situation in which we wonder whether the compromise between local availability in emergency services and maintaining specialists in tertiary referral hospitals wouldn't be to have a flying vascular surgeon who can travel to Bundaberg, if necessary, for that sort of situation?-- I don't know the answer to that question. Clearly there would be cases where, on an individual basis, that would be well worthwhile. I mean, it is not always the case where you can fly a surgeon in isolation anywhere. Sometimes it is a team involvement, and so those considerations would have to be taken into account. We do have retrieval procedures. We do have air transport, and we are always evacuating patients from centres to Brisbane. So, I think, in principle, that's a good idea. I don't know at what level you cut it off, though.

Yes. Mr Andrews?

MR ANDREWS: At paragraph 23, you make some comparisons about incentives in the public and private systems, and it is well understood what you mean by the Commonwealth private sector rewarding those who do more work. What do you mean that "the public system is about penalties, not rewards"?-- We have a capped resource available in the public system and, in a way, you know, doctors are the public system's worst enemies, because we are always wanting to do more work, using the later technologies, do more procedures, et cetera, and because of that system, in a way, we have to budget at the beginning of the year and say, "We will do X number of cases", or, "X number of these procedures", which everybody understands, but when you come to the end of that and you have patients who come in who require those services, then it is quite a process to try and get - sometimes to get those other extra things done. If you contrast that to the private system where you - financially you are rewarded as a doctor for doing more work and as a hospital for doing more work - the more work you do,

the more funding you attract - so there is a dichotomy in terms of those two practices.

COMMISSIONER: Doctor, looking at the practicalities of that, our function, of course, is to come up with suggestions for practical solutions. It seems to me there are two issues that need to be addressed very aggressively: one is the financial incentive for elective surgery, rather than for diagnostical/prophylactic procedures. It seems to me utterly bizarre that Queensland Health will pay money to remove a cancer, but won't pay money - extra money, that is - to perform the colonoscopy which will detect the cancer before it needs removing, if you know what I'm saying. So, that seems to me the first thing - that there has to be a greater emphasis on diagnosis and prevention being rewarded, rather than merely surgery being rewarded. How do you feel about that?-- I would agree entirely that - you know, that you are aware of the health demographics and the population demographics as much as I am, and if we don't focus on preventative strategies, we are going to be in a lot of trouble over the next 10 to 20 years. We have essentially got an unlimited amount of work to do over the next few years and limited resources to cope with that, and if we don't do something to try and stem the flood of people coming in through the front door, we are going to be overwhelmed. We are starting to get that occasionally now. Certainly preventative strategies, health-promoting strategies are really the only way we have to go forward in the next 10 to 20 years.

The other thing that I see as a significant practical issue is this: it relates to the decision-making process on funding. We heard, for example, from Professor Aroney who gave evidence a couple weeks ago there was a time when he was told he could do - I forget the precise number - 300 stents in a year, and his response was, "What happens when the 301st patient comes in needing a stent?" Of course the funding doesn't dry up, but applications have to be made up the line to Charlotte Street, or whatever. It seems to me one of the things that are really lacking from those funding decisions is the involvement of both the local community - and I have in mind the particular areas outside Brisbane - and the involvement of the clinicians in deciding the funding priority. Sometimes it is going to be tough decisions. Sometimes it is going to have to be said, "Well, we can't do any more hip replacements this year because those patients are going to have to wait, but the priority is to look after cardiac patients, because they are the ones that can't wait." It seems to me self-evident that, firstly, clinicians have to be involved in making those decisions, and, secondly, it is vital to have the local community involved, both so that the decision is reactive and responsive to community expectations, and, secondly, so that the community understands why those tough decisions are being made. What are your views on those issues?-- I would concur entirely. Community expectations have driven our practice enormously in terms of what we provide. We are stretching the limits as to who we are now treating and the outcomes we are getting, not always with good evidence, and I think as a

clinical group, I think we certainly need to get our act together there in finding evidence that all of the people we are treating in the ways we are treating are actually benefiting from what we do, and I think the community has to be involved in the sort of services they want. If I could just go into my own area of transplantation, in Oregon in the US, the community was sat down and told, "Look, we have this resource. It can only go so far. What are we going to do with it?" They actually elected not to do transplantation because it is a high-end, high-resource intensive, high-cost procedure, and they thought they could get better bang for their buck, so to speak, by spending in other areas. That was a community decision and supported by the community. I think you are right. The only way we can make decisions about what we provide is by asking the people what we want.

And I suppose a flow-on from that is that there seems to have been a tradition or a culture, if you like, in Queensland Health, of painting a rosy picture of the public health system and suppressing bad news, and that has given people expectations that can't be fulfilled within existing budget regimes, and it would be far better for everyone if the unhappy truths were told up front so that people - those people who can afford to have the choice of going through the private system and those who can't afford to at least know what to expect?-- I would absolutely agree with that, yes.

D COMMISSIONER VIDER: We have had it suggested to us that one way to involve the local community in a better understanding of the nature of the health service that can be provided in their particular district is to use that service capability framework, develop it and publish it, so that people have an expectation and knowledge of what is available locally and what's not available locally, and what they might have to access outside their own district?-- Yes, I think that's fair, yes.

COMMISSIONER: Doctor, in paragraph 23, you speak of the role of the Health Department, from the Minister down, being to enable clinicians at the bedside to do their jobs to the highest possible standard, not create barriers to hinder and penalties for doing so. That's a statement that I think should be framed and hung in every office in Charlotte Street, but can you outline to us what sort of barriers you are talking about? You have told us about, as it were, the financial penalties. What other barriers are there?-- I think when we try to do things. You know, we are all subject to emergency situations, urgent situations where we need to make decisions to do something on the spot, and the processes that we have to go through in some cases to enable us to do things can be laborious, and that hinders us providing what we would see as being the highest standard of care. Now, it is not that anybody doesn't want us to do these things, it is just the process that has been constructed is such that it is somewhat tortuous and labyrinthine in trying to get through it, so it will delay doing what we need to do when we need to do it. I see that, as a clinician, as a penalty, as most of us do - as a barrier.

Doctor, one example a number of medical officers have mentioned in their evidence is the insistence of providing a business case, so that if you wish to develop a new project or expand an operation, you need to present a business case. It seems to me that there are at least two problems with that: one is that doctors are good at treating the sick, not at writing business cases, and they should be left doing what they are good at; secondly, the whole concept of a business case has no place in a public health system which isn't a business, which is about treating patients. Is that the sort of obstacle you are speaking about?-- I mean, I guess I've swung a bit on the so-called business case, and I agree with your comment about calling it a business case in terms of medicine, but the process we go through in terms of constructing those business cases is one of gathering evidence and looking at the pros and cons, and that's a worthwhile exercise, because it is has forced us, as clinicians, away from shooting from the hip, saying, "Give us the money.", and off we go and do it. It helps us decide on the infrastructure and all the implications of doing a new service across a hospital. For instance, you know, if we bring in a new operation, there are implications to not only the theatre, but to the support staff, the pathology staff, right across the board, and those sorts of cases, if you like, putting them together, make us focus on those issues. So, I think that's a good process to go through. It makes us come up with some evaluation if we have got a new technology, which is equally important. Where we run into problems is that once we have done that and put it into the system, it just seems to just - you know, it is like wading it through treacle, it just doesn't go anywhere, and it takes an inordinate amount of time before those cases are processed, looked at and a decision is made and fed back, and that's where the problem, I think, has arisen.

You see, one of the solutions, I guess, that we are considering - and I have to say this is more relevant to provincial rather than tertiary referral hospitals - is to review the entire budgetary system and instead of this system of historical costing where if you weren't given - historical funding - if you weren't given enough money last year, that guarantees you won't get enough money this year and you won't get enough money next year; that we have a complete reallocation done by Queensland Health based upon a proper analysis of demographic needs and adjusted by considerations such as age, state of health, racial/ethnic factors, all the other considerations, so that at the end of the process, Bundaberg, to take an example, is told, "You have X million dollars to run this hospital this year.", and then it is the local community and the clinicians through an appropriate body that has those funding decisions, and when a doctor in charge of a clinical department at the hospital has a business case to present, he knows or she knows exactly who it is being presented to, who is going to make the decision, and has at least the opportunity to get feedback and be told why that business case has not been preferred over another business case, which is more urgent. Do you think that that can

work?-- I think it can work, and I think one of the great advantages of that is that at the moment, we act a lot in isolation in our own little areas, and things are siloed up, rather than a sort of an over-arching view of everybody putting their business cases in together and then saying, "Well, okay, here's yours, these are the merits", what-not, "Here's mine. Here are my merits. Clearly yours is better so we will put mine to the side and we will put yours up." So, we are not acting as a whole in terms of our hospital or organisation, we are acting in little silos. Everybody is trying to push their own barrow and that's creating a log jam at the top.

I guess the frustrating thing for someone in your position is that, for all you know, the right decisions are being made, the right people are looking at these business cases and evaluating them and saying, "Well, a Renal Unit at Townsville is more important than extra funding for cardiac work in the Prince Charles Hospital.", but without feedback and without transparency?-- Absolutely.

You have no idea of how far off the mark you are?-- Absolutely. That's right.

D COMMISSIONER VIDER: We have had a lot of evidence presented to us about the frustration caused by the layers and the bureaucracy, but they have never been described as "wading through treacle", so thank you for that.

D COMMISSIONER EDWARDS: I was going to ask a question in passing. What percentage of donors of organs come from outside of Brisbane?-- Outside of Brisbane? I can't comment on all organs, but for hearts and lungs, probably about 30, 40 per cent.

Thank you?-- Some come from interstate.

So, there's a transport involvement in some of your cases?-- Yes, definitely.

COMMISSIONER: I have been told by - I'm sure you know Dr Stephen Lynch who is involved in liver transplant - that there are very short time-frames within which he has to harvest and utilise a liver, and I assume it is the same with hearts and lungs?-- It is even more critical for hearts. They are the most critical. They have to be retrieved and used within six hours.

So, a donor in Thursday Island or Weipa is really just not an option?-- No, we go to Perth and Auckland.

Really?-- Yep.

D COMMISSIONER VIDER: How do you manage your peer review? Do you call on clinicians from similar units throughout Australia?-- You mean in terms of transplantation?

Yes?-- Two ways: one, we submit all our results to the

Australian-New Zealand Transplant Organ Register, so we are benchmarked against the other units, and that data is then submitted to the International Society of Heart-Lung Transplant Register, so then it is benchmarked against international figures as well.

COMMISSIONER: Doctor, just going back, if I may - sorry, these questions tend to be a bit random - but the discussion earlier about full-time staff and VMOs, we keep getting feedback from the VMO side of the medical staff that their primary interests aren't in actually being paid more money, their primary interests are in receiving the respect to which they feel entitled as senior members of the profession, and the things that go with that - having a carpark at the hospital, rather than having to park down the road or pay for parking, having a sitting room, where they can go after surgery and have a cup of coffee and talk with their colleagues, having their filing and correspondence attended to for them by clerical assistants rather than having to do it themselves, those sort of things. Do you have any perception from Prince Charles as to whether those are problems for VMOs at that hospital?-- I would have to say that we are pretty well off at Prince Charles. I think we work - our combination of full-timers and VMOs works extremely well together and always has and there's a great clinical respect there and, facility-wise, we are not too badly off in terms of car parking - certainly we have got a lot of room there at Prince Charles, as you probably know, so I wouldn't say that's my perception that that's a major issue out at Prince Charles, but I have heard certainly in peripheral areas those things have been brought up.

And more dense hospital campuses like the RBH and PA, it seems to be very critical?-- Parking especially is a major problem at Royal Brisbane, isn't it, as you know.

Yes. Thank you, Mr Andrews?

MR ANDREWS: You spoke of the public system's penalties and barriers and, as I understand your evidence, paraphrasing it, some of the barriers are the frustrations caused when there's a need for budgetary compliance, the frustrations caused when you make applications for something, and the process is treacle-like. Are there penalties as well as these frustrating barriers?-- I guess what I meant by "penalties" is that we are unable to provide the sort of service that we want - that we really want to. You know, it is the frustration of knowing that you can do something and it is difficult to get that done. I see that as a professional penalty, if you like, in terms of what I do.

The remuneration packages in other States, you say that in Victoria in some cases they're twice as much as the Queensland award. Do you have any particular cases in mind? Is it a particular specialty or a level? As I understand the Queensland award it is categorised by seven levels, or thereabouts?-- Yes, and it is going through a bargaining process now. At the time that that - that this was being formulated, there were two famous job advertisements from Bendigo for full-time anaesthetists - and you may well have heard of those - and the packages that they were offering were fairly significant, certainly much more significant, and we lost two of our full-time anaesthetists to those positions, unfortunately.

Am I right in recalling that those packages offered a special kind of flexibility; that is a number of days employed in the public system and a number of days in which the specialist might do private work?-- Yes, they did. I think that most, if not all of the Victorian packages have some sort of flexibility built in in terms of public work and private work.

Is it a flexibility that is different from the option B kind of packages that Queensland Health can offer?-- Yes, it is different. It is flexibility in terms of time and the way set hours are worked.

Could you explain that, please?-- The - what they can do in Victoria, I think, from memory, is that if you are rostered over 40 hours, you can work those 40 hours in four days. Then you have the option of the 5th day of the week, if you like, to either work in private practice, do research, teaching, education, play golf, I guess, whatever. So it is a flexibility in how the working hours are actually put in at the institution and that, I believe, I understand, is negotiated with the employer.

COMMISSIONER: Doctor, that sort of flexibility strikes me as being something that is particularly viable with this increasing phenomenon of collocation, which of course you have at the Prince Charles campus and the Holy Spirit Northside as part of the same site. Would you welcome a system in which, to take that example, the management of the two hospitals can get together and say, "We need an extra specialist. We can give him or her three days a week at the public expense in the public hospital and that person will be provided with a room and facilities at the private hospital for the other two days a week"?-- I think in a lot of cases that would be wholly welcome - not me personally, but I know there would be people who would think that would be a great system, yeah.

MR ANDREWS: You observe at paragraph 25 that it is not far off until the time that there will be no-one to train medical students, junior house staff and training registrars. Can you suggest a solution?-- Well, I think we need to both retain the people that we have in the system now, both the full-timers and VMOs, and try and attract people back into the system so that we do have that critical mass to be able to

train. We're going to get more medical students over the next five years as the medical schools come on line.

Forgive me, but you have just expressed an ambition as opposed to a solution. How does one attract them?-- Well, I guess it is a far reaching proposal. I can only say in my own personal level what will keep me in the system, well, I want to keep doing what I do best, to do transplantation, to do whatever else goes with it, to do research, teaching, education, to be valued to do that, to have the resources to enable me to do that the best I can, to be able to work in well with my colleagues and the people that run the organisation. I have to say I have a very good working relationship with my administration and with Queensland Health in general. But that doesn't hold for all people, and I suspect that if we could engender a culture that rewards and values what we do and that enables us to get on and do what we do to the best of our ability, that will keep people in the system or bring them back.

COMMISSIONER: I wonder, too, doctor whether it is going to become imperative for the private hospitals to take up a bigger part of the training program, particularly when we've got the number of medical graduates in Queensland leaping from 230 odd per year at the moment to something close to 500 over the next few years. It is really going to be necessary for Queensland Health to put in place arrangements with the likes of Wesley, or St Andrew's, or Holy Spirit to ensure that training is provided there as well?-- Yes, it is a tantalising thought. What concerns me about that is that, as I have said, training and education takes a lot of time. You know, if you have a registrar or medical student with you at outpatients, what will take an hour and a half will take three hours with - if you are going to do the training and education properly, and, of course, in the private system time is money. It means probably less throughput, more time in the rooms. So provided those obstacles can be overcome, you know, the patient population is the same and there is no reason why it couldn't be used. I think some specialties will be very suited, perhaps surgery, specially, with more senior surgical trainees, where it is perhaps not so much basic work but where they can get on and do things in a good time-frame. Those sorts of things are probably well suited to start out training in the private sector.

And it does seem to me there is also some merit in increasing at a formal level the degree of cross fertilisation of experience and practice between the public and private sectors?-- Absolutely. I mean, there is a tremendous amount of experience in the private sector. All the VMOs have been through the public sector and have moved out into the private sector and we need to retain that for the system as a whole, both clinically and educationally.

MR ANDREWS: When speaking about the things that you look for that will keep you in the public system, one of the observations you made - I forget the word but it was either that you be respected or you be appreciated, something of that

kind. That's obviously not just shown by way of financial reward, that's something else, is that the case?-- Absolutely, yes.

That - is that something that can be inculcated into a system, or is that dependent upon your own administration?-- I think - I think it starts at the top and filters down, and it depends on all levels, at whatever level you are looking at. We're very lucky at Prince Charles. I have to say we have got, as I said, a supportive administration that does make us feel valued. Simple things like lockers, like having a staff tearoom where you can go and discuss things, where you can have showers, where you can get food after hours, things that are saying to people, "As an employer I value you being here and I am going to provide you with these things because I think it is worthwhile." Just simple things like that.

There is clinician involvement at Prince Charles through a Medical Advisory Committee?-- That's correct.

Can you explain how it relates to the district executive?-- Yes, the Medical Advisory Committee is comprised of senior clinicians and also the District Manager and Executive Director of Medical Services sit on that committee and they meet once a month, and the Chairman of the Medical Advisory Committee sits on the District Executive Committee. So there is cross fertilisation there.

D COMMISSIONER VIDER: Does that committee have any role in the credentialing of medical staff?-- Yes, the Medical Advisory Committee is directly responsible for the credentialing and privileging of the medical staff.

MR ANDREWS: Do the clinicians have any persuasive - do they have any decisive role in the allocation of the budget pie at your hospital?-- Yes, the budgets are decided at the program levels, so each program will work up its budget submission and that will then be submitted for discussion at the executive level, and then it will go back to the group as a whole for further discussion once the decisions have been made. So there is some involvement.

D COMMISSIONER VIDER: Given the unpredictability of your particular unit, do you have budget caps put on the unit, or is it acceptable that the nature of the work means-----?-- I have a budget which is a nominal budget based on a number of transplants.

Yes, is that based on historical data?-- It is based - yes, largely on historical data. We have a rare relatively stable number of donors available to us. However, I also have an understanding that if there is a transplant to be done over and above that, then there is no barrier to that being performed.

COMMISSIONER: But, doctor, I am really very heartened to hear what you say about the working relationship at the Prince Charles between clinicians and management. I guess my concern

is that that sort of informal system involving advice rather than decision making is terrific if the people involved in making the decisions have open ears and open minds. But as a system it is fallible and that's why I am concerned to explore whether something formal should be put in place so that every hospital in Queensland enjoys that same relationship that you describe of a genuine involvement of the clinicians and also the community in decision making?-- Right. Look, I would agree. It is a coming together of like minds, if you like, and it works well but, you are right, if we had - if we didn't have any ears, anybody listening to us, we would be at loggerheads, I am sure.

MR ANDREWS: I have no further questions, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. We might then take the morning break and resume a little before midday.

THE COMMISSION ADJOURNED AT 11.42 A.M.

THE COMMISSION RESUMED AT 12.06 P.M.

KEITH DAVID MCNEIL, CONTINUING:

COMMISSIONER: Mr Boddice?

MR BODDICE: Thank you, Commissioner.

EXAMINATION-IN-CHIEF:

MR BODDICE: Dr McNeil, you gave some evidence in relation to the suggestion of specialists going out to the regional hospitals so that the Registrars can in effect stay at the local environment. Is your intention something like this - take Bundaberg for example - if there was a local person from Bundaberg who was a registrar, they would have the opportunity of being able to do their training, to a large extent, in Bundaberg by having Brisbane-based specialists go out there for a period of time to undertake that training for them, and in that way it is more likely that they might remain in Bundaberg either as a staff specialist or as a VMO in their later lives?-- Yes, that sort of thing. They would still require some training in Brisbane to broaden their experience, but they could concentrate their training, we could facilitate that in a particular region. I think they're more likely to

set up in that area and stay in those sort of areas.

Rather than the present system, which, of course, means they largely base themselves in Brisbane and do some time during their training out in country areas, which may include being back in their home town, but in that time they have set up their roots, as you call it, in Brisbane so tend to come back to Brisbane at the end of their time?-- Yes, that's right.

You also gave some evidence in relation to - in response to one of the Commissioner's questions about the retrieval team and whether you could fly, in effect, a retrieval team in. Is one of the limitations with that practice also the fact that the particular hospital may not have the equipment or clinical structure to be able to support that retrieval team in doing any procedure at that hospital?-- Well, that's certainly a consideration, and the retrieval team would have to be formulated around what it was doing and where, yes. We could be a bit like what the army does with some of their fly-in facilities, or an individual going to a hospital that's well set up. So it would be dependent upon the situation, I would think.

One of the things you would have to consider is not simply that they arrive and assess the patient, but if they have to perform a procedure, that the patient can be maintained until in a stable enough condition to be able to be transferred out to the larger hospital?-- That's right, yep.

Doctor, at paragraph 16 of your statement you spoke about the fact that the large teaching hospitals have the more flexibility in their workforce make-up to the higher number of staff. Are the sorts of matters you are referring to there the fact that there is a greater number of staff to share the on-call work?-- To a certain extent, yes. I mean, the more staff you have, the more flexibility you have in terms of your work practices and more sustainable after-hours roster. I mean, depending on the - especially after-hours can be very onerous and it can involve quite a lot of time after working hours, so realistically about a one-in-four is a long-term sustainable rostering for after-hours, specially for specialties which are going to be heavily called upon after hours. So where you have more people, you are obviously able to sustain those sorts of rostering arrangements.

Is that a factor in the more regional hospitals in considering whether, for example, VMOs, staff specialists are employed to undertake certain procedures, whether there is enough back-up to be able to provide a realistic service?-- I think it is an important consideration. I mean, I have been in a situation - I have been one-in-one on-call and it is impossible to do anything other than provide the service that you are called in to do, day in day out. So I - you know, those regional centres where there are only two or three doctors when they are on call after-hours, it is a very difficult thing to sustain. So you - really, you need a critical number to make it sustainable in the long-term and probably a mix of VMOs full-time, if possible, to give some flexibility if situations

arise needing that.

At paragraph 21 you refer to the thoracic department at Prince Charles Hospital, speaking, though, in terms of how it is run, and you point out that it is a combination of VMOs, part-time specialists and full-time staff specialists, the numbers being three VMOs, two part-time specialists, and seven full-time staff specialists, and I take it that the duties are then shared between all of those people?-- To a certain extent. I mean, we have the subspecialty transplant cystic fibrosis units within that and they do their own after-hours work but we all share the other after-hours work, and it works extremely well. And the key to that working well is that we all sort of share the same goals and visions and we have got the right - I think we have got the right mix in terms of the specialties we provide for and in terms of the flexibility that we need in those areas.

You were asked some questions about the Medical Advisory Committee. You obviously sit on that committee?-- I am the Chairman.

You are the Chair of the committee?-- Mmm.

The types of things that the Management Advisory Committee deals with-----

COMMISSIONER: Medical Advisory Committee.

MR BODDICE: Sorry, the Medical Advisory Committee.

COMMISSIONER: I think you said the Management Advisory Committee.

MR BODDICE: Did I? Yes, the Medical Advisory Committee deals with, does it include things such as if an issue arises between a doctor and management that that will be referred to the Medical Advisory Committee?-- Yes, generally if there is a professional issue in any respect, the Medical Advisory Committee will be involved in some way, in either monitoring it or in helping to resolve it.

And does the committee also have responsibility for professional standards?-- Yes, direct responsibility for professional standards.

And you speak that the District Manager that you have has been very receptive to the problems and feedback. Which District Manager was that?-- Originally we had Ms Gloria Wallace - first of all, we had Deb Podbury, who has now gone to the Princess Alexandra, and the Medical Advisory Committee was set up at that time. Gloria Wallace came in as the District Manager and she has now left, as you might know, and Michael Cleary is the Acting District Manager.

Thank you.

COMMISSIONER: Mr Harper?

MR HARPER: No questions, thank you.

COMMISSIONER: Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Dr McNeil, John Allen for the Queensland Nurses' Union. In paragraph 24 of your statement you identify some factors as leading to difficulties in Queensland Health retaining skilled doctors. Firstly, frustration of being unable to provide appropriate standard of care for patients and, secondly, the lesser remuneration as compared to other States. Would you agree that those factors would equally impact upon Queensland Health's ability to retain skilled nurses?-- Yes, I can only comment from my personal experience, but certainly the nurses that work in my transplant unit do a very unusual - they perform a very unusual role. In fact, it is unique within the health system, and I think it is fair to say that it is very hard to have what they do recognised within the usual way that nurses roles are recognised, and that's been a bone of contention. In fact, one of our nurses is leaving because of that now. So I think that there are factors like that. And I would have to say across the board that I think nurses are poorly remunerated for what they do, for what they are expected to do and the roles they fulfil.

Obviously in paragraph 28 of your statement, where you refer to a steady drain of highly trained medical and other health professional staff from the system, you include nurses in that?-- Yes.

And therefore that places steadily increased pressure on those that remain to meet the ever increasing demand?-- Yeah, absolutely. I mean, the demand doesn't change. It is just the number of people available to service that demand becomes smaller and smaller, so the - so it becomes a self fulfilling prophecy that the stress goes up on those people and they leave because of stress, placing more stress on those that are left. And trying to get good nursing staff and allied health staff is increasingly difficult across the board.

So we have a situation where both doctors and nurses are working harder but being paid less than their interstate counterparts?-- I can't comment - I don't know what the nurses are paid in respect of their interstate counterparts, I am sorry.

You wouldn't be surprised that a similar situation exists as with doctors?-- No, I guess I wouldn't.

All right. And we have got a situation where both doctors and nurses are frustrated by the level of care they can provide their patients?-- Yeah, I think that's a fair statement.

And in paragraph 28 you really identify the root cause of the crisis, as you describe it, in Queensland Health as being the chronic underfunding of the public health system?-- Yeah, that's my own - I guess my own personal opinion on what's gone on, but I think we have been under-resourced for many years. We have been lean and mean and very efficient, but I think that that has then translated into being somewhat underfunded. As community expectation has increased, technology has increased, then as medical costs around the world have increased, I don't think we have really kept up, certainly not with the rest of Australia and probably not with the rest of the world.

Would it be fair to say then that there would be no real solution to the crisis without a greater allocation of public moneys to public health?-- I think there would be two ways. I think there is more money needed, although as to where that should go, I am not going to comment, but I think also there are ways we can do things better but we've just about exhausted the way we can get efficiencies out of our clinical delivery now.

Staff are working harder and smarter, but the bottom line is more resources are needed?-- I believe so, yes.

Thank you, doctor.

D COMMISSIONER VIDER: Doctor, can I ask you a question? In your role as head of the transplant services at Prince Charles, do you have time allocated in that position for research?-- Not specifically, no. Most of our research we do after hours, on weekends and things, although I have tried to - our last appointment we tried to get some protected time for research for the person we appointed but I don't specifically have any protected time.

COMMISSIONER: I was going to ask Mr Devlin next.

MR DEVLIN: I have no questions.

COMMISSIONER: I am sorry?

MR DEVLIN: I have no questions.

COMMISSIONER: Thank you, Mr Applegarth.

CROSS-EXAMINATION:

MR APPLEGARTH: Just picking up on the last point about the chronic underfunding of the health system-----

COMMISSIONER: Doctor, I should explain Mr Applegarth of counsel represents Dr Buckland?-- Thank you.

MR APPLEGARTH: Sorry, I should have introduced myself. Dealing with the chronic underfunding of the health system as a whole in Queensland, you understand that it is substantially below the national average?-- Yes, I do, yeah.

And that in a decentralised State like Queensland, you would expect it to be higher than the national average?-- That would be - I think that's reasonable, yes.

In fact, the Productivity Commission's Report of 2005 records that Queensland has the lowest recurrent health expenditure per capita of any State or territory?-- Yes, I understand that's true.

Can we deal with your particular area of concern, cardiac care. Is it the case that health indicators that are assessed by people who know what they are doing, indicate that Queensland has perhaps the worst result in death rates from heart disease in Australia?-- I must - I should point out, I am not specifically involved in cardiac care other than heart transplantation but obviously from my discussions with colleagues at the hospital they tell me that that is the case, yes.

Now, your eminence and your daily work is in acute care as you've just explained?-- Yes.

But from your evidence before, do you see in a policy sense that there's great urgency in having preventive strategies to try and decrease the incidence of coronary heart disease, coronary disease?-- Absolutely. I mean, Prince Charles Hospital probably wouldn't exist if it wasn't for smoking and obesity and I think that the legislation that brought in the smoking control I think last year is probably going to do more good for the health of Queenslanders than a whole lot of other direct incentives and unless we can prevent illnesses, specifically smoking and obesity, diet/lifestyle related illnesses, you know, we're going to be flooded.

Because even if your budget in your unit went up by 20 per cent, if something is not going to be done about prevention, you're going to get swamped. That 20 per cent wouldn't be enough?-- Absolutely.

You obviously deal with patients and their families, you have a feel for the type of people they are and how they got in the health condition that they are in from smoking or eating too much; is that a fair comment?-- Yes, yes, absolutely.

You have a feel for the patients you're dealing with. Is it important that those people get the right message in a form that they understand about prevention?-- Yeah, it's critical. What's really critical is getting to the children I think, children and teenagers. A lot of the adults, you know, the dye is cast for them unfortunately and they'll need acute intervention or services, or the services that we currently offer, but it is important to get that message down to the younger - younger generations.

Now, in paragraph 30 of your statement, Dr McNeil, you talk about politicians treating health as a political football and things had to pass what you describe as The Courier-Mail test. Speaking of The Courier-Mail, did you see a letter in Saturday's paper by Professor Peter Brooks, the Executive Dean, Health Sciences, University of Queensland, RBH Herston?-- No, sorry, I was skiing on Saturday.

I'm very happy you didn't break a leg. I didn't bring an extra copy of it but one of the points he makes about all the justifiable debate about waiting lists and I'll quote him here, that "Some issues of fundamental importance to the health of Australians tend to be sidelined if we just concentrate on things such as waiting lists", and he continues, "These include disease prevention and health promotion which are given little air play as we focus on acute hospital based medicine and the issue of the health workforce." Would you agree with that?-- Yes, absolutely.

Now, there are a lot of good news stories come out of Queensland Health like the one that's on the front page of today's paper; correct.

COMMISSIONER: Is that the VMOs leading the-----

MR APPLEGARTH: I will come to that bad news?-- I don't know, I haven't-----

I will deal with the good news first. There are some good news story?-- For sure.

But there are a lot of bad news stories, aren't there, and it is important that we have an informed public debate about these sorts of issues that you've raised, which Professor Brooks has raised and that it be informed by information, reliable information?-- Yeah, I think that's critical.

Are you aware of a document called "Health Determinants 2004"?-- I recollect the title, yes.

It profiled the state and provided information about the health profile of the state as a whole and within particular regions, indigenous communities, remote areas and the like?-- Yes.

Is it your recollection that that report revealed that health outcomes and morbidity rates in places that would be less than an hour's drive from where we are at the moment, in suburbia, are appalling?-- Yes, and the further you go out, the worse they tend to get and indigenous communities in particular. In particular.

Exactly. But some of our suburban population have morbidity rates that aren't much better than indigenous communities?-- Yep, that's true.

Just in terms of prevention and educating the public, not everyone can afford the CSIRO diet book, can they, to see how they can improve their health so how, with your knowledge of dealing with patients, would you think is a good way to go forward with educating people?-- Well, that's a very interesting question and one that clearly has been struggled with around the world. There are various ways of doing it. You can do it - we do it on an individual basis, so if we have a patient and a family, we educate them at that level and then try and take that out further into the wider community that we deal with in terms of our patient population that comes in. You can - you can do it in large media campaigns which have been very effective in things like asthma, the national asthma campaign was very effective, and there has been some antismoking campaigns overseas which have been very effective on a blanket level but, essentially, the key is to get the message out and find out what it is that really hits the nerve of the people that you're going to get the message to, and one message won't get to all people which is why you have to have multiple ways of delivering a message.

Can I turn to another topic and that's dealt with in your paragraph 22 of your statement, Dr McNeil, and that is talking about the fact that the budget has become a priority in hospitals. That isn't something that just happened in the

last year or two?-- No, I've been back in Queensland Health now for three and a half years and, certainly, it was evident when I came back.

And so far as you know, it had been evident for some years before that?-- Yes, definitely.

Because the focus on fiscal management meeting the budget is all well and good but it suppresses the ability of the system to respond to the types of challenges that you've just discussed?-- It certainly can do that if that's the only focus.

And the problem with close attention to fiscal management and each unit like the one that you're in has to meet budgets is that it results in a disaffected workforce?-- Yeah, I think that that's a fair statement. If you - we need - we need some sort of control over what we do and we are as much to blame as anybody for letting things get out of hand and - but it can go overboard. If it's too tightly constrained, then it stops you from doing what you need to be doing.

And the demands that are placed upon nurses, doctors, allied health professionals to keep constantly busy, meet budget, be more productive, must place great strains on the relationships between individuals and the relationships between groups?-- Yeah, it does. It does - as I said before, I think that we then tend to focus on our own areas and become very protective of what we do in our own areas and we tend to miss out on what the bigger picture might be.

And you don't have 15 minutes to talk to someone in the coffee room?-- We don't have a coffee room.

If you have a coffee room. As you've reminded us, you don't?-- Yeah, it is difficult.

Now, I have asked you some questions about areas that you know and I don't want to ask you some questions on areas you don't feel confident on. Can I just check: you're not aware of the political process that decides how much funding is given to the health system as a whole?-- No, I have no knowledge of that.

You're not aware of the political process as to how that funding is allocated?-- No.

And you're not aware of the political process that decides what full-time health specialists like yourself are paid, who determines it?-- I have some knowledge of that, having been peripherally involved - been peripherally involved in the current bargaining arrangements but I don't know the intimate details, no.

That's important not to lose people to Victoria, people who are valuable to the system here in Queensland, isn't it, that-----?-- Oh, very much so.

-----people are properly remunerated?-- Oh, very much so, yes.

Can I just deal with funding within your area, not just transplant areas but cardiac care. What's it - cardiac services, is that a convenient term that embraces-----?-- Yes, you could - you could talk about that.

It is very unfortunate, isn't it, that when the whole system is underfunded, when cardiac services are underfunded we get into a realm where a particular hospital like Prince Charles seems to be in competition with another hospital, say Princess Alexandra, as to who should get what?-- Oh, I think, you know, from the cardiac services point of view, that, yeah, we shouldn't be in competition across the state. I mean, we should have a collaborative that works together to make sure that the service is delivered efficiently and effectively across the state.

Now-----

COMMISSIONER: Doctor, does that exist now, do you think?-- Not to any great degree, no. I mean, there are some small services, I think, which offer a stateside focus but although there are - there are services which cater for the statewide population, they don't run in a collaborative or a coordinated fashion. And I think cardiac services is one that really cries out to have some sort of statewide control or not control but collaborative in terms of how the service is delivered to all parts of the state, because it is one where there is a disparity in level of care that's offered within Brisbane and outside of Brisbane.

Yes. The sort of transplants you're involved in, is the Prince Charles the only hospital in Queensland that does those?-- The hearts and lungs, yes.

Yes?-- Yes.

D COMMISSIONER EDWARDS: And should remain that to get the expertise in a central-----?-- Oh, yes, yes, we would dilute the expertise too much if we had more than one centre. You know, you wouldn't be able to retain the skills with the number that we do.

COMMISSIONER: But general coronary care is split within Brisbane between the Prince Charles, the Royal Brisbane, the PA and I assume the QEII as well?-- Coronary care, yes. Not all the interventional procedures, highly specialised interventional procedures, but general coronary care would be performed at most hospitals within an Intensive Care Unit, yes.

MR APPLEGARTH: In short, there is not enough money to go around each of those institutions, is there, in coronary care?-- Not for the level of demand that's currently hitting us.

Can I deal just briefly then with Prince Charles and you're

the Chair of the Medical Advisory Committee?-- That's correct.

Do you remember attending a meeting in 2004 where you were there, Dr Darren Walters, who I think was Acting Director of Cardiology, Kerry Gallagher from the AMA and Gloria Wallace and Dr Buckland attended?-- Yes, I recall that meeting.

And Dr Buckland asked you collectively what Prince Charles needed in terms of cardiac services?-- Yes.

And is it the case that there were some increases that came after that?-- That's true, yes.

And was that the Prince Charles in that area received an additional $1.07 million in October 2004?-- I don't remember the exact amount but-----

About a million?-- About a million, yes.

About a additional 1.4 million in December 2004?-- Yes, there were allocations.

And then in April 2005 there was additional funding, I think recurrent, of $3 million, not just for cardiology but some other services but principally that's recurrent funding for cardiology services?-- I think that's correct, yes.

Did you appreciate Dr Buckland coming to that meeting?-- Yes, yes, we did. You know, that occurred on the background of some acrimony that was occurring around cardiac services and it was great that he could come out and talk to us face-to-face. We really appreciated that.

Could I end with this matter, and it is not intended to sound trivial but it's talking about someone like you and your entitlements to go overseas to improve knowledge. I take it - I don't want to know about your remuneration package but someone of your eminence would have some entitlements to go overseas?-- That's correct, yes.

To pursue your professional education and to inform yourself about developments in your clinical field and in health in general?-- Yes.

And that's your entitlement?-- That's right, yep.

Isn't it the case that if you wanted to go to your Alma Mater in Cambridge, you would have to get the approval of the Minister to do that?-- If I wanted to do it on Queensland Health time, yes.

And so, you or someone would have to fill out a form and would have to go up through the system?-- Eighteen pages to be precise.

Terrific. And that 18 pages or a summary of the 18 pages, I'm pleased to say I haven't seen all the documents that go across the Director-General's desk, that has to go through the

Director-General's office?-- I believe that's the case.

And then on to the Minister?-- Yes.

By which time your plane has probably left?-- I haven't been in that situation just yet but there have been people who have been informed of their ability to leave while they've been at the airport, so.

Now, if a politician issued an edict that ministerial approval was required before someone like you could go overseas, can you think of any reason why that edict shouldn't be rescinded before the sun goes down?-- I think it's fair to say that most of us have questioned why the Minister needs to give approval but I don't know how the politicians' minds work.

No, neither do I. That's all my questions, Dr McNeil, thank you.

COMMISSIONER: Just on that last subject, as I understand it from other evidence, it's actually even worse than it's been put to you by Mr Applegarth because it's one thing to fill in the 18 pages and get approval before you go but then when it comes to claiming your expenses afterwards, what we've been told from various sources is the amount of time you'd spend filling in forms and processing applications and so on, it's literally not worth your time to claim the taxi fares or the lunches or whatever that you would be entitled to receive?-- Yes, it is quite an onerous procedure. I mean, a lot of people take annual leave to go to meetings now rather than their entitlements because it is just too difficult. We often get notification of these meetings quite late, especially if you're an invited speaker, you're sometimes asked to do things at a month's notice if you're available and that can be quite difficult within the system, although I'd have to say, to be fair, in all my occasions, that we've managed to get the applications through in time but sometimes it's pretty fine.

I guess I can understand, Doctor, that the whole convention issue has become on occasions a scandal both within your profession and mine, with people going to conferences at Aspen or Cortina where there is a sort of half hour video in the morning before you go skiing and another half hour in the evening before dinner, but it doesn't seem to me that having the Minister involved is necessary to prevent people rorting the system. A competent Director of Medical Services or District Manager would be able to make sure that the conference is a genuine and useful one rather than just a junket?-- Well, I would have thought so. The checks it goes through, it goes through your head of unit, then it goes through your head of program, then it goes to the EDMS, then the District Manager, then the zonal manager, then Queensland Health then finally up to the Director-General, then on to the Minister. So I don't know how many checks are along the way but it is a considerable number.

Yes?-- And I wasn't at a conference when I was skiing either. I was on holidays.

D COMMISSIONER VIDER: But definitely wading through treacle?-- Yes, definitely.

COMMISSIONER: I have to say, Doctor, when I go skiing, the last thing I want to see is other members of my own profession. I'm not sure that the same applies to you. Mr Applegarth, anything arising out of that?

MR APPLEGARTH: I'd finished, thank you.

COMMISSIONER: Yes, Mr Diehm.

MR DIEHM: No, thank you, Commissioner.

COMMISSIONER: Ms Feeney?

MS FEENEY: Nothing, thank you.

COMMISSIONER: Any re-examination, Mr Boddice?

MR BODDICE: No, thank you.

COMMISSIONER: Mr Andrews.

RE-EXAMINATION:

MR ANDREWS: I notice that you have, from your second-last page of your statement, been an invited speaker in 2003, four and 5, in 10 or so countries in two years. Was that on your own time?-- Quite a bit of it was, yes.

Does that mean that you funded it with your own funds?-- No, no, usually an invited speaker, there'll be funding from a conference to attend.

Nothing further.

COMMISSIONER: Thank you. Doctor, thank you very much for your time. Whilst I don't want to betray any confidences from my meeting this morning with the Premier, one of the points we discussed was the fact that with so much talk about the smart state, the medical profession in Queensland is and has for a long time been the standard bearer for what the smart state is all about and you personally, if you'll forgive me for saying so, would be at the head of that. It is humbling for us sitting up here to have the benefit of input from people of your eminence. We do enormously appreciate your contributions and we have no doubt that they be will be useful in our final deliberations and conclusions. You're excused from further attendance?-- Thank you very much.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews.

MR ANDREWS: Commissioner, I'm relying upon Queensland Health to find one of the five or so witnesses which it wishes to call before the inquiry evidence concludes.

MR BODDICE: And I also, I suppose, could look down the other end of the Bar table but I have indicated to my learned friend that we're endeavouring to see if Dr Cleary, who was one of the witnesses, is available this afternoon. It looks like he will be. His statement, however, has yet to be distributed, which of course could be an issue, but at least we could get him started.

COMMISSIONER: Certainly, Mr Boddice. If Dr Cleary does give evidence, how long will we expect for him to take?

MR BODDICE: I would think he would take most of the afternoon.

COMMISSIONER: Is he the only other witness anyone has planned for this afternoon?

MR BODDICE: As I understand it, yes.

COMMISSIONER: Well, it is a bit early to break for lunch but if we break now and resume at, say, 2.15 will that give sufficient time for his statement to be distributed and considered by everyone concerned?

MR BODDICE: Yes, it should.

COMMISSIONER: All right. For the benefit of everyone else at the Bar table, let me simply say that if that causes any inconvenience we will do what's necessary to ensure that people's interests aren't prejudiced but we'll proceed on the footing that the statement will be distributed as soon as conveniently possible and then resume with his evidence, Dr Cleary's evidence, that is, at 2.15.

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 12.41 P.M. TILL 2.15 P.M.

THE COMMISSION RESUMED AT 2.29 P.M.

COMMISSIONER: Yes, Mr Andrews?

MR ANDREWS: Commissioner, I call Dr Michael Ian Cleary.

MR BODDICE: Commissioner, we seek leave to appear on behalf of Dr Cleary.

COMMISSIONER: Such leave is granted.

MICHAEL IAN CLEARY, SWORN AND EXAMINED:

COMMISSIONER: Doctor Cleary, do you have any objection to your evidence being filmed or photographed?-- No, that's fine.

MR ANDREWS: Doctor Cleary, have you prepared three statements which are each signed by you today?-- Yes, I have.

Does one relate to your involvement with the Bundaberg Base Hospital?-- Yes, it does.

Does another describe features relating to your role as Executive Director of Medical Services of the Prince Charles Hospital Health Service District?-- Yes.

And does a third relate to the provision of cardiac services in Queensland?-- Yes.

Are the facts recited in those thousand-odd pages true and correct to the best of your knowledge?-- They are.

Where you express opinions, are they honestly held by you?-- Yes, they are.

Commissioner, I tender Dr Cleary's three statements.

COMMISSIONER: Now, let's try and get these in some order. There's the statement of 70 paragraphs, which has on the first page, after paragraph 6, the subheading, "Involvement with the Bundaberg Base Hospital." Can we call that "The Bundaberg Statement"?

MR ANDREWS: Yes.

COMMISSIONER: That will be Exhibit 301A.

ADMITTED AND MARKED "EXHIBIT 301 A"

COMMISSIONER: I have got another statement in front of me with the subheading on the first page, "Role of Executive Director of Medical Services". Is that the one principally related to the PA?

MR ANDREWS: To the Prince Charles Hospital.

COMMISSIONER: Prince Charles Hospital, I should say.

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: That will be Exhibit 301B, and, just for convenience, I'll refer to that as "The Prince Charles Statement"-----

ADMITTED AND MARKED "EXHIBIT 301B"

COMMISSIONER: -----with due apologies to His Royal Highness. I don't have the third one, but that relates to the Cardiac Unit, does it?

MR ANDREWS: Yes, and it responds to some matters raised by Dr Aroney.

COMMISSIONER: That's not what you are holding, is it?

MR ANDREWS: Yes, this is the third one, Commissioner.

COMMISSIONER: All right. That will be 301C.

ADMITTED AND MARKED "EXHIBIT 301C"

MR ANDREWS: It is a statement of 126 paragraphs, and I haven't counted the annexures. With respect to Exhibit 301A, it describes your involvement with the Bundaberg Base Hospital. Doctor, you were appointed as an acting District Manager of the Bundaberg Health Service District for a period of about three weeks in May 2005; is that correct?-- That's correct.

From paragraph 8, it is ambiguous. I can't tell whether you've intermittently been Director of Medical Services since then or during that three week period?-- My apologies for that. The time that I was in Bundaberg was difficult in terms of keeping continuity with the Medical Superintendent's role, so on occasions when the Medical Superintendent position was vacant, I also took up the role as acting as the Medical Superintendent for the hospital.

Doctor, was that in that three week period?-- That was within that three week period.

Do you have a copy with you of that statement which relates to the Bundaberg Hospital? If not, I can provide you with one?-- I would be very grateful, thank you.

While you were there, it appeared that Dr Patel had had contact with about 900 patients as a surgeon and 400 patients for endoscopy procedures. I see that from paragraph 19 of your statement?-- Yes, that was the information that I was provided with when I first went to Bundaberg.

At paragraph 34, you speak of potential issues relating to patients who had endoscopy procedures. It appears that it was felt they needed to be reviewed in light of a patient having a normal colonoscopy with Dr Patel, but the patient seems to have subsequently been identified as having a carcinoma of the rectum?-- Mmm.

Did that suggest that - were you meaning to convey that after Dr Patel had performed a colonoscopy, it appears the patient was told that there was nothing untoward, but that a subsequent investigation showed that there was a carcinoma and the probabilities were that Dr Patel had missed it?-- That's correct. One of the arrangements we had in place in Bundaberg was for patients who had a high risk to be referred to Dr De Lacy, and Dr De Lacy identified a patient who, at one of those early clinics, had had a normal colonoscopy but subsequently was noted to have carcinoma of the rectum.

Doctor, what's happened to the 400 patients who had endoscopy procedures conducted by Dr Patel?-- I can't detail exactly what's happened since my departure from Bundaberg-----

I meant have they been referred for inspection by someone else?-- Yes, given that there were a number of concerns relating to the colonoscopies that were performed by Dr Patel, we arranged for those patients who needed urgent review to be referred either to specialists in the private sector who could undertake colonoscopies, or referred to specialists who came to Bundaberg from Brisbane on a regular basis, and they were given priority. The other thing that I arranged while I was in Bundaberg was for a large volume clinic to be organised with specialists from Royal Brisbane who flew up. I think that occurred in June or July. On that occasion, we were planning on scheduling something in the order of 70 patients to have their colonoscopies redone-----

Thank you. Paragraph 34, you see, does refer to 70 patients?-- Yes.

I wonder if you can shed any light on the other 330?-- The other 330 were being managed through the processes that I alluded to earlier where if they were a higher risk patient, they had already been referred to other specialists. If they were intermediate risk patients, they would have been referred

to the usual clinic that's conducted in Bundaberg by the specialist gastroenterologist, and the lower risk patients - those that there didn't appear to be any significant concerns in relation to their care - and I guess that's an assessment taken on the grounds not only of their history, but some of the information we had in our records and the advice of the specialist gastroenterologist that was helping us - and they were referred to these large volume clinics. The plan was to continue those clinics until all 400 patients had been assessed.

And you have left them in good hands, I understand?-- Yes, I feel quite comfortable that those arrangements would be put in place.

COMMISSIONER: Doctor, sorry, I'm a little confused. Paragraph 19 talks about 400 patients for endoscopy procedures, but then when we get to paragraph 34, there seems to be a confusion between endoscopies and colonoscopies. Am I missing something there?-- I apologise for the confusion. "Endoscopic procedures" is a general term which can cover colonoscopy or endoscopy - so, if you are having a colonoscopy for an examination of polyps or cancer of the colon, or an endoscopy where you are being examined to see if you have an ulcer or some other abnormality of your stomach - so that the term "endoscopic procedures" can be used to include both of those types of investigations, and, as you have indicated, colonoscopy is very specific, which is the examination of the large bowel.

Yes. I must admit I had assumed that endoscopy was top down and colonoscopy was bottom up, but it is not as specific as that?-- Well, I guess the umbrella term would be endoscopic procedures, which really refers to the arrangement where you use an endoscope to look at the particular area, be it top down or bottom up.

MR ANDREWS: At paragraph 51, you observed that at Bundaberg the clinical audit processes were not well developed. Is that something you saw or something you have learned from others?-- I believe it is a combination of both. It is an opinion I formed from discussions with some of the senior doctors in Bundaberg. I was particularly impressed with the views and opinions of one of the paediatricians in Bundaberg who seemed to have a very well-developed system in place for managing the care of patients in the paediatric service, and certainly had what I would regard as contemporary views on how audits and processes around those would occur. In some other areas, I guess they appeared to be less well developed, and certainly from my discussions with some of the surgeons in Bundaberg - I can say I met with them as a group of an evening on two occasions - the information they conveyed to me is they felt concerned that the audit processes that were in place were not as well developed as they should be, and that they often felt that it was not in their interests to participate in those processes, as at that stage Dr Patel was chairing those meetings.

Were these surgeons who were VMOs at the Bundaberg Hospital?-- Some of them were full-time surgeons, some of them were VMOs, and some of them were surgeons who worked in the community but didn't have appointments at the hospital at that time, and they expressed opinion in relation to the time that they had been part of the hospital's medical workforce.

As I understand it, two surgeons had had experience with the audit process as managed by Dr Patel and were critical of it. Was that your evidence or have I-----?-- No, I think it would be more than two. I think the meetings that I had included seven or eight surgeons, and they all had strong views that the audit processes weren't robust. The documentation I reviewed at the time when I was there was limited, but again, I guess from my experience, I would still feel that there wasn't ample evidence of extensive review of some of those cases.

At paragraph 52, you mentioned the credentialling and privileging documentation which you located. It revealed to you that there was a process consistent with QH policy that was managed through a joint Fraser Coast-Bundaberg Health Service District Committee?-- That's correct.

A "process consistent with Queensland Health policy" doesn't convey a lot. Are you able to tell us whether you were in a position to conclude whether the process had been followed consistently?-- My opinion would be that the process that was in place was flawed, and that's for a number of reasons.

But the process was consistent with Queensland Health policy. Do you mean the implementation was flawed, or the process was flawed?-- The "implementation" would be a better way of describing it. I think the process in terms of establishing a committee, having a group of people review the credentials and privileges for staff was consistent with Queensland Health policy, but that the implementation in some of the high risk - or some of the clinical areas that were ones that I regarded as high risk hadn't been examined. Certainly the GPs who worked in the rural hospitals had been reviewed appropriately and had appropriate clinical privileges, but, for example, the surgeons in the hospital hadn't. If you look at the areas where I think you would start with credentialling and privileging of medical staff, you would start with the surgical staff, the staff that provide endoscopic procedures, and staff that undertake invasive procedures, because that's the area that would be the high risk area, as opposed, perhaps, to other staff who may have similarly important roles, but the risk associated with their clinical practices is somewhat less.

Dr Cleary, were you able to conclude that there were persons other than Dr Patel who had not been through the credentialling and privileging process in accordance with the QH policy?-- Yes, the areas that had been - the specialists that had been reviewed through that committee included the physicians, the obstetricians and the paediatricians, but as I mentioned, the areas that I would have been particularly keen

to start with would have been the surgical staff, the intensive care staff, the anaesthetic staff, and the staff that undertake endoscopic procedures. That group of staff hadn't had their credentials reviewed or privileges reviewed through that committee. I noted when I reviewed a number of their personnel files that there were letters included in those from the then District Manager granting them privileges within the hospital, but that there was certainly in the files that I reviewed no evidence that there had been a comprehensive review of the credentials held by those staff, and it would have been - it would have been, I believe, appropriate to have undertaken some form of review prior to providing letters, granting privileges to staff, and in my other statement - I can talk about it then - I can talk about how we managed this process, which is rather complicated, but - which is rather complicated, but it is how we have managed it at the Prince Charles Hospital - and subsequent to my departure, I provided to the Bundaberg district a comprehensive suite of documents which included the policy framework that we use, or the procedure that we use, the application forms that we use, the standard letters that we use, the way we minute these arrangements and the database we use to track doctors who have been reviewed. So-----

COMMISSIONER: Doctor Cleary, in paragraph 52 of your statement where you mention that surgeons and anaesthetists had not been reviewed, you go on and say, "This was said to be due in part to being unable to gain assistance from the royal Australian College of Surgeons." Who told you that?-- There's a letter I came across on file where that comment was included in the correspondence. I may be wrong. It may not be a letter, it may have been the minutes of the credentialling committee, but there was certainly documentation which included that comment and, having thought about it a little more, I think it was in the credentialling and privileging committee meeting minutes that I examined while I was in Bundaberg. The reason that I've said "in part" is that if, for example, the College of Surgeons was finding it difficult to assist - and I can't say whether that's correct - but it wouldn't have been unreasonable, for example, to contact one of the major facilities in Brisbane and ask for a surgeon to assist in relation to the credentials and privileges process.

Precisely. What I'm concerned about is what excuse was given rather than the validity of the excuse, and the only excuse you found written anywhere was that it was - that the failure to credential surgeons and anaesthetists was due to a lack of assistance from the Royal Australian College of Surgeons?-- Yes, Commissioner, that was-----

There was no other explanation for that failure?-- Not that I could identify from the documentation, no.

And that explanation, so far as it goes, you would not regard as a particularly plausible one, given that it would not have been difficult to get a surgeon involved, either locally or from Brisbane - if necessary, by telephone link-up or

otherwise - to have a proper and effective credentialling process?-- Yes, I think it would have been a reasonable option to seek - to have support from one of the senior surgeons in Brisbane, and I would imagine that would be forthcoming.

Well, certainly more reasonable than having an uncredentialled surgeon practising at the hospital. Would you agree with that?-- I would agree, Commissioner.

Then you go on and say that, "The District Manager had provided interim privileges for surgical and other staff." You say you observed correspondence granting those interim privileges. Was there such a letter relating to Jayant Patel?-- Commissioner, my memory isn't very clear on that matter. I don't recall whether there was or was not a letter in relation to Dr Patel. My recollection would be that there wasn't such a letter in Dr Patel's file, and the reason for that may have been that Dr Patel was employed as a locum and that, as such, his review would not have been undertaken in the same manner as some of the more permanent staff who were employed in the district, but an examination of his personnel files would identify that very quickly.

We have heard that before - the expression "locum" applied to Jayant Patel. You would hardly describe someone who has come for 12 months on a 12 month contract with the expectation of renewal as being a locum?-- I would agree with you, Commissioner. I think that there was certainly a perception that Dr Patel was going to work within the Bundaberg Health Service District for a long period of time. In terms of the phrase "locum", it's perhaps a simplified way of - within the medical administration of talking about someone who is on a 12 month or shorter contract.

You see, I can't recall over the last three months seeing one document connected with Dr Patel which described his position, in terms as suggested - that there was some evanescence or temporary aspect to it. He was described, for example, as the Acting Director of Surgery. He was the Director of Surgery. There's nothing in any of the documents to say his position was anything other than the man in charge of the Surgical Department for as long as he held that position. Did you come across any documents that contradict what I've just put to you?-- No, Commissioner. I think that his description in some of the correspondence that I noted did refer to him - and he certainly referred to himself as the Director of Surgery. The one area that may be appropriate to raise with you is that his employment contracts were on the basis of 12 month periods, so his first contract was for a period of 12 months, and then there was a second contract for a further period of 12 months. So, in that respect, he was a - he was on a temporary contract, but I also noted the correspondence that you have referred to where he was referred to as the Director of Surgery, not as the Acting Director of Surgery as may have been more appropriate.

Yes.

D COMMISSIONER VIDER: Doctor, in paragraph 57, you mention that the hospital achieved ACHS accreditation in 2003 and you have got three dot points there that outline the recommendations of that review. In paragraph 58, the last dot point there talks about the District Director of Nursing was allocated the ACHS accreditation as a portfolio to line manage. Is that implying that nothing had been done - that you could see evidence of - to implement those recommendations from the 2003 review?-- No, Deputy Commissioner. The issues that were identified in paragraph 57 were areas that were mentioned in the original review, and there had been some work undertaken to change the systems that were in place to address those. My concern from the period of time I spent in Bundaberg was that the activities may not have been adequate, having regard to the nature of the issues raised in that review. I should also go on and say that ACHS has changed the manner in which it undertakes reviews. At the time Bundaberg was reviewed, it was under the old system where, as long as you could demonstrate that you were making progress in an area and that progress looked as though it was going to be ongoing, that accreditation would be granted. Under the new system, you have to reach a minimum standard before you can be granted accreditation, and there are, from memory, 18 areas in which you have to achieve that. Our district has recently gone through this new process, and it is much more stringent. We were able to achieve our four year accreditation at the end of the most recent review, which was in December last year, but had we had these same issues identified by the ACHS review team at the Prince Charles Hospital, I don't believe we would have gained accreditation. So, there is a difference in the way the ACHS approached accreditation for Bundaberg some years ago, versus how it is now managing these matters. To go on, the Director of Nursing, who was working with me in Bundaberg at the time, had a great deal of background and knowledge in relation to quality management and ACHS accreditation, and within the team that were there, she was clearly the person who had the skills and knowledge to be able to take forward this portfolio and move the district into a position-----

So, some of those recommendations would now be being implemented?-- Yes.

Moving on to paragraph 59 where you are talking about patient complaints, could you just give us a snapshot? You talk about the fact that there was some incomplete documentation and record of complaint management. Was that when you were there?-- Yes, when I was there, we had an experienced liaison officer working with the response team who undertook a review of the existing arrangements that were in place, and these comments are drawn from the review that she undertook. In terms of some of the areas that were identified, there was certainly documentation issued in terms of tracking some of the material. Some of the ways in which complaints were handled, I think, could have been addressed in a different manner. There was certainly some areas, for example - for example, some staff had a number of complaints about them, which might have related to communication, and yet each

individual complaint was managed, yet the group of complaints weren't tackled.

Were these complaints that were received after the Dr Patel issue became public or were these complaints that had inadequate documentation and registration and process attended to? Were these complaints that had been received prior?-- These were complaints-----

They were in the system?-- They were in the system, yes, Deputy Commissioner.

And who dealt with those then? The district liaison officer, was she dealing with some of those?-- Well, at the time I was - I took up my role in Bundaberg, there was no district liaison position within that organisation. The complaints were tracked through the quality unit there and allocated to a member of the district executive which could have been the Medical Superintendent, or the Director of Nursing, or the Director of Corporate Services who would then manage those matters and bring them to a conclusion, but there wasn't - there wasn't anybody that really acted as the advocate for the patient. Perhaps in our organisation, being the Prince Charles Hospital, we have a person who is the district liaison officer.

Yes, did you find evidence then were there complaints that had not been attended to that related to Dr Patel?-- There were a small number of complaints, I was told, that related to Dr Patel. I think there were four in total. Three of those four related to communication issues and I believe one of them related to a clinical issue. I didn't further review those because that was being reviewed by the Queensland Health review team, so I saw those as out of scope for my review.

D COMMISSIONER EDWARDS: Could I ask just on the matter his being employed as a locum for 12 months and then a further 12 months, what do you think is the reason for that, rather than being appointed? Even though he was given a title, he actually was a locum for, it seems, almost two years, and is that unusual in the health department, particularly for overseas-trained doctors?-- Thank you, Deputy Commissioner. In terms of Dr Patel, he was employed to exactly two years - the day he finished was exactly two years from the day he started. In terms of the employment practice, I did find that unusual, in that if you are employing someone using the process that the Bundaberg Hospital was using, that's the general process that we would use at Prince Charles Hospital or other hospitals in the State to employ someone into a registrar or a resident position, perhaps into a Senior Medical Officer position. But where we - certainly in our practice where you are employing someone into a specialist position, we have a very close liaison with the relevant college and on occasion they will approve the person taking up the role, sometimes they will suggest a period of oversight and sometimes they will suggest some ongoing training that may be required. So I guess my personal feeling would be that if you are employing someone in a senior position, then it would be appropriate to use a different section of the Health Practitioners regulations or the Act - the name eludes me, I

am sorry - to allow them to work under an Area of Need, but preferably as a deemed specialist because that would be the scope of the practice that you employ that person into.

Thank you.

MR ANDREWS: Dr Cleary, you observed that the District Manager provided interim privileges for surgical and other staff. It was last year and is it still the case that Queensland Health policy relating to privileging and credentialing does allow for a district manager to award the interim privileges?-- I think the policy will vary from district to district. In the larger hospitals, the Medical Superintendent or Director of Medical Services provides interim privileges, and that's generally put in place so that if there is an urgent need for a surgeon or anaesthetist to come on to the staff, that that can be arranged expeditiously, or if, as occasionally happens in our organisation, where there is a need for a renal surgeon to operate at Prince Charles who doesn't normally operate at Prince Charles, then there is a way of granting them privileges to allow them to undertake the work that they do.

Dr Cleary, for interim privileges in a regional hospital, it seems unwise to allow a district manager, who has no clinical background, to be the person awarding the privileges. Is that a fair criticism?-- My - my response would be that the way that the policy is set up is that there will be advice to the district manager on what appropriate privileges should be. Certainly in our organisation if the district manager is non-medical, then our procedures are that the district manager can't award privileges wider than has been recommended by the Medical Superintendent or the Credentials and Privileges Committee. One of the roles that the district manager has in this regard is to consider the role delineation of the hospital and the scope of services that are being provided and link that back to the privileges that are being sought or provided to the medical practitioner, and in that respect one of the roles is to make sure the scope of practice isn't greater than what the hospital can undertake. That's probably not a complete answer to your question, which is really one of how appropriate is it to have a non-medical professional make comments about credentials and privileges for medical staff.

Well, as I understand your answer, it can be appropriate if the non-medical district manager has taken appropriate advice from clinical people on a credentialing and privileging committee, or from a - well, you said a Medical Superintendent, that could also mean a Director of Medical Services?-- Yes.

At paragraph 60-----

COMMISSIONER: Sorry, is it just too narrow minded to say that a person who is not a trained medical practitioner or a trained clinician shouldn't be unilaterally deciding credentialing privileging issues without at least consulting with medical people?-- If I understand your question, Commissioner, it is really if you are going to be in a

position as a non-medical person, then you should take advice from clinical staff as to how and what sort of privileges should be provided, and in that regard I would agree with you. I think it would be extraordinarily difficult to award privileges to a clinician without seeking that expert advice, and for my part, when we look at credentials and privileges for staff within our organisation, I would seek advice from other experts in the field before granting privileges, except in that interim arrangement where there might be an expedited process, you may only speak with the director of the anaesthetics department before granting privileges to an anaesthetist, having, of course, made all the appropriate checks with the Medical Board and the registration and other appropriate reference checks before making that decision. But I would think that it would be - it would be inappropriate not to seek advice before making a decision.

And I would have thought in any event that unless the case is a locum in the sense in which that expression is ordinarily used a temporary replacement for example for someone who is ill or on holidays, an appointment which is not expected to go four or six or eight weeks, then formal credentialing privileging should be invariably undertaken?-- Yes, Commissioner, I would agree with that, and that's certainly the approach that we take. If it is someone for two weeks, then it falls to the Medical Superintendent - and I am using that term because I - there are a variety of terms used for medical personnel in administrative roles but I think that one is linked very clearly to some of the legislative requirements. So certainly the Medical Superintendent in that role can provide short-term interim privileges, but for longer term arrangements - and I guess the arbitrary cut-off in my mind has always been around the three month mark-----

Yes?-- -----then I would go through the formal process.

I am going to allow myself to be led down the side track, since you raised it. It has been very interesting throughout the entire course of this inquiry that people still talk about medical superintendents even though that expression was, I think, formally abandoned in the late 80s or early 90s. And a number of witnesses have told us about the name changing that's gone on within Queensland Health, patients becoming clients and the organisation being spoken of as a corporation or a business rather than a service, and so on, and I wonder how you feel about the word "superintendent". It has got a sort of old fashioned ring to it, but my impression is that it emphasises the importance of actually undertaking supervision or oversight rather than expressions like "director" or "executive director" which sound like someone who sits in an office reviewing the paperwork. Do you have a view about that?-- Personally I think the term Medical Superintendent is a very appropriate one to use. When I speak with patients, or frequently with addressing inquiries with the media, I would normally say, "Hello, my name is Michael Cleary. I am the Executive Director of Medical Services. However that's the new name. I am really the Medical Superintendent for the hospital." And on the whole I think certainly the patients

that I speak with would go, "Oh, yes, now I understand." So I don't have a particular strong feeling towards some of the new terminology, but I can also understand how it has come about.

Doctor, I don't want to get bogged down in these sort of semantic or word-based discussions, but so many witnesses have spoken to us about what they describe as cultural problems within Queensland Health, and it seems to me that at least part of those cultural problems can be attributed to the removal of the traditions under which the Medical Superintendent or a Nursing Superintendent was seen to have that role of actually superintending the work, just as the use of the word "client" can distract from the fact that the relationship between a medical practitioner and a patient is a far more noble and invasive one than the relationship between a lawyer and a client or an accountant and a client. So I just wonder whether to, as one step towards addressing these cultural problems, we need to bring back some of that traditional language. What do you think?-- Personally, I have always been very comfortable with the term Medical Superintendent, and I think it does describe the role that I undertake, certainly for the majority of my working day. In terms of some of the other activities that are now in place in hospitals or districts as they are at the moment, many of those aren't part of the traditional or the historical Medical Superintendent role. For example, I am very involved with the rebuilding program that we've got at the Prince Charles Hospital. I'm involved in some aspects of organisational change, but the lion's share of the work that I am involved in relates to patient care, although these days we often talk about patient safety, but it really relates to the care of the patients that we have, and safety is just one element of that. It relates to managing the public - probably the public perception of the organisation, and I think it is very important for the medical superintendents and nursing directors to be involved with the local community so that the local community can feel confident that the care that they receive is at the highest quality, and that if they do have concerns they can raise them with you. There are a range of other administrative tasks that you have to undertake relating to the recruitment of medical staff, the management of education programs, the support of clinical research, and they're also very important, but they're of - they sometimes are more of a management focus than some of the other areas, which are very clinical, such as the care of the patients and looking after patient safety.

Mr Andrews?

MR ANDREWS: At paragraph 60 you say that on 10 May 2005 there were 23 outstanding ministerials in the district, seven of which were not related to Dr Patel. Could you tell me what a ministerial is?-- They're letters - generally they are letters from constituents or from other Members of Parliament to the Minister for Health, in which the constituent or the other Member of Parliament has raised concerns on behalf of their constituents. Essentially they are complaints that have gone through the Minister's office and they would generally

come back to the district to review the case and provide advice to the Minister on those particular complaints and how they are being resolved. So in this case, that's quite a large number of complaints from the Minister's office and, as you can tell, the majority of them related to Dr Patel, with only seven not relating to Dr Patel.

And the 16 relating to Dr Patel, are you able to recall whether they were complaints that predated or postdated the publicity that was given to a speech by Mr Messenger in - on about the 22nd of-----

COMMISSIONER: March.

MR ANDREWS: -----March 2005?-- No, I can't recall the details of those, apart from the numbers that I have recorded. I wouldn't have - I was involved in drafting the responses to the majority of them, and certainly would have cleared the responses before they went back to the Minister's office. My recollection is that the majority of the responses that I cleared did relate to complaints that related to Dr Patel after there had been the general publicity about Dr Patel, because in those responses we detailed what actions had been put in place locally to address the concerns of the local community.

Thank you. Doctor, I direct your attention now to Exhibit 301B-----

COMMISSIONER: You are moving on to the PA-----

MR ANDREWS: To the Prince Charles.

COMMISSIONER: I am sorry, the Prince Charles.

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: We might take the afternoon break. 3.30 or 25 to four.

THE COMMISSION ADJOURNED AT 3.19 P.M.

THE COMMISSION RESUMED AT 3.41 P.M.

MR ANDREWS: Dr Cleary, with respect to Exhibit 301B, your statement, which speaks of your role of Executive Director of Medical Services at the Prince Charles Hospital Health Service District, I note that you are in some way connected with the Medical Advisory Committee. Do you sit on that committee?-- Yes, I do. The Medical Advisory Committee has been in place at the Prince Charles for probably three years, and we developed that as a forum through which we could have

appropriate dialogue with the medical staff of the district. The Medical Advisory Committee is chaired by a senior clinician, Dr Keith McNeil, and I essentially act as the deputy chair for that group, and we have on that group the senior clinicians from each of our major work areas, or programs. That includes the senior clinicians from both the hospital and from the community services that we support and we have been, I think, somewhat innovative in that we have also invited on to the group young leaders, clinicians who are going to be our future, so that they have an opportunity to participate in some of the discussions that occur at that level, but also to really have some input into the way we shape our future. The chair of the Medical Advisory Committee within our organisation also sits on the districts, district executive committee, which means that in this case Dr McNeil attends the district executive committee meetings, that includes the ones where we talk about operational management, some of the strategic directions that we're moving in and some of the more business meetings that relate to activity, budget and performance.

And it's been in existence for three years, did you say?-- Yes, that's my recollection.

How many persons sit on that committee?-- Oh-----

Approximately?-- There would be 10 to 12 senior doctors.

For instance, we have heard evidence from Dr Aroney. Is he a person who has sat on that committee?-- No, Dr Aroney hasn't been a member of this committee. The director of the cardiology program is a member of the committee, and in my attachments MIC3, the terms of that committee are attached, as is the membership. The people who are representative of cardiology as an area would be the Director of Cardiology, the Director of Cardiac Surgery, and we do have one young leader from cardiology who had subsequently become the director, and that's Dr Darren Walters. So we do have a number of people representing that area. We also have the Director of Paediatric Cardiac surgery who is on that group.

Now, Dr Aroney, as I understand it, was a Director of the Coronary Care Unit?-- Yes, that's correct.

As such why was he not a member of that group?-- Within the cardiology program - and there is an attachment which I am not sure of the numbering of - but there is a description of our cardiology service. There are a number of units within that, and that includes our catheter lab, our electrophysiology lab, our coronary care unit, and our paediatric cardiology service. Within the Prince Charles Hospital, the coronary care unit has 16 beds, and that's the area that Dr Aroney was the director of, but above Dr Aroney is the Director of Cardiology, who is the person who takes the leadership role within cardiology and represents the group as a whole. There are five clinical directors that sit in a hierarchical structure underneath the director and these are very senior clinicians who manage a particular aspect of cardiology. And in Dr Aroney's case, his

role was to manage the policies and other clinical protocols that would be used within the coronary care unit. Having said that, Dr Aroney has been essentially on leave for the last two years, so this committee would have only been in existence for a period of maybe 12 months before he started taking periods of leave.

The privileging of international medical graduates is referred to at paragraph 8 of your statement. How soon are they privileged, before or after they become employees?-- In terms of the credentials and privileges processes that we have in place, the staff on appointment are privileged before they become employees. Their employment letter - or their letter of employment includes in it, in addition to all the, can I say, administrative detail relating to their employment, a paragraph that sets out the specifics of their clinical privileges, and those clinical privileges are determined by the appointment and selection committee at the time that it meets. In terms of some of the cardiology selection process, the questions that candidates or clinicians are asked at those appointment meetings allow the committee to determine what an appropriate scope of practice would be. The committee also looks at all the relevant documentation, including the Medical Board registration details and appropriate certification from bodies such as the Cardiac Society for some areas. It might be of interest if I could digress for-----

Perhaps just before you digress?-- Yes.

I'm still not sure, Dr Cleary, whether international medical graduates go through the privileging/credentialing process before they are employed by the Prince Charles Hospital or after their employment commences?-- Mmm-hmm. The process is undertaken before their employment commences, and those people have long-term contracts with the hospital such as Dr Dunning, who works with us-----

I was thinking of the international medical graduates rather than the Australian-trained employees?-- Yes, Dr Dunning is a graduate from universities in the United Kingdom and holds a Fellowship with the College of Surgeons in England. So as an example, he being a very highly trained cardiothoracic surgeon, when he was appointed we would have gone through his appointment process, looked very carefully at his credentials, his privileges, liaised with the Medical Board, liaised with the Royal Australasian College of Surgeons and the Australian Medical Council before concluding the appointment process and offering him a position, which would have included in it, in the appointment letter before he was appointed, what his scope of practice in terms of his privileges. Every three years we then re-credential our medical staff and at that time his credentials will be re-examined and his privileges reaffirmed. During the time that he's been with us however, he's actually started doing some new and somewhat innovative procedures and so his credentials - sorry, his privileges have been extended during that time to include such things as heart/lung/liver transplantation and pulmonary thrombo-endarectomy surgery. Both of those hadn't been undertaken in Queensland until John Dunning joined us and, personally, I think he is a great asset to our organisation in terms of the skill that someone who has been able to - sorry, the skill that he brings with him from his previous work. What I was going to say is that we also provide support not just for the staff at the - in our campus. For example, one of our orthopaedic specialists travels regularly to Bundaberg to assist with the oversight and support of orthopaedic surgeons in that town and he does that on behalf of the Australian Orthopaedic Association but, certainly, he will travel there, scrub in with them, meet with them, go to outpatient clinics with them and support their training. We also have cardiologists from Cairns who are international medical graduates who work with us. One of them is currently flying to Brisbane on a monthly basis. He then scrubs in with our cardiology department to undertake procedures and they provide a level of oversight and support for that particular clinician-----

With respect to the orthopaedic exchange with Bundaberg, who instigated that initiative?-- We - we were approached - although, I should say the specific doctor was approached by the Australian Orthopaedic Association and then approached me to determine whether it would be something that we would support. Naturally, we did and-----

But there is an expense involved in that, is there, that you have to meet, or does - does it come from your budget? You'd,

after all, be losing an orthopaedic surgeon or specialist, surgeon I assume, for whatever time that practitioner is in Bundaberg?-- There is an expense that we would incur in doing that but as a major centre, we - I think I could speak on behalf of the medical staff, we believe we have a role in supporting our colleagues and the patients in peripheral areas, be they major areas such as Townsville or provincial centres such as Bundaberg, and that's something that we would normally do and encourage. We have a large number of our medical staff who travel around the state on a regular basis. We conduct outreach clinics in Cairns, Townsville, all of the major centres up the east coast. So we see it part of our role to be out of Prince Charles Hospital, if you like, and working in some of these other centres and supporting those centres. Extending that to providing support for people who require some oversight is just another extension of that.

D COMMISSIONER EDWARDS: Do they have the right of private practice when they go to those centres?-- Yes, they do. On the whole, where we provide outreach clinics, we do tend to run those as private practice clinics and the doctors that undertake those will be either employed under option A arrangements or option B arrangements, and I apologise to the Commission if those terms haven't been discussed before.

COMMISSIONER: No, that's - we understand those terms?-- So most of the time our outreach clinics are arranged as private outreach clinics and that certainly does provide some benefit to the hospital in offsetting some of the costs associated with providing those outreach services. But that's - but that's not always the - always the case. Some of our specialists have recently been talking to me about starting up some clinics in indigenous communities because when they've gone to do some of the clinics in paediatric cardiology, they have found that many of the patients don't - don't travel to the major centre to be reviewed, and we're currently looking at how we might be able to start up some clinics actually in the communities so that we provide improved access to the communities - to that somewhat specialised service, and I think that that will probably come into play in the next few months.

MR ANDREWS: Doctor, at paragraph 22 of your statement you set out some of the problems you see with the current elective surgery program and they're set out very clearly in the statement. You have an opinion that it would be appropriate to develop a sophisticated system so that non-elective surgery interventions could be rewarded with funding?-- Yes, that's - that's correct. Again, as some background, I should probably highlight for the Commission that in 1996 I was asked by the then Director-General to work on the - on the development of the elective surgery program and I did that for a period of approximately 18 months and the program as it currently stands is very similar to the program that was developed during that 18-month period from about January-March 1996. I'd have to say that, in my experience, during that time Queensland went from the worst performing health system in Australia in terms of waiting times for elective surgery to

one of the best and I think that's a significant achievement for Queensland Health, certainly at that time. There are a range of reasons why I think that's the case. One of them would be the significant involvement we had from clinical staff at the time, the leadership shown by many of the colleges and support provided throughout the organisation to take that forward. Having-----

Please explain to me the reduction in waiting times for elective surgery. Can you explain its relationship to your expression "the leadership shown by colleges"?-- Yes. Well, for example, at that stage there was a great deal of discussion about whether we should have a categorisation system for elective surgery. This is the category 1, category 2, category 3 patients, and the parameters that were set in terms of waiting time for those - for those procedures. So for example, again, with the indulgence of the Commission, I can describe that but if you're aware of those performance parameters, I won't. So at that stage, those types of classification systems weren't in place in Queensland and it was only after extensive discussion with the College of Surgeons, who subsequently published in their newsletters and journals in Queensland their support, their very strong support for those types of classifications that we were able to take forward many of the initiatives-----

Dr Cleary, speaking of initiatives, you suggest that there should be a system for financial rewards for non-elective surgery interventions and medical interventions, for example, endoscopies for implantable pacemakers, for atrial septal defect closure devices, for laser surgery on lung cancer and for coronary stenting. I deduce from that initiative that you suggest that there is no funding for those particularly important interventions; is that the case?-- No, that's not the case. There is funding for those interventions. The difference is that most of the funding for those particular interventions comes through the base funding that hospitals receive whereas there is a special allocation of funding for elective surgery and-----

Have you made any recommendations for funding for these non-elective interventions?-- Yes, through the Medical Superintendents Advisory Committee, which has recently been renamed the Directors of Medical Services Advisory Committee, we made representation through the Department of Health that there should be an arrangement put in place to allow those types of procedures to, firstly, be identified because although I can identify the ones that I believe are important, I work in a hospital that's principally relating - provides care to cardiothoracic patients and there may be similar interventions at other hospitals where you may wish to also identify some of these types of procedures, and that's - that's been proposed, and there had been work on that probably over the last two years to identify the procedures and put forward the proposition. Part of the difficulty of course is that the Commonwealth government counts elective surgery using a particular group of procedures. So the Commonwealth department of health counts elective surgery in a particular

way and the states are bound to count it in a similar way because of the Australian health care agreement. So for us to do something different in Queensland would mean that we perhaps were doing elective procedures that weren't then going to be able to be counted in the way Queensland Health reports to the Commonwealth.

Dr Cleary, so as I understand it, about two years ago this apparently sensible idea of yours was at least proposed and the result so far as you know was that a way of identifying these procedures was to be explored. Do you know how far progressed that process is?-- I couldn't comment on how far progressed the process is at the moment. However, I can say that within our organisation we have been, on two occasions, given approval to count some of these procedures against our elective surgery activity and they have been funded through elective surgery funds. They were on a case by case basis, you know, a specific submission where we indicated we felt that implantable defibrillators, some angiographic procedures and some atrial septal defect procedures should be considered as elective surgery, and that was agreed to. But in terms of a more broad-based approach across all of health, I'm not aware of an outcome to that proposal.

COMMISSIONER: Doctor, we have received submissions from people who either work or have worked in Queensland Health system who refer to a concept described as desktop surgery. Are you familiar with this expression?-- I'm afraid I'm not, Commissioner.

Apparently how it works is that if there's a problem with waiting lists, instead of performing surgery in the theatre, you perform it at the desktop by transferring a whole lot of names from one category to another and the problem is solved. Are you aware of that sort of thing going on?-- I am aware of - that there was a report in the newspapers within the last few days about that but more detail than that, no, I'm not aware of. Certainly, my position and my perspective or my take on this is that the categorisation of patients is a clinical responsibility and the various colleges and societies have agreed to the categorisation system that we put in place back in about 1996 and it really does fall to the clinicians to categorise the patients. On occasion there will be some administrative support to clinicians to allow them view their waiting lists and that means patients who are on the waiting list are either made more acute or less acute depending on information that's often conveyed through the elective surgery co-ordinators. But to come back to the crux of your question, certainly in my experience the management of waiting lists is - the management of the categorisation of patients on a waiting list is a clinical responsibility and rests with the treating clinician.

The added suggestion that comes with those submissions is that there is a particular sting in the tail with this desktop surgery because when you take a patient out of one category and put them in another category, the clock starts ticking all over again. That patient has just joined that category and

therefore, rather than backdate that patient to the time when they first went on a waiting list, you can say, "Well, that patient has only been in that category for 24 hours, therefore they haven't been on the waiting list very long." Do you know whether that is at least theoretically possible under the existing structure?-- Yes, there is a theoretical way that that can occur but it generally would, from my understanding, require you to be transferred from one hospital to another and that's - that's the experience where I've seen this. For example, when Townsville Hospital might be overly stressed with cardiac surgical cases and they refer some of their more important cases to Brisbane for us to assist them with, then they come off the Townsville waiting list, having waited for however many days, and come on to the Prince Charles waiting list, and in those circumstances the clock does reset but they are also cases that we very actively manage in terms of the way those patients are cared for. So they're not treated in the usual manner where they would wait for so many days before they get their surgery. But certainly, if there are people transferred from one facility to another, you can have the - the clock, as you put it, reset. I'm not aware that if you change people's categories that the clock resets but there may be a - an algorithm within the classification system which does that which I'm not aware of.

Doctor, you would agree that for the average person in the street, the critical period to measure is between the date when that person's GP says, "You need to see a specialist", until the person receives the treatment, whether it's surgical or medical or procedural, or whatever, for which that person has been referred by the GP, but it seems that those statistics just aren't kept; is that right?-- To answer the first part of the question, I think the date from which a GP refers a patient or a specialist refers a patient for care and that care is provided is a very important parameter. From my review of some of our waiting lists, people who are, for example, referred for orthopaedic surgery, we may have of all the patients referred to the orthopaedic surgical service, maybe 10 per cent go on to have some form of surgery.

Yes?-- So there is a screening process where some of those referrals are referred to physiotherapy or for other treatments before they get to surgery. So there's a - so there is, as you say, a period of time that you may wait to see a specialist in outpatients. There may then be a period of time that you wait to have some investigations done. You may require further specialised X-rays like CT scans and then once those have been reviewed there may be a period in which you wait before you receive surgery, if that is the recommendation. That's, I guess, the pathway that many patients will progress down before they get to surgery. In terms of the outpatient waiting list data and, for that matter, the waiting list data for elective surgery, they're very important pieces of information for hospitals to have and to manage. Without them it will be difficult for us to determine where we need to prioritise patient care and although it's not often talked about, you actually need a waiting list to be able to schedule the surgery in the public

system so that you can manage it efficiently, and some years ago our cardiac surgical waiting list was so short that we weren't necessarily filling all of our surgical sessions for the following month. That was only a temporary - a temporary arrangement. Waiting lists do give us an opportunity to bring people in for the surgical waiting lists to have their pre-admission assessments before surgery.

Doctor, I understand why that may be important from the hospital's viewpoint and I don't in any sense downcry the importance of having those sort of statistics but would you accept the proposition that for the ordinary person in the street, what they want to know is that if they go to a GP with, shall we say, rectal bleeding and the GP says, "You need to see a specialist at the Royal Brisbane Hospital", how long it's going to take from the day that patient sees the GP to the day the patient reaches the point of receiving some actual treatment at the hospital; that's what's counts, isn't it?-- Yes, Commissioner, I would agree with you.

And it's the case, isn't it, that Queensland Health has historically resisted any sort of disclosure of those sort of statistics that people want to hear?-- I'd find it difficult to comment on how that's come about. Having said that though, the waiting list data for surgery is available and has been available since I was involved in setting up the project some years ago. I think that's been very beneficial to the community because people have an understanding. However, I think, as you've indicated, the community would benefit from knowing how long they're going to have to wait to see the doctor in outpatients and how long the delay, if there is a delay, there will be before they have their surgery and I would concur with you that those types of information would be very important for the community to have access to, and probably for the general practitioners who are referring patients to have access to because they may be able to make decisions about do they send the patients to hospital A or hospital B, which has got the shortest waiting time.

Yes, indeed, or for the individual citizen of the state, whether or not it's worth sacrificing some of the other luxuries of life to have private health insurance because at the moment there are over 100,000 people ahead of them in the queue to see specialists in Queensland public hospitals. The people are entitled to know that, aren't they?-- I have always been a very strong believer in transparency with the information we have and I think it, in my experience, has only improved the community's understanding of the health care system by making it available.

Exactly. Exactly. And we heard Dr McNeil this morning talking about, you know, the political argy-bargy that goes on with the politics of health provision. But if people know the truth, they can put pressure on their elected representatives and say, "It's not good enough that there are 100,000 on the waiting list." It serves the interest of the community but it also makes the democratic process more efficient if people have the facts. Would you agree with all of that?-- Yes,

Commissioner.

See, a few weeks ago this inquiry obtained the details of the numbers of people waiting for appointments with specialists in hospitals throughout the state but I apprehend that even that doesn't tell us the full picture because we don't know how many people have been referred by GPs and haven't yet gone on a list to have an appointment with a specialist, and there are certainly people in that category, aren't there?-- There may be in some hospitals. I can confirm that for our organisation though, when there is a referral made we do track that and those numbers are kept by us in terms of those people that have been referred but have no booking yet, those people that have been referred, have got a booking but that booking hasn't yet occurred, and I think at the end of July we had something in the order of 1500 people waiting in either of those two categories to be seen by a doctor at the hospital.

It's also been suggested, particularly in submissions from the AMA, that there's yet another hidden waiting list and that is people waiting for the sort of procedures you talk about in your statement because those people haven't traditionally been included in Queensland Health's surgical waiting lists. Is that correct?-- That's correct, Commissioner. Certainly the waiting list data that's presented only relates to the defined group of surgical procedures as set out by the Commonwealth department of health and they're things such as total hip replacements, total knee replacements and a range of elective surgery, but it is that type of surgery. The type of procedures that we've been talking about such as angiography, the stenting or the correction of small holes in the heart using atrial septal defect closure devices, which is a new technology, that means you only have to stay in hospital for a short period of time and the risks of having your - of having major surgery are reduced, those types of procedures aren't identified in - on waiting lists and, certainly, they're not - they're not, from my understanding, collated across the state and made available.

Doctor, I have to say I'm not very impressed with this notion that because that's the way the Federal Government categorises things for their funding purposes, then Queensland Health has to adopt those same categories for its statistical or publication purposes. Just to give you an example which comes across my mind, for tax purposes, companies around Australia have to adopt a depreciation schedule approved by the Tax Department, and a piece of equipment may be depreciated over 10 years, but the directors of that company know very well that the piece of equipment will finish its useful life within five years, so in their report to their shareholders, they are very candid about it and say, "Well, whilst for tax purposes we can only write off 10 per cent a year, for our disclosure to our shareholders or our stakeholders, we are adopting a 20 per cent write-off per year." There's no reason in the world why Queensland Health can't say, "Well, we keep those statistics for the Federal Government because that's their format, but for full disclosure for our stakeholders, we are going to use statistics that are meaningful, tell people how long they have to wait to get an appointment, how long they are going to have to wait after they get an appointment to see a specialist, how long they are going to have to wait for some diagnostic or prophylactic or interventional procedure that isn't classified as an operation by the Federal Government, and how long they have got to wait for other types of operations.", and from what you tell us, those statistics, at least at the Prince Charles, can be produced instantaneously?-- Commissioner, I would agree whole-heartedly with your view in terms of the publication or the community awareness of that information. At Prince Charles we do have computer systems in place that do track that information. I wouldn't say it was easily available. I would say some of our computer systems are not necessarily 21st century technology and obtaining information from them can be a little bit more difficult and often requires pen and paper, but certainly the information can be obtained. If those types of data were going to be presented in the community, I would think there would need to be very clear definitions of what the information is about and it would need to be made very simple, because the types of waiting lists that exist in hospitals are many, and how you count things differs, I believe, from hospital to hospital, and the criteria used differs from hospital to hospital. So, there would be a body of work that would need to be undertaken to pull a lot of that information together, and to have very clear definitions on what some of these things are. For example, is the waiting list the number of new patients waiting to see a specialist, be they booked or unbooked, or is it all those patients in out-patients waiting to see a specialist, which would include the new patients and the existing patients who are coming back for a second or third visit. So, there would need to be some clarity around the terms that would be used, and the reason I mention that is I would be putting forward the proposition that if you are already in the system, you really don't need to know when your next appointment is because you will be aware of that from your contact with the hospital, but it would really be things

like the new patients who are coming in to see a specialist, be they booked or unbooked, that would be a meaningful thing for the community to have access to.

Doctor, I don't want to be offensive, and I'm not sure that this is exactly what you are suggesting, but my own view is that it would be very patronising for the people of Queensland to say, "We won't give you these figures because you might not understand them." I'm sure it is within the capability of a person like yourself and the administration of Queensland Health to explain those figures in a way that makes them intelligible. The difficulty to date is that those figures simply haven't been provided. That's the case, isn't it?-- Yes, Commissioner, and I guess what I was alluding to was that I just think it needs to be put in a way that can be easily understood, because if there is - in my experience, if there's too much information, it sometimes doesn't - it is difficult to interpret. So, if it is very simple and you know that if you are a patient and you have been referred to the Cardiology Department, that, on average, your appointment will be in three months' time and those types of promos I think would be very useful to the community.

I guess, doctor, that's where you and I may have a fundamental disagreement. I don't accept that there is such a thing as too much information in terms of telling the public what's going on in the hospital system which (a), they are paying for, and (b) they are looking for to provide them with treatment. They are just as entitled to know what's actually going on as the shareholders in a public company or the members of a sporting or social club. It's their public health system, and it's the responsibility of both administrators and politicians to be up front and frank with them about what the true situation is. Do you have a different view?-- No, look, I would entirely agree with you. I was just trying to indicate that if we are going to provide the information, it needs to be understandable.

Yes?-- And that was it in a nutshell.

D COMMISSIONER EDWARDS: And it needs to contain everything?-- Yes.

It seems that we are not knowing what is out there because we haven't made an appointment, yet there could be up to thousands of people waiting for an appointment with a specialist?-- Yes, and perhaps I could explain a little further, which is a personal experience. Obtaining some of this information and interpreting it I find difficult from the computer systems that we have got, so I guess I was also reflecting on the difficulty that I have had in interpreting some of the information that we currently collect through our administrative systems, and I find that, to be honest, challenging, in terms of understanding what it really means, and I think we have got some way to go to improve the way we generate and provide meaningful information, both within the organisation and to the broader community.

D COMMISSIONER VIDER: Doctor, you may not know the answer to this, but given you had a bit to do with the development of the Elective Surgery Services Program, you say in paragraph 22 that the health service districts are potentially penalised if they fail to meet their elective surgery targets. If the districts are involved in some sort of evaluation and they fail to meet their targets, they therefore would be able to respond, which may stop their being penalised; for example, their elective surgery sessions might have been limited because of the amount of emergency work that they had to do; there might be staff shortages, so they mightn't have had an anaesthetist available; they might have beds closed, so it is not available for them to be admitting the patients, or they might have theatres that they are not able to staff. Now, if that information was made available - I mean, if you have got two operating theatres and they are both going with emergency work, you can't be doing elective surgery through them, so you shouldn't be penalised. That's accommodating patient services in a corporate way, and I can understand the motivation behind the program, but do the districts have a right of reply so they are not penalised? It seems a funny way to have to do business to almost go and have to get a bonus to do the fundamental, which is caring for the sick, whatever category, and so I'm just wondering whether they have a right of reply to say, "We didn't meet our target because", and that could be published. That helps the public understand there are workforce shortages - you know, there are no staff - and we all get used to that idea, because it is the real situation?-- What would normally occur would be that there would be a review of activities within an organisation, like the hospital, and if the hospital wasn't able to meet its targets, that might be discussed with them by one of the zonal management units, and certainly districts do put up reasons why they haven't been able to meet their elective surgery targets, and, on the whole, as you have indicated, Deputy Commissioner, one of the difficulties is that the demands of the emergency work that comes through the door you have relatively little control over and is clearly a priority for health to deal with. Having said that, in my experience at our hospital, we have had two occasions in which there has been a post financial year budget adjustment for our inability to meet targets, and - or meet our elective surgery targets-----

You have been penalised. They are my words?-- I guess in some respects, you could say it was a penalty for not undertaking the work that you had agreed to undertake earlier in the year. I'm not sure I would use the word "penalty". It is probably-----

You have had your funding adjusted?-- Yes.

In the negative?-- Yes.

Whatever words we use. We understand that.

COMMISSIONER: It is a negative incentive?-- It is certainly a very strong incentive to undertake all the elective activity

that you had agreed to at the beginning of the year.

See, doctor, as an outsider from the medical world, I see things a bit differently, but I would have thought the best possible outcome is the hospital that says, "Well, we've reduced our surgery this year because we've done lots of endoscopies and colonoscopies and mammograms.", and so on and so forth, "And we have detected conditions early so that the patients don't need surgery." You know, I'm rather hoping that there will be a day when the value of medical care can be judged by results rather than number of procedures?-- I'd agree, Commissioner. A personal view is I believe there needs to be some fundamental rethinking of how we provide funding to hospitals. There are a wide range of - there are a number of ways that funding arrives. Partly it is in the base budget, partly it is through these incentive arrangements, in things like elective surgery, but it does, to some degree, create perverse incentives within the system, and although we try to balance those up - and, for example, we would look to try and make sure we didn't miss any elective surgery - we have a number of audits in place to make sure that we capture every patient that has elective surgery so that we can count those types of cases towards our elective surgery target, but I would agree with you that we need to look at how we fund health in a different way, because you could do - you could treat 2,000 extra patients who were emergencies or extra patients, and certainly that's so over the last few years, and not reach the number of elective cases you should treat, and you actually could lose funding as a consequence.

Doctor, one of the implications of the current system that's been demonstrated by the evidence in this case is that the system of weighting - weighted separations effectively encourages operations on very ill patients - complex operations which attract a lot of money but don't present very high prospects of success for the patient. We have, just to take one example from the evidence we have heard - there was a Mr Kemps had an oesophagectomy. The suggestion is that no thoracic surgeon or general surgeon would have performed such an operation on a patient in his condition, and certainly wouldn't have done so in Bundaberg. He ended up dying. But the outcome was that Bundaberg Hospital gets more money because that has a very high weighted separation. Even though the separation in that instance is death rather than discharge, it is still a weighted separation. Surely if we are going to have incentive payments, it has to be an incentive to do good, rather than harm?-- Mmm. Again, I would concur with your remarks, Commissioner. The way I would see measures such as weighted separations or case mix is it is a by-product data. It is something that the surgical staff wouldn't necessarily be actively involved in. We tend to talk to our surgical staff about numbers of patients that they are going to treat and leave the calculation of the weighted separations as a by-product of what they do. I would think that the surgical teams that I'm involved with would treat patients on their clinical priority and on the merits of the treatment that they would offer-----

And if that's so, you don't need incentive payments at all. If you leave the clinical teams to decide what is the best for the patient in the circumstances, then there's no place for having incentives. The very fact that there is an incentive scheme means that someone in Charlotte Street, possibly in George Street, seriously imagines that doctors are going to get through more surgery if their hospitals are paid more money, or if the superintendents or district managers are put under pressure to get more surgery done, and the logical conclusion of that is the Jayant Patel model that says, "Well, if I find someone on death's door and do a really complex operation and kill him, then there's all that money going to come into Bundaberg." That's the problem with incentive payments, isn't it?-- I think if we are going to have some form of incentive, then it needs to be structured in an appropriate manner, and incentives to do more elective surgery is one way of looking at it. There could be other incentive arrangements in place, such as incentives to have low infection rates or incentives to have best outcomes for patients, incentives to have low numbers of deep vein thromboses in people who have operations where they are bed-bound afterwards. So, I think that within an organisation, the benefit of incentives is to help drive change; incentives like elective surgery are just one. I personally would like to think there would be some incentives for us to do more non-elective surgical procedures, to do more treatment of patients on an out-patient basis, and those types of appropriate clinical treatments.

You see, doctor, I start really from the other end entirely. I assume that clinicians, doctors, nurses, physiotherapists, what-have-you, are extremely dedicated professionals who want to do the best for their patient with the limited resources available to them. It is an insult to them to even suggest that their clinical behaviour will be influenced by incentive payments. What we, as a community, should be doing is saying, "We have this many dollars available for clinical services, and it is going to be split up according to who needs it, and if you have a town of 20,000 people, then that town will be resourced to provide medical services to 20,000 people." You will look at whether that population, if it is Mount Isa - which has a relatively young community compared to the rest of the state, but also an indigenous community that has to be looked after - you factor in all those matters and say, "Well, this is the fairest and most equitable share of the funding cake that we can decide upon.", and leave it to clinicians. Trust the clinicians to decide how best to use those funds to provide the best outcome?-- Perhaps I wasn't clear in my original answer, Commissioner. I apologise for that. I was thinking about when you need to change the system, and if I can go back to when we were looking at elective surgery, the clinicians were saying, "We need to have pre-admission clinics, we need to have surgical preparation areas in our hospital, we need to be able to support people in the community early after their discharge, but we don't have those facilities available in our organisation to do that.", so we had a special incentive pool of money which was very - which was relatively small, but you could actually go to hospitals

and speak with the clinicians and then you could fund things, like the development of a pre-admission clinic or a surgical preparation area, which then allowed the clinicians to, as you say, take forward their view of how the system can perform better. Without those - and in retrospect, they were relatively small amounts of money, but the relatively small amounts of money made some of the - in my experience, made some of the biggest differences to those organisations because they could put in place infrastructure that would allow them to look after the patients that they are caring for in a manner that was appropriate.

And, doctor, don't misunderstand me, I'm not criticising the motives or the intentions of those who set up the present system. I'm just suggesting to you that it doesn't work, and, indeed, it is counterproductive, and the best possible example of that is Jayant Patel, who, as we have heard in evidence here, used to go around the hospital crowing about the fact that he was the favourite of the hospital management because he was making them so much money, and I want to emphasise very clearly that that's not to say that he was, in fact, a favourite of the hospital management. I mean that not in any sense as criticism of Mr Leck and Dr Keating, but there's one man who thought that he had won brownie points by achieving those incentives for his hospital through the performance of operations which, in many cases, proved unsuccessful and sometimes fatally unsuccessful?-- Mmm.

That's why I think we have got to move away from incentive systems altogether and concentrate on an equitable distribution of available funds across all aspects of the health administration in the state?-- Mmm.

I see you are nodding?-- I couldn't agree more. Notwithstanding from what I understand has happened in Bundaberg - and I'm not familiar with some of the matters that you have referred to in detail - but clearly that type of behaviour wouldn't be appropriate, and it is regrettable that that's potentially led to some of the difficulties that we find ourselves in now.

It's almost like a system that says, you know, ambulance drivers get paid per patient, and therefore they go around knocking people down so they have got more patients. It is almost that level of absurdity when, like me, you have the advantage of standing outside the system and seeing how it has worked - at least in Bundaberg?-- Mmm.

Mr Andrews? Sorry.

MR ANDREWS: You have the opinion that it is appropriate to publish in the public arena the Emergency Department performance measures and out-patient and other ambulatory waiting times. Have you ever urged this upon the Health Department?-- When I was - going back to the late 1990s, when I was involved in setting up the elective surgery project, one of the things that I was very supportive of was - I was moving out of that role - was to do just that - was to start to

publish-----

Did you urge it upon anyone?-- I can't recall the specifics, but we were - when I was there, we were in the process of developing a reporting arrangement for out-patient departments, and there were guidelines written for the management of out-patient waiting lists, and it wouldn't have been a large step to move from that to collating that information and publicising it. We also were fortunate to receive $5 million as an incentive payment, if you will excuse the phrase, as additional money for emergency departments, and that was used across the state to grow some of the medical and nursing staffing and putting in computer systems. So, we do, in fact, have an infrastructure across the state where the publication of that data was possible, and that was, I guess, my involvement - was putting in place infrastructure to allow it to occur. The next step is not complicated.

And do you ever recall any debate about whether it would be appropriate or not appropriate to publish this information?-- I don't have any detailed recollections, but it would have been something I would have discussed with various people at the time, but I don't have a specific recollection of that. But it was certainly in my mind, if I can say that. It was in my mind that we should be moving towards publishing Emergency Department performance parameters and out-patient waiting lists in all of the major hospitals, and that would have included the 32 elective surgery hospitals that we had at the time.

Commissioner, the third statement is one that's very bulky, and accordingly it's physically been delivered to the parties only within the last five minutes.

COMMISSIONER: Yes, and we haven't got it at all yet. I think we might call it a day, if no-one has any complaints.

MR ANDREWS: Commissioner, I propose, subject to anything - any applications that the parties might make-----

COMMISSIONER: You almost sound like you are encouraging one.

MR ANDREWS: I discourage one. We propose tomorrow morning, if Dr Cleary is available later in the day, to call Dr Aroney, who apparently has clinical obligations tomorrow afternoon. I propose to call him so that his evidence - his cross-examination can be completed, and then to ask if Dr Cleary is available then-----

COMMISSIONER: Does that suit your convenience then, doctor?-- I have a national meeting that I'm to present a report at tomorrow. I'm not sure of the specific time that I'll be required to present the report. I could speak with the chair of that committee this evening and ask if I could do that in the morning and be available in the afternoon.

We'd appreciate that, but we certainly don't want to keep you away from something as important as that if you can't adjust

your schedule. But can I ask you in any event to keep in touch with Mr Andrews or one of the counsel assisting either when you get back to your office this evening or first thing in the morning so that if you are not available, we can schedule another witness and time won't be wasted?-- Yes.

MR ANDREWS: There currently is no other witness for tomorrow. It seems that Dr Scott, through no fault of his own, is still in a situation where he has either not identified his legal representatives, or if he has, they won't be in a position to assist him tomorrow.

COMMISSIONER: Doctor, feel free to stand down, by the way. There are a couple of other administrative matters I wanted to canvass, if people at the Bar table will indulge me.

As we all know, we're not sitting next week, so Friday would be the end of this session of evidence and then there will be up to two weeks' evidence in the week starting Monday the 5th and Monday the 12th of September. Consistently with the arrangements approved by the Premier this morning, that only gives the three of us two weeks in which to finalise our report on systemic issues after the close of evidence. What I was therefore going to urge is that if anyone has submissions relating to systemic issues, they be provided by Friday 9 September, and we would also advertise that on the website and elsewhere as the closing date for public submissions. That would not, of course, prevent people who are represented here, the AMA, the Nurses' Union, and other organisations and Queensland Health making further submissions in relation to systemic issues in relation to evidence received over those two weeks, but we will treat the 9th of September as being the closing date for submissions on systemic issues. That, of course, Ms Feeney and Mr Diehm, leaves you out of contention for the moment.

MR DIEHM: Yes.

COMMISSIONER: And there are obviously some things to be resolved with your clients, with timing in any event, so I would imagine you wouldn't have to do anything by 9 September, unless, of course, either of your clients wishes to advance submissions in relation to structural or systemic change in Queensland Health.

MR DIEHM: Yes, thank you, Commissioner.

COMMISSIONER: Does everyone at the Bar table regard that as feasible?

MR DEVLIN: I have no problem with that.

MR ALLEN: Yes, Commissioner.

COMMISSIONER: Mr Mullins?

MR FITZPATRICK: Yes, Commissioner.

COMMISSIONER: All right, we will proceed on that footing.

MR ANDREWS: The tentative calendar for the balance of the week is to call Ms Edmond on Thursday and Mr Nuttall on Friday.

COMMISSIONER: Splendid.

MR ANDREWS: Dr Jayasekera is in contention for either Thursday or Friday afternoon.

COMMISSIONER: Right. I shall also place on the record that following my meeting with the Premier this morning, I have agreed to meet tomorrow afternoon with the leader of the opposition to provide him personally with an explanation as to

the scheduling issues with regard to the rest of the inquiry's evidence and the provision of reports. Unless anyone else wants to raise anything?

MS KELLY: Yes, Commissioner, can I seek a clarification to what exactly you consider to be outside the definition of systemic issues?

COMMISSIONER: Look, I am sorry for using that shorthand. Really, the extension has been sought and granted because there are some individuals - Mr Leck and Dr Keating may be among them - but they may include others such as possibly - and I only say possibly - people like Dr Buckland, Dr Scott, Professor Stable, maybe even the two ex-Ministers, Mr Nuttall or Ms Edmond, in respect of whom a potential arises for adverse findings and who in accordance with the principles of natural justice ought be entitled to an opportunity to respond to those matters. That, as I see it, doesn't affect what I have referred to as the systemic or structural issues in relation to Queensland Health.

In other words, what we need to do to fix the problems to make sure that a Patel situation doesn't arise again in Bundaberg or anywhere else, issues such as the allocation of funding to hospitals, the structuring of regional hospital organisations, the involvement of clinicians in decision making, involvement of the public in decision making, and the whole variety of issues that we have raised in the discussion papers. So that's what I mean by the systemic or structural issues.

MS KELLY: So am I right in taking you to mean that the systemic issues are not all of those other than Bundaberg and Patel and overseas-trained doctor issues, that the non-systemic issues include all of those issues which might give rise to adverse findings?

COMMISSIONER: I think that's right, yes.

MS KELLY: So bullying - generally the bullying culture, of which much evidence has been led, should there be potential for adverse findings, that would be contained within the last two weeks?

COMMISSIONER: Well, that depends on whether you are talking about bullying as a feature of a system or a culture which needs to be addressed, and I have made it clear, for example, in one of the discussion papers that I think one way to address the problems with bullying is a great degree of decentralisation of management. Those sort of structural solutions to bullying should be treated as part of the systemic issues, but if an allegation is going to be made that particular individuals are guilty of bullying, then that's a matter on which they should have the opportunity to respond. Candidly, I don't see that a finding that Mr X is guilty of bullying takes anyone anywhere. I am going to work towards everyone focusing on the future rather than the past and fix up Queensland Health if they can. That doesn't mean we will shy away from making adverse findings if it is necessary, but

I think you would agree with me that in the interests of the group of people that you represent, it is far more important to look at the systemic issues as to how we restructure or improve Queensland Health for the future, rather than be dwelling in the past with issues about who bullied whom, when and where and over what issues.

MS KELLY: Thank you.

COMMISSIONER: Does that help?

MS KELLY: Yes, it does, thank you, Commissioner.

COMMISSIONER: Thank you. Okay, Mr Andrews, were you planning on 9.30 tomorrow?

MR ANDREWS: In fact, Dr Aroney is available at 9, and I have the stamina for it.

COMMISSIONER: Mr Andrews, I have heard it before you get up at 4 o'clock every morning, which I certainly don't. But 9 o'clock is fine, if no-one else at the Bar table is going to be inconvenienced? No? Okay, 9 a.m. it is.

THE COMMISSION ADJOURNED AT 4.51 P.M. TILL 9.00 A.M. THE FOLLOWING DAY