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Transcript of Proceedings

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SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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MR E MORZONE, Counsel Assisting
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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 24/08/200

..DAY 48

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THE COMMISSION RESUMED AT 9.19 A.M.

COMMISSIONER: Good morning, ladies and gentlemen. Ms Dalton?

MS DALTON: Commissioner Morris, there is a new face at the Bar table this morning.

COMMISSIONER: Yes.

MS DALTON: I seek leave to appear for Dr John Scott.

COMMISSIONER: Such leave is granted.

MS J DALTON (instructed by Clewett Corser & Drummond) for Dr John Scott

MS DALTON: Now, Commissioner, I was briefed at 10 to 9, and I think my solicitors, Clewett, Corser & Drummond, were briefed at half past eight last night.

COMMISSIONER: Yes.

MS DALTON: I was going to seek leave immediately to withdraw with my solicitors and speak to Dr Scott to get some instructions.

COMMISSIONER: Certainly.

MS DALTON: The matter, I suppose, that's particularly urgent from our point of view is apparently I will need to cross-examine Dr Aroney.

COMMISSIONER: Ms Dalton-----

MS DALTON: I am obviously not in a position to do so at the moment.

COMMISSIONER: Ms Dalton, this sort of situation has arisen once or twice before. You will understand I am very anxious to ensure that everyone is given the opportunity to conduct their cross-examination efficiently, as well as comprehensively. If that makes it necessary for Professor Aroney to come back on another occasion, that will have to be arranged.

What I suggest is that you withdraw, consider the position. I imagine that Professor Aroney won't be finished in the next couple of hours. So if it suits your convenience to come back later in the morning-----

MS DALTON: I was going to suggest that perhaps just before you rose for lunch or something, to let you know how we're

going.

COMMISSIONER: I understand the Professor does have clinical commitments this afternoon.

MR ANDREWS: Yes, that's so, Commissioner. With what might be naive optimism, I am hopeful that Ms Dalton might by 12.30 be in a position to know the issues that relate to Dr Scott that need to be pursued with Dr Aroney to protect her client's interest, and, as I perceive them, from seeing Dr Aroney's current statement, if Ms Dalton's able to have her instructions, for instance, by 12.30, one possibility is she may even be able to cross-examine before Dr Aroney leaves at the luncheon adjournment.

COMMISSIONER: That's possible, but I am not going to put any pressure on her or her client.

MR ANDREWS: I was doing that.

COMMISSIONER: My recollection - and I don't pretend to have a comprehensive recollection - is that Dr Aroney didn't have much to say about Dr Scott, but it may be that there are references to practices within Queensland Health that are - that reflect on Dr Scott, even though not mentioning him by name.

MS DALTON: Well, Commissioner, can I have leave to withdraw with my solicitor and come back at 12.30 to let you know how we're going?

COMMISSIONER: That's very convenient, yes. Can I also mention, you may not be aware, Ms Dalton, that Deputy Commissioner Vider has, to use the American expression, recused herself from this part of the proceedings on account of the fact that Aroney practises at the Holy Spirit Northside, which is where Commissioner Vider normally works.

MS DALTON: Right.

MR APPLEGARTH: If I could assist the Commission, and hopefully assist my learned friend Ms Dalton, I apprehend that it will be difficult for Ms Dalton to cross-examine Dr Aroney today, but she will have to make her own judgment on that. I have got about a million things to do but I am happy, as I walk back long George Street, to give Ms Dalton the relevant piece of transcript, because I can read it.

My client is in a similar position that there were some references to him. And it was on the last occasion, I think, when Dr Aroney was here that you previewed that Dr Scott and Dr Buckland may wish to cross-examine. So I hope I will be able to be of some little assistance to my learned friend.

COMMISSIONER: Yes.

MR APPLEGARTH: And if she needs to cross-examine on those issues - she has to, I think, cross-examine on more issues

than I ever would - perhaps we will find ourselves in a similar position. So might I come back at 12.30, too.

COMMISSIONER: Yes, indeed, Mr Applegarth, and may I say, if it is of any assistance to either or both of you - and this follows on from the matter Ms Kelly raised yesterday afternoon - we must all bear in mind that under our Terms of Reference, our principal area of concern has always been and remains Bundaberg and the incidents which occurred there.

Evidence about issues in other hospitals and other circumstances is relevant, because one of the provisions in our Terms of Reference requires us to have regard to systemic practices and procedures within Queensland Health, and evidence like that given by Professor Aroney may be relevant in the long run to deciding whether we recommend systemic changes. But as matters presently stand, I cannot foresee any circumstance where we would be making specific findings relevant to individuals like Dr Buckland and Dr Scott in respect of anything other than what occurred at Bundaberg. Evidence about their conduct may give us some guidance as to systems that do work and systems that don't work.

Now, none of that is to detract from the entitlement of both gentlemen, and, indeed, anyone else mentioned, to protect their reputations if they feel that evidence reflects poorly on them, but to take an example with Dr Buckland, as you know, Mr Applegarth, we have some concerns about his involvement in matters involving Dr Miach and Bundaberg and that's quite specific to Bundaberg, but with Dr Scott, I think I am right in saying that he had almost no connection with the matters which transpired at Bundaberg, and, therefore, evidence by him and evidence about him will only be relevant to the extent that it sheds light on those sort of systemic issues. Does that assist at all, Ms Dalton?

MS DALTON: Of great assistance, yes, Commissioner.

MR APPLEGARTH: Commissioner, I don't want to take too many more minutes of Dr Aroney's valuable time.

COMMISSIONER: Yes.

MR APPLEGARTH: But - thank you for what you just said but - and I will do the communications in writing or through counsel assisting not to take any more of your time, but, quite frankly and with all due respect, my client has not a clue as to what issues he has to defend himself in respect of. For example, you have expressed yourself in extreme terms concerning his conduct in relation to Dr Berg in Townsville. Now, I don't know whether you apprehend that the matter in relation to Dr Berg is within your Terms of Reference, but because you have expressed yourselves in emphatic terms in relation to Dr Berg, currently my instructing solicitors are working tirelessly to assemble documents in relation to Dr Berg so that we can understand the chronology of events in relation to it and prepare him and properly advise him as to whether the Berg matter is within your Terms of Reference.

So I appreciate the general comment that you made that your focus is upon Bundaberg, but that really doesn't assist me to prepare my client to give a witness statement, or to prepare him to give oral evidence, or to advise him about whether the Berg matter is a matter that he has to prepare himself for or not. So I appreciate the general observations you make, but general observations are of no assistance to my client in relation to matters such as the Berg issue.

COMMISSIONER: Well, Mr-----

MR APPLEGARTH: Where you have expressed yourself in quite emphatic terms on the record.

COMMISSIONER: Mr Applegarth, if general statements are of no assistance, let me give you some specific ones: under our Terms of Reference, there is a focus on overseas-trained doctors and particularly the way of attracting more doctors to Queensland. The evidence which we heard in relation to Berg in Townsville raises, in my view, very serious systemic flaws in the way in which Queensland Health was administered at a time when your client held senior management positions. I have used the expression - and I don't shrink from repeating the expression - that it was arrant stupidity to cover up facts relating to Dr Berg rather than exposing them to public scrutiny, and unless and until I hear something to the contrary, I will remain of that view as regards the system of administration.

It may well be that when your client gives evidence, he tells us that that wasn't his call, that he was under ministerial direction to do it that way and that it wasn't his fault. I am concerned only about the system, and a system in which facts like that get covered up rather than revealed is a bad system.

MR APPLEGARTH: I am concerned about the system, too, as my cross-examination of Dr McNeil would have shown yesterday, but my primary concern must be my client. And it gives my client no comfort, and could only give my client reasonable apprehension that you do express yourself in such firm language before you have heard all the evidence and given him or anyone else an opportunity to lay out the relevant documents in relation to Dr Berg and to make submissions and give evidence if so advised, in my submission would give my client an apprehension that you have already made up your mind about Dr Berg and my client's conduct in relation to it.

In my submission, it is entirely inappropriate for you to express yourselves in the terms that you have in relation to my client and in relation to the Berg matter until you have heard all of the evidence.

COMMISSIONER: Mr Applegarth, we need to keep two things clearly separated: one is the systemic problem, as I say, the facts as they are demonstrated in evidence and have not been challenged by anyone, including your client's representatives

when your client had other representation.

MR APPLEGARTH: Well, we can talk on another occasion, but my client's other representation and my client may not necessarily be held entirely to blame for his representation when his representation at the time was subject to political direction about what could or could not be done.

COMMISSIONER: Well, I didn't hear any complaint from your client at the time when the government was providing him, at taxpayers' expense, representation through the Crown Law office. If he wants to now distance himself from anything that was said and done at that time, he will have that opportunity. But the fact remains that as we sit here, the evidence was received without challenge, without complaint from your client's then legal representation, which demonstrates, I think to the satisfaction of anyone with an open mind, that the situation in relation to Berg could have been far better handled.

MR APPLEGARTH: Are you talking about his registration, or are you talking about what advice was given to my client and what advice my client passed on as to whether potential or actual irregularities in Dr Berg's registration should be communicated to mental health patients via the media? I really don't know whether you are talking about a systemic problem in relation to the registration of Dr Berg or whether you are talking about some other matter?

COMMISSIONER: Well-----

MR APPLEGARTH: Or both.

COMMISSIONER: I will be very specific again: what we received evidence of in Townsville was an action plan put together by the people in charge of mental health in Townsville, which your client not only countermanded but criticised them for even proposing. Now, as I say, he may have very, very acceptable explanations for that. He may have been under political pressure to cover it up. There may be all sorts of reasons. He may have had advice from other sources that suggested that the psychiatrists in Townsville were wrong and that what they thought was in the best interests of psychiatric patients was inconsistent with other psychiatric advice as to what was in the best interests of psychiatric patients, and we'll hear all of that from Dr Buckland when his opportunity comes.

But, Mr Applegarth, the fact remains that on the unchallenged evidence, the psychiatric experts in Townsville considered that the best thing for the psychiatric patients was to allow the facts to be disseminated in the public media in a controlled way, so those on whom Berg had had an impact had the opportunity to obtain proper professional responses from people at the Townsville Hospital, and that was not only emphatically countermanded by your client, but done so in language which was extremely critical of those who had made those proposals. Now, we will hear his explanation.

MR APPLEGARTH: Well, I am not sure when because there is an incomplete account of the events so far, as I can understand on the record of this Commission. If you want to explore that issue, which is what happened a couple of years after Dr Berg left Townsville, then you no doubt will. You will presumably wish to explore it with Ms Edmond when she comes because-----

COMMISSIONER: You will have your opportunity to cross-examine Ms Edmond if you choose to.

MR APPLEGARTH: Well, I won't have much of an opportunity if she comes tomorrow, and I still haven't got the Berg documents. I mean, if you want to go into the issue of what you describe as a cover up but which others would say was a sensible sound thing not to communicate to mentally challenged people, then we will have to address that if that is within your Terms of Reference, but in my submission I can't even begin to prepare for that issue at the moment.

COMMISSIONER: Well, I am sorry, Mr Applegarth, but we went to Townsville, we heard evidence from the people who appear to be in the best position to make that judgment; the people who are in control of the situation, people who knew the patients, the people who knew the likely impact on the patients. And we saw their documentation, including the documents that they sent to Charlotte Street, and to your client in particular, we saw the response that they got from your client-----

MR APPLEGARTH: Well-----

COMMISSIONER: All of that evidence - I mean, you complain that you don't have the documents. There has never been an inquiry in history that has been more open than this one. Every document that's been received in evidence is on our website, other than two or three confidential exhibits. Every page of the transcript is on the website. It is all there.

MR APPLEGARTH: Commissioner, I wasn't complaining about the documents that were tendered in Townsville not being on the website.

COMMISSIONER: What do you want-----

MR APPLEGARTH: I am concerned about the fact that the documents that were tendered in Townsville are an incomplete account of the documents in relation to the Berg matter, and I will agree with you there has never been a Commission of Inquiry like this one.

COMMISSIONER: Mr Applegarth, if your client's then representation had considered that other documents were relevant and tendered them, they would have been received. If you now coming into the picture want to take a different view of it and produce other documents, you are very welcome to, but we've got no control over the fact that your client, for whatever reason, has changed his representation and now wishes to criticise the way in which matters affecting him were

handled at an earlier stage of proceedings. And I don't want to labour that point because I think it will be apparent to any fair-minded observer that Mr Boddice and his learned juniors conducted the case with absolute enthusiasm and commitment to their client's interests at every stage, but if you want to launch that sort of criticism, you will have the opportunity.

MR APPLEGARTH: Thank you. I won't take any more of your time. But can I say, of course, my client has to consider his position in relation to your remarks about him in the context of the Berg matter, your remarks about him in relation to the dirt matter. I haven't had a chance to read the 4,500 pages that have been here, but I don't want anyone to be under any illusion that my client doesn't need advice about the respects in which the Commission has been conducted in relation to his interests and emphatic statements that you have made in relation to the Berg matter and other matters.

I won't take any more of Dr Aroney's valuable time but I will come back at 12.30 and we will see where we're going then, if the Commission pleases.

COMMISSIONER: Well, Mr Applegarth, in light of what you say, I can only make it clear again that my remarks - if you want to describe them as emphatic, you are welcome to do so - but my remarks were based on evidence that was unchallenged at the time. If you wish to challenge it or if you wish to call further evidence, then matters will be reconsidered afresh. I don't want anyone walking out of this room thinking that we've got a closed mind about certain matters, because on the evidence that had been presented to us and had not been challenged, including the absence of any challenge by your client's then legal representatives, it all pointed one way. If such a challenge is now going to occur, or if contrary evidence is now going to be adduced, then, of course, we will open our minds to that evidence and reconsider the position. But it is not very constructive, frankly, to say that we formed an emphatic view on unchallenged evidence because your client, through his then representation, chose not to challenge it.

MR BODDICE: Can I just raise one matter?

COMMISSIONER: Yes, Mr Boddice.

MR BODDICE: Commissioner, you may recall that at the start of the Townsville sitting the question was raised whether in fact Dr Buckland was continuing to be represented by us and we indicated we were getting instructions. So I think in fairness, both to probably ourselves and also Dr Buckland, that all of that evidence occurred in that state of flux, which was that-----

COMMISSIONER: That's true.

MR BODDICE: -----Dr Buckland was getting independent advice. So I wouldn't want Dr Buckland to be blamed for that, because

it was raised right at the start, at the outset, and I indicated we were seeking further instructions. Obviously advices were given at that time.

COMMISSIONER: Yes.

MR BODDICE: And there is a result of the separate representation. And, of course, it would have been not correct for me to be doing things in relation to Dr Buckland if I am not acting for Dr Buckland and-----

COMMISSIONER: I accept that entirely, Mr Boddice, and I would assume that in those circumstances Dr Buckland was informed that evidence relevant to him was being given and that if he wished to challenge that evidence he had to make his own arrangements.

MR BODDICE: But, of course, in the context where he needed to get separate legal representation, which takes time.

COMMISSIONER: Yes.

MR BODDICE: I just think in fairness, that scenario should be put on the record.

COMMISSIONER: Yes. Mr Andrews?

MR ANDREWS: I call Dr Aroney.

COMMISSIONER: Thank you.

CONSTANTINE NICHOLAS ARONEY, CONTINUING EXAMINATION-IN-CHIEF:

MS KELLY: Dr Aroney, have you been provided with a copy of Exhibit 301C, being a statement of Dr Michael Ian Cleary, dated 23 August 2003, relating to the provision of cardiology services in Queensland?-- Yes, I was given this late yesterday evening.

All right. Have you had an opportunity to examine that statement and its 22 attachments, and do you have any evidence arising from which you wish to give to the Commission?-- Yes, I have. The statement was provided to me late in the evening, and on looking at it during the night, I've found a number of misleading statements which need to be clarified to the Commission and I would like to bring those up this morning.

Yes. Can you take us to the first of those, please?-- Firstly, in paragraph 16, Dr Cleary stated I was on leave for two years prior to my resignation. In fact - and as Medical Superintendent of the hospital, I would have expected Dr Cleary to have known - I was on leave for exactly one year prior to my resignation. He criticised me after that, that being on leave for such a long period I wouldn't have known

what was happening at the hospital, and, yet, in fact, during this period of leave I continued to participate in staff meetings, including some which are minuted, and to take an active interest in what was happening in the cardiology division, so-----

During that period you remained the President of the Cardiac Society?-- Yes, I did.

Yes, thank you. Is the next matter you want to address in paragraph 35?-- Yes, in paragraph 35, Commissioner, Dr Cleary states that the cardiology waiting list at the Prince Charles Hospital for category 1 patients was 229 and for category 2 patients was 79. He goes on to say that the waiting list at the Princess Alexandra Hospital for category 1 was zero and for category 2 was two patients. You, Commissioner, may find this rather strange that there was such a huge waiting list at one hospital and not at the other. Clearly, this statement provided by Dr Cleary was extremely misleading to the Commission. In fact, this was used in order to shift cases from the Prince Charles waiting list to the PA in order to cut services at PA. The truth of the matter is that there were several hundred patients on a hidden category 3 waiting list, which Dr Cleary doesn't mention which were present. Category 3 means that patients don't require to have procedure done within three months. Now, in fact, Dr Cleary's own submission, MIC11, says at best practice patients should have an angiogram within 20 working days. So you have several hundred patients on a hidden waiting list at PA who are not being done within a 20 working day recommendation, and yet this is used as a method for cutting procedures at the Prince Charles and moving across to another hospital.

COMMISSIONER: Doctor, if I can interrupt you there, I actually raised this matter with Dr Cleary yesterday afternoon as to how people get shifted to category 3 waiting lists, and one of the suggestions we received in submission is that it is what's called desktop surgery. Instead of performing physical surgery in a hospital theatre, you perform the surgery on the desktop and just transfer people from category 1 or 2 to category 3. His response was people only go into the lower category if the relevant clinician, the relevant specialist dealing with that patient decides that they should be in category 3. So how do we have this several hundred in the category 3 list at PA?-- Well, it is apparent to me that Queensland Health or Dr Cleary feel that there is a different species of patient on the south side of the river that can be categorised as category 3 rather than category 1 or 2. This is really entirely illogical. This, in fact, was backed up by Dr Buckland in Dr Cleary's attachment C12 where Dr Buckland says in response to these discrepancies in waiting lists, that Princess Alexandra Hospital has immediate capacity to address patients on the PCH waiting list and, hence, the transfer occurred, and occurred over the following 12 months. Now, Dr Cleary goes on in paragraph 41 to say that "Queensland Health has a standardised process to categorise patients on the waiting list. Prince Charles uses these categories." Mr Cleary then states: "It was assumed by me that Princess

Alexandra used the same categorisation process." Now, this is an extraordinary statement to have made. He then goes on to say that it became apparent to him later in January of this year, 2005, that PAH used a different categorisation process. Now, this is incorrect, and he was well aware of this hidden waiting list. We had known about this. In fact, the hidden waiting list, we understand, may be difficult to locate because it was allegedly carried around in someone's brief case rather than written down so it could be obtained, but he was well aware there was this hidden waiting list and, yet, during the whole period of 2004, these transfers were occurring and cuts were occurring as a result at the Prince Charles Hospital, and those cuts led to some of the deaths that are listed in this statement.

So I consider this miscategorisation at PAH to have been a problem and Dr Cleary and Dr Buckland perpetuated it and used it as a devious excuse to transfer patients and cut services at the Prince Charles.

Ms Kelly.

MS KELLY: Yes, thank you. You said earlier that this was a mechanism by which the result was - the result was achieved that services at PA were to be cut. You meant to say Prince Charles?-- Prince Charles, yes.

Yes, thank you. Now, in relation to paragraph 78 of Dr Cleary's statement you had some further evidence?-- Yes, Dr Cleary stated that there was - and I had stated in my submission that there was a petition of staff at the Prince Charles to save the director of the cath lab at the Prince Charles from dismissal by hospital manager Deb Podbury. Mr Cleary writes in his statement, and I quote him, "I have also spoken to Ms Podbury who informs me and I verily believe that there was no petition of staff as referred to by Dr Aroney." Now, I can assure the Commissioner, and he could subpoena any of the senior staff at the hospital including Dr Debra Myers, who took the petition around, that this petition was indeed taken. I received this last night. In fact, I'll try and obtain a copy of the petition and forward it on to the submission in the next few days.

COMMISSIONER: Thank you?-- But this is an incorrect statement by Mr Cleary and he alleges also by Ms Podbury. And further, I mean, the - this threat of dismissal, Dr Cleary very kindly provides e-mails and memos detailing the code of conduct and threats of dismissal against both the director of the cath lab and against a senior paediatric surgeon and I hadn't seen these memos before. They, in my view, represent extreme bullying of very senior medical staff whose loss to the system would have been catastrophic, and if these two men were not so committed to the public system, they would have resigned after receiving these e-mails, and I know that during this Commission, retention of staff has been seen to be a priority and this degree and attitude to senior staff is clearly incorrect.

MS KELLY: Just in relation to Ms Podbury referred to in paragraph 78, when did she move from Prince Charles to Princess Alexandra Hospital?-- I believe it was in the early months of last year. I can't tell you exactly the month that occurred.

All right. Thank you. Now, at paragraph 86 of Dr Cleary's statement there is reference to a VAD device?-- Yes, Dr Cleary makes another incorrect statement in paragraph 86 and says that, "The VAD device in both children was a Biomedicus device." Now, this is incorrect. Dr Pohlner, the senior cardiac surgeon, has told me directly, and you can obtain this information from him, that for the first child, the device was a Thoratec device. Dr Pohlner tells me that this device was working and available and the statement by Dr Cleary of course

refer to the second device, which is used in smaller children. So this paragraph, again, is a totally incorrect and misleading statement.

Thank you. Can you turn to attachment 17A of Dr Cleary's statement?-- Yes, in this attachment, and it's really an attempted refutation of the deaths which I had raised in the mid year of last year, and I can go through each of these if you wish, but just two glaring errors in these, patient A - and I won't identify that patient, but in fact that's patient 13 in my statement. It's alleged in Dr Cleary's statement that this patient died on a certain date. In fact, that patient died three days later according to my very strong and contemporaneous information. So that was quite incorrect and those three days may have been critical if the patient had been able to be moved. Similarly, patient B, which is patient 15 in my statement, again the dates are out by three days. The patient died three days later than is alleged in Dr Cleary's statement. This is two obvious examples of cover-ups by Queensland Health of the deaths that have occurred.

Thank you. Dr Aroney, would you turn to attachment 10 to Dr Cleary's statement, please, the Thomas Ayre report. This is the report which you say in your statement you had sought access to from Ms Wallace and had - it had not been provided. So this was provided to you last week, last Friday?-- This was - thanks to the Commission, who obtained this document, this is the first time I've had access to this document. As the Commissioner will remember, we prompted two inquiries, this was the first one, which was investigated in January of last year and has only been provided thanks to the Commission. The second inquiry, the Maher report was obtained again very late and after I had no response earlier in the year, earlier in this year, I think in rough - in April I think it was provided. So this first report, and the first time I have had to look at it, details and tries to refute the three deaths which I have written to the Premier about and just to take you - again, I won't identify those three patients but I consider this, and I obviously - this is the reason why this document was never released, is that this, again, is a cover-up of the true issues regarding these three deaths. The first death was a severely ill patient at Hervey Bay Hospital who should have been transferred immediately upon discussion with the Prince Charles. We know at this time that beds were at a premium, that many patients are waiting for beds at the Prince Charles at any one time. If this patient had been transferred immediately and it was stated in the submission in fact that the director of cardiology and the director of the cath lab nursing area also said that this patient should have been transferred immediately, the patient may well have survived. The second patient was a patient who had an acute coronary syndrome. This patient was put on the list on the 30th of September and died on the 28th of October. Now, patients with acute coronary syndrome as we discussed in my previous statement here and as are evidenced in the unstable angina guidelines should be transferred within 48 hours of presentation. This patient waited from the 30th of September

to the 28th of October, when he died. He was put on a category 1 list. This patient, I think, came from Lismore. A lot of patients from that area have been transferred to Brisbane because it's closer. They should be transferred to the Princess Alexandra Hospital but Dr Mumford, who is the cardiologist at that hospital, had a great difficulty because of access block to the PA and had been transferring patients to Prince Charles and we were accepting those patients because they couldn't get into PA. And a lot of these patients could not be transferred within the 48 hours or even at any time during that hospital because of lack of beds and were put on category 1 lists, as this patient was done, which is actually quite inappropriate. So this was a completely avoidable death. The third case again was a high risk case who required an implantable defibrillator. The decision to make this was on the 23rd of September. The clinician is quoted in a submission as saying that, "Budgetary restrictions prevent an earlier procedure" - he stated that - and the patient died on the 29th of November, more than two months later. What's even more outrageous at the end of the submission about this patient, the investigators actually blame the patient by saying that the patient did not appreciate the urgent need of the ICD implant, which is quite outrageous. So I consider all of these to have been potentially avoidable deaths. This report was not released and we can see why.

Yes, thank you. If I can take you in that attachment to page 9 under the heading "Discussion", "The original referral letter from the Hervey Bay Hospital to the Prince Charles Hospital is missing"; do you see that first sentence?-- Mmm-hmm.

Is that referral letter a document you would ordinarily expect to be in the possession of the Prince Charles Hospital?-- Yes, these referral letters should be kept in the hospital.

All right. You can turn to the next page. "There's no record of a request for transfer of the patient." It's the last sentence on page 10?-- Mmm-hmm.

Is that a request you would normally expect to be recorded?-- It should certainly be recorded.

Thank you. Page 11, the second-last paragraph, or the last complete paragraph, "There's no information to indicate that this booking was discussed with the triage clinician, who was unavailable for this to be verified." Is that discussion something you would expect to be in the records of Prince Charles Hospitals?-- Yes, it should and, as I say, Dr Mumford and others at the Lismore Hospital have very frequently reiterated the difficulty they have in getting sick patients transfer to Brisbane hospitals because of lack of beds.

And further to what you said in answer to the Commissioner earlier, the following paragraph refers to there being no evidence to suggest that the patient was referred to Princess Alexandra Hospital for assessment at any time. Are you able to comment on whether - on the reasons for that lack of

assessment at Princess Alexandra Hospital?-- Again, I don't know the circumstances pertaining to this case specifically, about whether a request was made to PA. I do know, however, that Dr Mumford had spoken to me and had said on occasions - on many occasions that he had given up trying to transfer patients to the Princess Alexandra and because of bed issues or refusal to take patients and was therefore sending them instead to the Prince Charles, which is not in the draining region of the southern - of that area, the southern region.

So in relation to the evidence that Prince Charles had a 200 plus category 1 waiting list and that Princess Alexandra had a zero category 1 waiting list, your experience is that Dr Mumford failed to refer this patient to Princess Alexandra because of the unavailability of treatment there?-- Dr Mumford frequently told me that this was the case. This degree of bed access block has not only occurred from Lismore but continues to occur at the Gold Coast Hospital. You would note from my previous submission I've raised problems there. I had raised a death at the Gold Coast Hospital but feel that this may have been a one-off issue and not something which was possibly avoidable. But what has been raised just in the last week to me is continued access problems from the Gold Coast Hospital to the PA where the clinicians there are doing their best and are doing a very good job, are still failing to transfer sick patients to the PA and the patients are suffering and this information has only been supplied to me in the last week when I met with cardiologists from the Gold Coast Hospital.

Are you aware of the reason for that failure to refer to Princess Alexandra?-- Well, it's a case of bed access block presumably. You would have to ask the Princess Alexandra Hospital for those details.

Thank you. Now, in relation to the 48-hour treatment that is set out in the guidelines, are these the guidelines referred to in - or set out in attachment 1 to Dr Cleary's statement?-- Yes, I believe they are.

And turning to page 3 of that attachment, that Constantine Aroney, the principal author, that's you?-- That's correct.

All right. Now, at paragraph 7 to 9 of Dr Cleary's statement where he refers to attachment 1, Dr Cleary seems to indicate that the increase in demand from 1996 - sorry, from 2000 after the introduction of these guidelines is in fact attributable to the guidelines. Are you able to just have a look at paragraph 7, 8 and 9 of Dr Cleary's statement?-- Yes. And I would agree that a proportion of the increase in transfers from 2000 to the present time is due to the guidelines which represent a much more aggressive strategy of taking patients, doing angiogram and revascularising them before they die or have further heart attacks. There are additional factors for this increase such as growth in population, our ageing population, and a severe unmet need of coronary angiography due to chronic under-servicing of the community for the past

20 years. So there are several factors involved.

So in the planning for the introduction of these guidelines at Prince Charles Hospital, there was no increase in the range and number of procedures so as to take account of the new guidelines?-- The - there was a submission in late 2003 that the numbers should increase and I provided that in my submission, I can't remember the attachment number.

Yes?-- It was supplied by the cardiology division, Dr Galbraith and, in fact, it was just at that time that the first and second cuts were occurring rather than increase in numbers. So rather than numbers increasing according to demand, cuts were occurring at the Prince Charles Hospital at the very time when the numbers should have been increasing.

Yes, thank you. Turning to Dr Cleary's statement in the attachment - the November - I think it's attachment 20, yes, attachment 20, the November 3, 2004 meeting between yourself and Ms Gloria Wallace and Dr Cleary and Dr Peter Tesar, is it?-- Tesar.

Tesar. Do you recall that meeting?-- Yes, I do.

All right. Do you recall having indicated that you might return to work if you were made Director of Cardiology?-- The circumstances with regard to that - I'm not sure what Dr Cleary said in his transcript but the circumstances regarding this was prior to that meeting the - there was a leadership vacuum at the Prince Charles Hospital. The previous acting director had resigned and the - several members of the cardiology department approached me to become the acting director of the unit. This, in fact, was voted upon at a meeting of all staff cardiologists and they unanimously elected me. I did, I accepted their nomination, reluctantly, because I told them it was very unlikely that in all - after all that had happened, that Queensland Health would accept this nomination. But, nonetheless, a cardiologist insisted upon putting this up. It was no surprise to me that a week later, that this was turned down and I see that Dr Cleary has brought this up to use as evidence against me later to say that I was upset or in some way sulking as a result of this, which is totally untrue. I in fact had not expected this would be accepted and at that meeting I in fact recommended who should become the director of their unit and that person has indeed become director and a very good director.

Yes, thank you.

COMMISSIONER: And I suspect that your interest is mainly in getting on with clinical work rather than the administration that goes with being a director in any event. It doesn't sound to me like there would have been much attraction in being in a position of director?-- No, I was really quite reluctant to accept this position as my main love is clinical work and research work and teaching of medical students and residents and registrars, which I'd done the previous

15 years. So, an administrative job like this was not something which I sought at all.

Thank you.

MS KELLY: Yes, thank you. Dr Aroney, is there anything else arising out of Dr Cleary's statement which you want to draw the Commission's attention?-- No, I think we've covered that. I have only had a chance to look at it briefly overnight and that - the most glaring, misleading statements I have brought - I have already brought to the attention of the Commission.

Yes, thank you. If I can then ask you to turn to your statement, can you to attachment CA4, please.

COMMISSIONER: Ms Kelly, I don't want to curb your enthusiasm but you can take it that anything in the statement we have read and anything that is unclear or ambiguous or we feel needs fleshing out has either been dealt with by Mr Andrews or can be dealt with by way of questions from the bench. I don't want to deprive you of the opportunity in your client's interests to flag matters of particular concern but for the purposes of the Commission of Inquiry, we don't need detailed enlargement on matters which are already in the statement.

MS KELLY: Yes, thank you, Commissioner. There was a particular attachment to which I want to take Dr Aroney.

COMMISSIONER: Of course, of course, I won't-----

MS KELLY: Well, if you could turn to CA11, attachment CA11. This is the memorandum which embodied or set off the third round, what you've described as the third round of cuts, the memorandum of Ms Wallace. Can you explain - at paragraph 3 of CA11, can you explain the response of Dr Walters in terms of what it was that Ms Wallace was proposing?-- The proposed cut to 57 cases, which was - which we considered to be totally illogical, this was responded to by Dr Walters in this memorandum obtained by FOI and one of the things which was mentioned here was that he'd been instructed that the cath lab should be open not before 9 a.m. and the last case completed by 5 p.m. In other words, a very strict roster. Now, as a result of this, obviously any urgent cases which came during the day would find it very hard to fit into this schedule. It was also instructed later that approval had to obtain from the Medical Superintendent for any add-on cases as they came in, making these administrative blocks to appropriate patient care, and that the cath lab should shut up shop at 5 o'clock, and this to facilitate this cut to 57, a cut which, as I say, was totally illogical. And Ms Wallace was well aware that a statistician had been employed by the cardiology department to show that this cut would lead to a severe blow-out in the waiting list and obviously this blow-out would have major effect on patient outcomes and, yet, this cut was proceeded with and these very difficult arrangements whereby patients had to be accommodated on a 9 to 5 basis with special arrangements being made for any urgent cases made the workings

of the cath lab very difficult. And this proceeded for a three to four-month period until the hospital realised that they weren't doing enough to get funding, because funding is based on activity and these funds - these activity cuts were then withdrawn in January and then the numbers have been pushed up and, over time, was encouraged in order to obtain the appropriate funding for activity. Totally irresponsible management behaviour.

COMMISSIONER: Dr Aroney, can I make it clear, the message you're giving us is coming through very loud and clear. I guess the concern that the three of us up here have is that you make a tremendously powerful case for the fact that the Prince Charles Hospital, which had a world class cardiac facility, was being deprived of funding. I am confident that if we got your equivalents in other hospitals and other disciplines, we'd have a nephrologist telling us that renal units are world class but are being harmed by under funding, we'd have orthopaedic surgeons saying that they could offer world class facilities if only the money was there, and on top of that we have got regional and, particularly, rural hospitals that are desperate for funds to maintain even - even the most basic medical services to their communities. I think we all know what the problem is and it's that there is not enough money. I wonder if you can offer us any insights into how the limited financial resources can be better utilised to ensure that committed, dedicated and world class clinicians like yourself are given the opportunity to provide these services to the public?-- Commissioner, I think the first step that has to be taken in the process is honesty and once the system is shown to be inadequate, then we can move forward. The problem that's occurred in the last probably 10 years but certainly most prominently in the last couple of years is that these problems have been covered up and whenever we've spoken out about them, we have been attacked. So we first need honesty in the system and then we can move forward and appropriate rationing, if that's what's required, of activity. Now, Queensland Health has refused to accept any rationing, presumably because it's seen to be politically untenable. But if we are so short funded to provide funding for the entire ageing community, then the hard choices may need to be made as they have been made in other countries such as New Zealand and the United States.

Is when you talk about rationing, of course, the fact of the matter is that of necessity there is rationing, you've given evidence about the rationing of cardiac services even though the word "rationing" is banned from it. One reads in the press about the people of Cunnamulla experiencing rationing to the point that they don't have a doctor for six days because there's no-one to replace the local superintendent. It seems to me that if there's going to be rationing, at least it should be structured so that there is the least harm done to the community. What we seem to be hearing is that there's been de facto rationing for years and that that's unstructured and largely illogical that the money goes to where political lobbies are strongest or where the voices of the local clinicians or administrators allowed us rather than on a needs base or a patient health basis. Is that a fair comment?-- It is a fair comment, and the people who are the wedge in the sandwich are the clinicians who have to bear the brunt of the acute waiting list.

Yes?-- And the clinicians are often blamed when the waiting list blow out and these deaths occur, the first blame is directed at the clinician, why didn't you do these patients first? Why weren't they referred to another hospital? When these people are doing the best they possibly can under very difficult circumstances. So the government needs to take responsibility for the issues of long waiting lists and not put the blame on the very hard working both full time and VMO clinicians in the system.

Well, doctor, when you emphasise honesty as being the starting point, I guess I can say, and I'll probably get a blast from Mr Applegarth for saying this, but from the evidence that we've heard to-date, it seems to me that honesty can achieve a number of things: firstly, it can condition community expectations so that people who need hip replacements aren't surprised when they're told that it's going to be two or three years before they're - before they get that treatment; secondly, it can allow people to make informed choices about their own health care, whether or not, for example, they take private insurance rather than risking their own and their family's health to the public system; thirdly, it can inform the democratic process if people know what the facts are they can complain about it to their local member or to the government; fourthly, but perhaps most importantly, it can underpin rational planning of health care resources - if one likes to use the unpalatable expression of rationing, then let's call it rationing - but it allows people to make informed judgments based on the real facts rather than a distortion of the real facts, and, you know, you tell us, for example, that Dr Cleary knew what the figures were at the PA, I don't know, it may well be the case that Dr Cleary honestly believed that there were no people in category 1 and a couple in category 2, but whatever the situation, if the facts were there, then the right judgment could be made based on the facts rather than based on a distortion of the facts. Are there some other advantages you see in adopting this process of openness?-- Unless we have an open system where we can honestly discuss the problems in the system and unless we have

a community airing of those problems, we cannot come to any viable solutions in the long term, and hence community involvement in this whole process and in decisions regarding rationing is essential, and whether that's done at a hospital level or at a central level is something that we need to consider. These are the questions we need to be asking rather than the scenario of just covering up the problems on a continual basis.

For example, Dr McNeil made the point yesterday, and I'm sure you'd agree with us that he is a very impressive man and a very impressive witness, and he was making the point that in some jurisdictions, and I think he mentioned a particular jurisdiction in the United States, it could have been Oregan, those decisions have been made to the point that people have said, "Well, we can't afford to do transplants, you know, if it costs half a million dollars to have a transplant, heart lung transplant, that money is better spent providing services that could save 100 lives rather than just one". I would like to hope that we won't come to the point of making that sort of decision, but if we do come to that point, then it should be based on the real facts?-- Indeed it should. The heart transplant and transplant service is really a wonderful thing taking critically ill patients and giving them a length of life, but it is an extraordinarily expensive process, of course.

Mmm?-- But it's been extremely well funded by the Government and I think Dr McNeil would admit to this, because it is so public, because it is, it shows such wonderful benefits and I believe because it's such good political ammunition, if you like, whereas other systems, and there are many of them, many examples throughout Queensland Health, hip replacements, other very debilitating conditions which are poorly funded which don't have the profile of transplantation which obviously need to be looked at in accordance with these issues of rationing and where is the money best spent.

Well, I don't know what the best example would be, but one example that comes to mind is that the cost of a transplant, when you work out all of the costs involved and the equipment, the staff and so on and so forth, might pay for 500 colonoscopies, and if those 500 colonoscopies detect early cancer in even 20 or 30 people, that's a more efficient health service than one that channels all of its money into sexy operations that get a lot of press coverage?-- Yes, and in a health system which is so severely underfunded as Queensland Health has been shown to be in this Commission and the Forster Commission, these are the decisions we need to be taking, the degree of underfunding, the per capita spending on public beds is lowest in this State than any of the other major States and so this severe degree of underfunding which has not just been present for two years, it's been present for 10 or 20 years.

Yes?-- Means that there's a huge burden of disease out there which is untreated in Queensland which now impacts on waiting lists and the huge numbers of people waiting on waiting lists, and it's going to take years to correct this huge burden of

disease.

D COMMISSIONER EDWARDS: Could I just ask Dr Aroney, do you think there should be any consideration given to actual waiting lists for the next 12 month period, not just a side list or the hidden list, but actual waiting lists for various categories of surgery in at least the major surgical hospitals of Queensland being published and on the public record and whether the government's want to do about it, it's a political decision, but at least the facts are out in the public arena so that decisions can be made if wanted to and the political will to do so, but at the present time we gather that there are hidden lists and waiting lists of J and waiting lists of K and so forth, and the real facts are the waiting lists and the numbers of patients who are out there being diagnosed, told they need a procedure and nothing, but we will be in touch, and I'm just wondering if you have a view about the - we understand the odium of the output but I think it will only be a short time, quite frankly, but at least the knowledge of the situation so that there can be, if necessary, political pressure for a government of all colours to spend more on health and less on Primary Industries and/or more on waiting lists diminution than on Transport, and I'm just wondering if you have a strong view about publication of real figures, not hidden lists, real figures in major hospitals?-- Yes, I have a very strong view that these need to be published and we made in this cardiac meeting with Dr Buckland and Dr Scott last February, we insisted that the coronangiography, defibrillators, EP plas studies and angioplasties and stents, these are not published and yet most patients die on these waiting lists, so these lists should be published, the cardiac by-pass are published but they're further down the line, patients have to wait for their coronangiogram before they get on the by-pass surgery waiting list. We asked very strongly that these be published at our major cardiac meeting with Queensland Health last year and, of course, this has not happened, but these waiting lists are essential to be made public.

Waiting lists and waiting lists, we have heard different information about what one waiting list says but what really is the situation, what I am suggesting that the real facts be placed in an annual report each year that we consider that aspect of it in our report?-- No, absolutely, and the outpatient waiting times which are more relevant to the patients rather than just numbers are very well relevant as well, say the waiting times are over six months at many of the major hospitals for people to see a specialist, so these times is what the patients need to know about.

COMMISSIONER: I wonder also, doctor, whether part of the process isn't to re-write the Queensland Health dictionary and use language which is designed to be transparent rather than to conceal the facts as I raised yesterday with Dr Cleary, it seems to me what matters to most people is how long it takes from their GP saying, "You've got to see a specialist.", until you do see the specialist and get treatment that the specialist considers appropriate. Talking about surgical or

operative waiting lists is utterly misleading if that doesn't take into account: A, waiting time to get on a list to see a specialist; B, waiting time on the list to see the specialist and; C, waiting time for a procedure which is not currently classified as a surgery for the purposes of waiting list statistics. We've just got to change that language and aim at transparency rather than obfuscation?-- I agree, it makes a practice of medicine so exasperating not from only myself as a specialist who has to see patients who when I see them in the clinic I realise I should have seen them six months ago and I'm sometimes surprised that they're still alive, but even more exasperating for the general practitioners who are seeing these patients on a weekly basis and are desperate for them to be seen by a specialist and have appropriate care, and these people are really frantic and doing their best, and again, if we need to keep good general practitioners in the system, we have to have the functions in place, the processes in place so that their patients can be appropriately processed and we're losing GPs out of frustration in the system.

I think the other word that needs be changed is the word "elective".

D COMMISSIONER EDWARDS: Mmm.

COMMISSIONER: It's astonishing, since this Inquiry began, most people I meet socially I ask whether they have any sense of what Queensland Health means by "elective surgery" and the general assumption - I'm talking about broadly speaking intelligent well-educated people - and they assume that if you talk about elective surgery, you're talking about facelifts or tummy tucks or breast enhancements, and no-one seems to understand that anything is classified as elective if you can survive for 24 hours without having it, which seems to be the current Queensland Health definition. So you have, for example, people having bowel resections that are described as elective which is in many people's view bizarre, that no-one would elect to have a bowel resection, anyone who has to have a bowel resection needs it as urgently as possible?-- I agree.

Is that a convenient time for the morning tea break?

MS KELLY: I only have two more questions.

COMMISSIONER: Okay, by all means.

MS KELLY: So that might be convenient if you could indulge me. Dr Aroney, you indicated that speaking out gives rise to an attack, and I wanted to ask you about the third round of cuts which you refer to in paragraph 39 of your statement. The Commissioner's just asked you or proposed to you that we all know what the problem is, that there's not enough money; is that your evidence about the third round of cuts, that it arises from a lack of money or is it something else?-- To me, the third round of cuts which were initiated in September of last year are absolutely and totally illogical, led to patients dying and the implication to the people at the

hospital where these cuts occurred was that this was occurring because, as a type of punishment against the hospital for my stance on speaking out about all the deaths on the waiting list, and this was held - the view was held by most of the members of the staff, and as I stated previously, there was indirect evidence to support this with statements in the media by prominent members of Queensland Health, stating that I was lying and allegations against us and that we were behaving inappropriately in doing too many cases, and that Ms Wallace made at that meeting that the staff members were not politically savvy. Now, my implication to that is that if we'd been good boys and not said anything, that we would have got better funding, but because we weren't, because we were speaking out about our patients dying, we were being actively punished by having these cuts thrust upon us.

Or indeed your patients were being punished?-- Absolutely. Our patients were being - and the Queensland public were being punished. That was our view, and if Queensland Health has another explanation for these cuts which is different to that, I'd be glad to hear it.

Dr Aroney, when you say it was the view of those in the hospital and that Ms Wallace indicated that this was a lack of political savvy, did anyone else in Queensland Health bureaucracy earlier that year indicate to you that there would be retribution?-- Well, my meeting with Dr Scott in January suggested that there may be retribution, and that's been well publicised against me personally. I wasn't particularly scared against of personal retribution, my main concern in September of last year was that this was damaging the public and that my continued outspokenness was causing further cuts to the hospital.

Can I ask you is that the conversation you refer to at paragraph 23 of your statement which paragraph traverses a couple of pages?-- Yes.

I'm referring in particular to page 21?-- Yes.

Where Mr - Dr Scott is reported as saying, "You come after us with more shots and we'll come after you."?-- That's exactly what he stated.

Yes. And further, in relation to paragraph 30 of your statement?-- Mmm-hmm.

Where Dr Buckland attended a meeting and referred to information being irrelevant and quote "Prince Charlesentric"?-- That's correct.

Is that the basis for your, in addition to that which Ms Wallace said to you, is that the basis for the inference drawn by the medical staff at the hospital that the third round of cuts were essentially an act of retribution?-- That was the feelings of the cardiology staff at that time.

Thank you, I have nothing further.

COMMISSIONER: Thank you. Mr Boddice, would I be right in guessing that you may need a little time to get instructions on some of the points?

MR BODDICE: On some of the points raised this morning I will, yes.

COMMISSIONER: Yes. Would it be more convenient to have a long morning tea break to allow that to happen?

MR BODDICE: It probably would, although I'm of course troubled about Dr Aroney's-----

COMMISSIONER: As we all are.

MR BODDICE: Perhaps, Commissioner, if we could ask for a normal morning tea break of 20 minutes?

COMMISSIONER: Yes.

MR BODDICE: And at that time I can indicate whether I'm likely to be in a position or could only go to a certain point today.

COMMISSIONER: All right then. Well, we'll come back at 11.

MR BODDICE: Thank you.

THE COMMISSION ADJOURNED AT 10.35 A.M.

THE COMMISSION RESUMED AT 11.11 A.M.

CONSTANTINE NICHOLAS ARONEY, CONTINUING:

COMMISSIONER: Thank you, ladies and gentlemen. Mr Boddice?

MR BODDICE: Commissioners, thank you for the time. Commissioners, there is no practical way that I can get instructions.

COMMISSIONER: Look, I understand that, and we're all distressed to inconvenience a man of Professor Aroney's stature and importance, but in fairness to others, you have to be given that opportunity to take instructions.

MR BODDICE: And to do so will make the cross-examination concise, more concise to have the full picture, and do it once rather than do it in bits.

COMMISSIONER: I am tempted to say, Mr Boddice, you are well-known for being concise in all respects. Mr Harper, were you planning to have any questions?

MR HARPER: We have no questions for Dr Aroney.

COMMISSIONER: I see the Bar table is otherwise bare. What do you suggest we do, Mr Andrews?

MR ANDREWS: Allow Dr Aroney to return to the hour or so's leisure he would have for the day before he starts work and I suggest that we do the same.

COMMISSIONER: Yes, all right. I do apologise most sincerely for this inconvenience, Professor. You will understand, however, that we do work under at least some rules and one of the rules is that people about whom you have said things, which might be thought to reflect on their credit or reputation, need to have an opportunity to instruct their lawyers to challenge your evidence if those are their instructions.

You have heard what Mr Boddice has to say, and I accept entirely that the situation is necessary, even if regrettable. So I do apologise for that inconvenience. Let me say again, as I said last time you were here, we will do our very best to reschedule you for the completion of your evidence at a time that suits your convenience, and if that means we have to sit in the evening or at odd hours, we will do so. I am afraid I can't do better than that. But thank you again for your time this morning?-- Thank you.

WITNESS STOOD DOWN

COMMISSIONER: Now, we have Dr Cleary returning this afternoon.

MR ANDREWS: 2.15.

MR BODDICE: And he will be available for 2.15.

COMMISSIONER: So there is nothing useful we can do with the time.

MR ANDREWS: There are things I can do with the time.

COMMISSIONER: But not in this room.

MR ANDREWS: Not in this room - that I hope will abbreviate future proceedings considerably.

COMMISSIONER: I appreciate that. Well, I apologise particularly to the public gallery and the media, who are here to see progress, and we don't have any progress to offer you for the rest of the morning, but we will adjourn now till 2.15.

THE COMMISSION ADJOURNED AT 11.15 A.M.

THE COMMISSION RESUMED AT 2.20 P.M.

COMMISSIONER: Ms Dalton, welcome back.

MS DALTON: I couldn't resist the temptation. Commissioner, I really just want to raise some housekeeping issues with you. Timetabling, really.

COMMISSIONER: Of course.

MS DALTON: And they arise in this way: Dr Scott was, of course, until 8.30 last night, nominally represented under the Queensland Health umbrella, and, of course, on the first day of the hearing you raised some fairly fundamental problems about the generality of that retainer.

COMMISSIONER: Which has now come home to roost.

MS DALTON: Well, while being under that umbrella, and while factual instructions as to matters arising in the course of evidence have been taken from him, and while someone has attended on him to take a statement, he has been given no advice, and until the 19th - Friday the 19th - last Friday - in the afternoon was the first time he was given advice, and that was that he may need to consider getting independent representation.

Now, on Monday the 22nd he was told that he did need to consider getting independent representation and, as I have already said, that came into fruition at about 8.30 last night.

The difficulty, from my point of view, is that to cross-examine Dr Aroney, and both the former Ministers, I will need some time to be on top of the written material. The difficulty with that, of course, is that while I can sit back in my chambers and efficiently read things, I am not here to hear their evidence-in-chief, so I get no feel for it, no feel of how it is being accepted by yourselves. All of those matters are a severe disadvantage - and I am not saying this in a blaming way, but it is a practical problem because-----

COMMISSIONER: Look, Ms Dalton, I appreciate that, and that's why I expressed my concern right back in the first week, anticipating the sort of difficulties you have mentioned, and also some of those raised, if not quite so elegantly or pleasantly by Mr Applegarth this morning. I had planned to make a statement, which I think - Mr Andrews, have you seen that in draft?

MR ANDREWS: I have, Commissioner, yes.

COMMISSIONER: And is it the sort of thing, if I can ask out aloud, that you would wish to discuss with me before it is taken any further?

MR ANDREWS: I couldn't improve upon it or suggest a way of improving it.

COMMISSIONER: Now you see why we get on so well. Ms Dalton, I will make this statement now which may go some way towards addressing your concerns. There will be printed copies available that you can go away and study as well.

MS DALTON: Yes.

COMMISSIONER: But, in fact, if Sir Llew is kind enough to lend me a spare copy, I will have one handed down to you at the Bar table so you know what is being said.

MS DALTON: Thank you very much.

COMMISSIONER: I will have more copies made. Perhaps Mr Stella might arrange upstairs for further copies to be produced so that everyone has one.

MR ANDREWS: I believe there are ample copies within the room now, Commissioner.

COMMISSIONER: Excellent, all right. Well, I will read it out in any event. Feel free to sit down.

The exchange which took place this morning between myself and Mr Applegarth SC representing Dr Buckland, suggests some confusion regarding the methodology and procedures which have been adopted by this Commission of Inquiry. This is understandable given that Mr Applegarth has not anticipated in these proceedings prior to this week and his client previously had different legal representation, and I might be proposed to say that that plainly applies to Dr Scott as well.

The purpose of this statement is to resolve any such confusion.

Under the Terms of Reference establishing this Commission of Inquiry, it may be stated that, broadly, the Commission is concerned with two categories of issues: the first, there are specific issues relating to the Bundaberg Base Hospital and Dr Jayant Patel, which, for convenience, we will call "the Bundaberg issues"; secondly, there are general issues relating to practices and procedures within Queensland Health - which for shorthand we call "the systemic issues".

In the case of Dr Buckland, some evidence has been received connecting him with the Bundaberg issues - for example, his involvement in a meeting with staff at the Bundaberg Base Hospital in April 2005 and what transpired at that meeting; and as another example the timing and circumstances in which he became aware of Dr Patel's disciplinary history in the United States, and what he did with that information when it came to his attention.

As regards the systemic issues, plainly the Commission cannot evaluate the sufficiency and appropriateness of practices and

procedures within Queensland Health without examining the operation of those practices and procedures in a wider context. Were it established merely that practices and procedures had broken down in connection with the Bundaberg Base Hospital and Patel, that would not necessarily reflect the sufficiency and appropriateness of practices and procedures within Queensland Health generally; nor would it necessarily afford any guidance to the Commission in making recommendations as to the reform of practices and procedures within Queensland Health generally.

Accordingly, when considering the systemic issues, the Commission has not confined its attention solely to Bundaberg. Evidence has been received regarding circumstances and incidents at other hospitals throughout the State, essentially for two purposes: first, to ascertain whether issues and problems identified at Bundaberg are unique to that hospital, or are the result of systemic factors which operate Statewide; and secondly, to examine the approaches adopted in other hospitals, to see whether they offer solutions to issues and problems identified at Bundaberg.

The object, in both cases, is to inform ourselves - as specifically provided in the Terms of Reference - whether "any necessary changes to the Queensland Health practices and procedures" are required, not merely with reference to Bundaberg Base Hospital but with reference to hospitals throughout the State.

The evidence in respect of systemic issues necessarily and naturally has tended to focus on particular incidents, events, people and places. But the Commission is not concerned to consider and resolve specific issues in relation to those particular incidents, events, people and places - the evidence is relevant, and relevant only, to the sufficiency and appropriateness of practices and procedures within Queensland Health generally.

Thus, for example, the Commission has received evidence concerning the "Berg matter" at Townsville. It is no part of this Commission's function to determine, as a separate issue, whether the "Berg matter" was well handled or badly handled or whether anyone is deserving of criticism over the handling of the "Berg matter". It has been explored, solely and specifically, because the "Berg matter" in Townsville provides a useful comparison with the "Patel matter" in Bundaberg demonstrating how an analogous situation was dealt with - both locally, by the hospital administration in Townsville, and departmentally, by Queensland Health's corporate office in Charlotte Street.

The "Berg matter" has formed a small but significant part of the evidence before this Commission, for the obvious reason that it provides the closest analogy - in another hospital, in another part of the State - with events which transpired at Bundaberg. Whilst (thankfully) the analogy is not a perfect one, we're not aware of another case anywhere in Queensland which provides a better analogy.

It is therefore relevant for us to consider the "Berg matter" offering - as it does - another example of possible ways in which a problem of this nature can be addressed and what systemic solutions are available or should be recommended.

Any criticism of the handling of the Berg matter - or, indeed, any other event or incident which occurred outside Bundaberg - has occurred in the context of our examination of whether or not Queensland Health practices and procedures, as adopted in that instance, were appropriate. To the extent that such criticism may reflect on any individual involved, including Dr Buckland, he will (of course) be given every opportunity to address any potential harm to his reputation, such as by: contending that the practices and procedures adopted on that occasion are generally appropriate; or establishing that there were particular reasons (which have not yet been revealed in evidence) why the adoption of such practices and procedures were appropriate in the particular circumstances of that case; or demonstrating that he was not personally responsible for the practices and procedures adopted on that occasion.

Yet, whilst Dr Buckland will be given that opportunity if he wishes to avail himself of it, he - and those representing him - should understand, very clearly, that our only interest in the "Berg matter", and in other incidents which did not involve Bundaberg Base Hospital or Patel, is with a view to examining the appropriateness of Queensland Health practices and procedures, as demonstrated on that occasion.

The exchange which took place this morning suggests that Mr Applegarth is under the impression that Dr Buckland may need to "defend himself" in relation to the "Berg matter". Whether or not Dr Buckland chooses to challenge the evidence which has been received in relation to the "Berg matter", or to adduce additional evidence in respect of that matter to answer the evidence already received, is entirely up to him. If he feels that his reputation has been harmed by the evidence received to date, or comments made in the course of evidence, he will have that opportunity. No doubt, when he gives evidence, he will be asked to place on the record his version of events. Naturally, we will keep an open mind until we have heard all of the evidence and any tentative views expressed in the course of evidence are subject to revision when the evidence is complete. But it would be a mistake to assume that Dr Buckland, or anyone else, is expected or required to "defend himself" in respect of the systemic issues.

Mr Applegarth's impression that Dr Buckland may need to "defend himself" suggests an apprehension that it may be within the expectation of this Commission either: to refer the matter to the Queensland Police Service with a view to instituting criminal prosecution; or to refer the matter to the Crime and Misconduct Commission; or to recommend disciplinary proceedings; or to make adverse findings regarding Dr Buckland's involvement in that matter.

So far as Dr Buckland is concerned, it is therefore appropriate to say that nothing which has yet emerged in the evidence could conceivably give rise to any such referral or recommendation, and, as presently advised, the Commission has absolutely no intention of making such a referral or recommendation in respect of Dr Buckland.

It should also be said that the same applies to other witnesses, such as Dr Scott, Professor Stable, Ms Edmond and Mr Nuttall.

The situation may change, as further evidence comes to light. And, in that event, the person concerned will be given formal and proper notice of any adverse allegations. That has not occurred in respect of any of the persons whom I have mentioned, and there is no present expectation that it is likely to occur. Indeed, the present expectation is strongly to the contrary.

Insofar as Mr Applegarth's remarks about Dr Buckland "defending himself" may involve an apprehension that the Commission may make adverse findings, let me state, as clearly as I can, that, in dealing with systemic issues, the only findings which I expect that we will make are findings about the system - about Queensland Health's practices and procedures - specifically, whether the system works well or badly, whether it can be improved, and if so how. If we feel the need to refer to specific incidents (such as the "Berg matter") to illustrate or justify our conclusions, it will only be to say that this is a case where the system broke down, or this is a case where the evidence supports a need to make improvements to the system.

Beyond that, there is no intention of making findings concerning incidents, events, people or places except in relation to the Bundaberg issues. Specifically, there is no intention to make any finding - either positive or negative - regarding Dr Buckland's responsibility in connection with systemic issues; nor, for that matter, the responsibility of other witnesses, such as Dr Scott, Professor Stable, Ms Edmond or Mr Nuttall.

Once again it is possible - although, I think, highly unlikely - that the situation may change, as further evidence comes to light. Again, in that event, the person concerned will be given formal and proper notice of any adverse allegations. But I again confirm that this has not yet occurred in respect of any of the persons whom I have mentioned, and there is no present expectation that it will occur. Indeed, as I have said, the present expectation is strongly to the contrary.

To avoid any further confusion, I have directed counsel assisting to write to the legal representatives for each of the persons whom I have mentioned - that is to say Dr Buckland, Dr Scott, Professor Stable, Ms Edmond and Mr Nuttall confirming the position outlined in this statement.

Ms Dalton, I don't know whether that answers all of your concerns but I hope it is of some assistance.

MS DALTON: It is of considerable assistance, Commissioner, and I will, of course, take instructions, and I don't want to delay matters longer than is necessary.

COMMISSIONER: Of course.

MS DALTON: There are some issues, though, that it doesn't answer. Yesterday afternoon, right at the end of the day during the timetabling discussion which took place, my learned friend Ms Kelly asked a clarification from you as to what you consider to be outside the definition - outside the definition of systemic issues.

COMMISSIONER: Yes.

MS DALTON: In response you said, "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 inter alia Dr Scott." Now, we've written today to Deputy Commissioner Andrews after if he could tell us what those issues are, if he is able to assist us with that, the non-systemic issues.

COMMISSIONER: Let me make it clear, my recollection - and, Mr Andrews, I might need your help on this - my recollection is that Dr Scott's name hasn't emerged at all in relation to Bundaberg. I made the point that Dr Buckland has been connected in one or two relatively minor ways with the Bundaberg issues.

MS DALTON: Yes.

COMMISSIONER: My recollection is that Dr Scott hasn't been connected at all with Bundaberg issues. I might be wrong about that but-----

MS DALTON: No, but insofar as your statement deals with systemic issues, this statement yesterday afternoon seemed to deal with non-systemic issues.

COMMISSIONER: Yes.

MS DALTON: And, of course, we're concerned to define those, I suppose.

COMMISSIONER: Well, leaving aside the Bundaberg issues for a moment, which I think don't affect Dr Scott-----

MR ANDREWS: I believe that there may be a report in respect of a particular patient that may have been referred to Dr Scott. In that remote way, he may still be connected with the Bundaberg issues, but it is-----

COMMISSIONER: It is a gossamer of thin connection.

MR ANDREWS: Yes.

COMMISSIONER: In any event, when we come to systemic issues, Ms Kelly gave the example yesterday of bullying.

MS DALTON: Yes.

COMMISSIONER: I think you will get the flavour from the statement that we're not going to find that a particular person bullied a particular person on another occasion. It is not that sort of exercise. We may conceivably arrive at the conclusion that systemic changes are needed to address the issue of bullying. The reason I mentioned Dr Scott in that connection was simply because - and I couldn't recall at the time, but if someone has given evidence accusing Dr Scott of bullying them-----

MS DALTON: Dr Aroney does, I think, in a rather colourful way.

COMMISSIONER: Yes - Dr Scott should and will have the opportunity, if he wishes, to challenge that evidence. That's not because we propose to make any findings about it - far from it - but because, out of fairness to Dr Scott, having had those things said about him in this public forum, we consider he should have the right to challenge that evidence if he wishes. We certainly don't require it. Indeed, if we could, we'd very much encourage him to let that one - to use a cricket expression - go through to the keeper.

MS DALTON: It is always risky to use sporty analogies when talking to me, I don't understand them, but I do understand that.

COMMISSIONER: Out of fairness to him, if he wishes to challenge that part of Professor Aroney's evidence, he will have the opportunity.

MS DALTON: But you see that as the same - as in the same category as the matters that are dealt with in this statement you have just read to us.

COMMISSIONER: Exactly. Unless it relates to Bundaberg or Patel, then its only relevance is systemic, and we have no intention of descending into the making of specific findings about who did what on what occasion; whether they were right or wrong. I mean, bullying is a perfect example of that. We could spend a week of evidence on every alleged incident of bullying. What is called bullying by some people could be efficient and proactive management in other people's minds.

MS DALTON: Yes.

COMMISSIONER: We can't possibly go through the process of examining every incident of alleged bullying and saying, "The alleged bullier was in the right to take the course he did", or "the alleged bullier was in the wrong", so we're not going to attempt to do that. But there is a body of evidence which

may lead us eventually to a conclusion along these lines: either there is a significant incident of bullying, or there is, at the very least, a significant perception amongst Queensland Health staff that there is bullying, and that at a systemic level those things need to be addressed, and I can assure you it will go no further than that.

MS DALTON: All right. Well, Commissioner, I need to consider that, obviously, and take instructions.

COMMISSIONER: Of course.

MS DALTON: But it does go a long way towards satisfying the concerns I have in respect of timetabling.

COMMISSIONER: Yes.

MS DALTON: Could I again seek leave to withdraw, but perhaps just flag that it may be that in relation to both the ex-Ministers, I need to seek leave to cross-examine them at a later time than when they give their evidence-in-chief, just because, as I understand it, they're coming later this week?

COMMISSIONER: Yes. And, Ms Dalton-----

MS DALTON: And I would like to be here to hear their evidence-in-chief. It is just a terrible compromise because at the same time I am not getting up to speed on the bulky paperwork that I have to look at, too.

COMMISSIONER: Ms Dalton, there is one other thing that I should draw to your attention in that context. I think we're all aware from media reports of an event which occurred at a Parliamentary Committee hearing involving Dr Scott and Mr Nuttall.

MS DALTON: Yes.

COMMISSIONER: I am of the view, subject to persuasion otherwise, that that's covered by the Bill of Rights of 1688 and what occurred in Parliament can't be questioned or impeached anywhere outside Parliament, and therefore those matters are simply not traversable in these proceedings. I would therefore expect that Mr Nuttall will not be asked about those matters and Dr Scott will not be asked about those matters, but if you wish to persuade me that those fall outside the scope of parliamentary privilege and should be explored, then I will-----

MS DALTON: I will have to look at that because it is obviously one issue where my client has been subject to a lot of public exposure.

COMMISSIONER: Yes.

MS DALTON: But there may, at the end of the day, not be a credit issue about that. Both gentlemen might agree upon the ultimate fact.

COMMISSIONER: Well, I guess Royal Commissioners are allowed to have regard to what appears in the newspaper, and my understanding is that Mr Nuttall subsequently conceded that he had received briefings. So I am not sure that there is an issue at all, but I am just making the point that if that's the sort of thing Mr Nuttall's concerned about, I would not expect we will be going down that path anyway.

MS DALTON: No, but the other issues I suppose I am concerned about in relation to the ex-Ministers are the things Dr Aroney raised in his evidence-in-chief that rather implied it was in my client's gift to be handing out money for this and money for that, so there were no constraints upon him, which, of course, is complete contrary-----

COMMISSIONER: Yes.

MS DALTON: He is concerned because they are substantial allegations as to his conflict.

COMMISSIONER: I understand his concern, and I guess the best test is that if those things had been said about me, I would feel very upset and I would wish to get the situation sorted out, but I think Dr Scott and, for that matter, Dr Buckland should understand that merely because something is said in the witness-box, doesn't mean that we accept the criticism involved in it. Indeed, whilst you were absent this morning during Professor Aroney's evidence, I made the point to him that he says he wants lots of money to have the world's best cardiac service but no doubt there are nephrologists who wants-----

MS DALTON: Everybody would like some money.

COMMISSIONER: Yes, and the real problem is there is not enough money to go around, and Professor Aroney very properly conceded that is the case. He is passionate about cardiac care and it is great to see a specialist who is passionate about his field, but that doesn't justify any adverse finding or any criticism of those who are given by the Parliament a limited budget and need to make the most of that. So I think that's as far as we can take it. You have leave to come and go as you feel-----

MS DALTON: Thank you, Commissioner. The other thing, as I understand, looking at the transcript from yesterday afternoon, my client won't be required before Friday, is that-----

COMMISSIONER: He certainly won't be required before Friday and I understand there are some discussions as to - I've been told that your client was actually quite anxious to give his evidence.

MS DALTON: He is anxious to have it over but-----

COMMISSIONER: Yes.

MS DALTON: I think what he said was he had no - no idea of what the process of briefing independent lawyers would involve and how long that would take.

COMMISSIONER: Yes. Well, in any event, if it's feasible for him to give evidence on Friday, we will have time available for him. If your advice is that further time is needed to - particularly in light of this afternoon's statement, then of course we won't force him on.

MS DALTON: I can assure you, Commissioner, we are working as hard as we can and with a view to having it done as efficiently as possible but with the overriding concern, of course, that he needs every proper advantage.

COMMISSIONER: Ms Dalton, I'm well aware of the fact you work about 18 hours a day as it is. I wouldn't want you to take that any further.

MS DALTON: Thank you. I won't correct that misapprehension of fact, Commissioner. I seek leave to withdraw.

COMMISSIONER: Thank you, Ms Dalton, and you're free to come and go as you see fit.

MR ANDREWS: Before Ms Dalton leaves, there is a matter that will be of interest to her client. It's anticipated that Ms Edmond will give evidence this week. It had been anticipated that Mr Nuttall will also but it seems now that he - Mr Nuttall will be rescheduled to give evidence in the week commencing Monday the 5th of September.

COMMISSIONER: I heard something about this. Apparently parliament is sitting this week and that makes it almost impossible for Mr Nuttall to-----

MR ANDREWS: And I hope that that allows my friend to focus her attention on whether - on instructions she needs to take with respect to the cross-examination of Ms Edmond with the ambition that that might take place this week.

COMMISSIONER: Thank you.

MS DALTON: I'm grateful for Mr Andrews' assistance.

COMMISSIONER: Thank you. Anything further before the evidence resumes?

MR ANDREWS: No, Commissioner.

COMMISSIONER: Dr Cleary, I wonder if we can ask you to return to the witness box. I should formerly remind you that you remain under oath although I'm sure it is unnecessary to tell you that.

MICHAEL IAN CLEARY, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Had you concluded yesterday?

MR ANDREWS: Commissioner, there had been no questions asked in respect of the third of Dr Cleary's statement.

COMMISSIONER: Oh, of course, yes.

MR ANDREWS: I propose to ask in respect of only two matters and leave the balance to Ms Kelly, for that statement concerns primarily Dr Aroney. Dr Cleary, at paragraph 19 you observe that the Prince Charles Hospital was allocated elective surgery funding during the late 1990s. You say that the funding was negotiated at a marginal cost as the cost weights in the earlier casemix funding models in Queensland did not accurately reflect the real cost of cardiac surgery. Would you explain what that means?-- Yes. If you're looking at costing a particular procedure, for example a patient may come into a hospital, have open heart surgery and have coronary artery bypass procedures undertaken and perhaps even have a heart valve replaced with a new heart valve, then there were systems in place to try and cost that procedure-----

The concept of weighted separations has been well explained. Is that an example of weighted separations?-- Not quite, but it is used within that context. There are different costs used and the systems that were in place at that time were fairly limited in their ability to track costs and I guess in, summary, the costs which are at margin cost rates mean that you would get paid for what it would cost you to do one extra operation a year for example, but you don't get paid the infrastructure cost that you need to have in place to do those sorts of procedures. To do one extra operation, you might need the cost of the operating theatre's time, the surgeon's time, the valve and so on but you don't really need a great deal of additional infrastructure, for example additional beds in the hospital or catering infrastructure. So that funding at the marginal rate is significant - well, is less than the actual full cost of doing the procedure because it's - it's just at the cost of doing one extra procedure. The difficulty that was experienced at that time was because of the limited - because of the poor costing systems that we had in place, the costs of doing a procedure were under - were lower than - sorry, I'll start again. The money that you were paid for doing the procedure was less than the cost of actually doing the procedure. So that you would do extra activity but often you would not be paid the actual cost of doing that

extra activity.

And at paragraph 20, where you say that one of the cost pressures resulted from marginal cost funding of elective surgery, is that a pressure which arises from that very problem you've identified, that for doing extra elective surgery you were funded for only some of the extra costs?-- That's correct, yes.

I have no further questions for Dr Cleary.

COMMISSIONER: Now, Dr Cleary, I think, Mr Fitzpatrick.

MR FITZPATRICK: Yes, thank you, Commissioner. I should have sought leave to appear for Dr Cleary.

COMMISSIONER: I suspect you did yesterday but, in any event, such leave is granted.

MR FITZPATRICK: Thank you, Commissioner. Commissioner, would it be more efficient if Ms Kelly went now?

COMMISSIONER: Well, there would be an obvious attraction to that in the sense that she will identify those matters which Dr Aroney regards as contentious and then you can re-examine at the end if that suits you.

MR FITZPATRICK: It does, thank you, Commissioner, if that's suitable to other parties at the Bar table.

COMMISSIONER: Ms Kelly.

CROSS-EXAMINATION:

MS KELLY: Dr Cleary, you're identified in Dr Aroney's statement in a number of respects, some of which are not exactly complimentary to you; is that a fair comment?-- My response would be that Dr Aroney has - has made certain comments based on the information that he would have had to hand and I wouldn't presume to comment on those matters in the terms that you used them.

Sorry, you wouldn't presume to comment on those matters in the terms that he used?-- No, the terms that you used.

All right. Would you describe how you consider Dr Aroney's statement reflects upon you?

COMMISSIONER: I don't see how that's helpful to us. I really prefer that we focus on the details rather than how different people categorise different statements.

MS KELLY: Yes, Commissioner. Yesterday in evidence at page 4774 of the transcript, and in your statement, you

referred to Dr Aroney as having been on leave for two years. I suggest to you that you were in error in that respect. Paragraph 16 of your statement is the relevant reference?-- Could I just clarify. I don't believe I gave evidence to that matter yesterday. My statement was-----

Well, I can take you to the reference, Dr Cleary. It's at page-----

COMMISSIONER: No, let's just hear the answer, please?-- I don't believe we discussed Dr Aroney yesterday at all but I understand that my statement was put into evidence and perhaps that's where that-----

Well, let's not worry about that. It says in your statement, paragraph 16, that Dr Aroney was on leave for two years prior to his resignation and it's being suggested to you that that is erroneous?-- My contention there was that Dr Aroney has been on leave for a significant period of the current calendar year, being 2005, and for an extensive period during last calendar year, being 2004. The specific dates of his continuous leave I think would have been for a period of 12 months from - going back from the date that he put in his resignation, but prior to that he was on leave at conferences at - undertaking study leave and, of course, annual leave. In terms of absolute continuity during that period, I wasn't implying that he was on leave for two years but that over the last two years he's been using a great deal of his leave so that - which was available to him, and that he wasn't at work as much as perhaps some of the other clinicians who had not taken that extensive period of leave.

Dr Cleary, you're literally correct. You didn't imply he was on leave for two years. You said in emphatic terms in paragraph 16 of your statement, "I note that Dr Aroney was on leave for two years prior to his resignation." You accept now that's untrue, do you?-- Yes, I do.

Thank you.

MS KELLY: Thank you. Paragraph 35 of your statement, and when I refer to your statement, unless I specify, I'm referring to Exhibit 301C, and that is the provision of cardiology services in Queensland statement. Paragraph 35 of that statement, you made reference to information for advice - I'm sorry, advice from Queensland Health that Princess Alexandra had a waiting list consisting of zero category 1 patients and two category 2 patients?-- Yes.

Have you turned to that?-- Yes.

Now, you don't refer in that evidence to the category 3 patients which were currently - who were currently waiting for treatment at Princess Alexandra Hospital, do you?-- No.

And why was that?-- If I can refer you to attachment or - yes, attachment MIC12.

Yes?-- That's a - that's a letter - sorry, a memorandum from the Director-General-----

Yes?-- -----Dr Steve Buckland.

Yes?-- At the bottom of page 1 Dr Buckland outlines conversations that he has had, which if I could read from that, "As part of my consideration of these issues I have consulted with the District Manager, Princess Alexandra Hospital, Dr J Young, Executive Director of Medical Services Princess Alexandra Hospital and Dr Paul Garrahy." Dr Paul Garrahy is the Director of Cardiology at the PA Hospital. "The waiting list for the Princess Alexandra Hospital angiography reveals the no category 1 patients and only two category 2 patients waiting. On the other hand Prince Charles Hospital angiography waiting lists reveals 229 category 1 patients and 78 category 2 patients waiting. Executive management at the Princess Alexandra Hospital advise that they have immediate capacity to address the patients on the Prince Charles Hospital angiography waiting list." The reason I referred to that is that reflects a conversation that I had with I believe Dr John Scott about that time and those - those - that information on the PA waiting list was provided to me in that conversation. I do not have from - from my hospital access to any other hospital's waiting list, so apart from the information that's provided to me by the other hospitals or by Queensland Health corporately, I couldn't comment on the category 3 waiting list numbers and that wouldn't have been provided to me at the time. Category 3, of course, are the non-urgent patients and at this time there was a significant disparity in the number of long-wait category 1 patients which are urgent patients between the two hospitals and the Director of Cardiology and the Medical Superintendent had indicated that they could immediately take on some of that work from the Prince Charles Hospital. I could also say that subsequent to this memorandum, there is an e-mail that I have sent Mr Dan Bergin and I will just locate that.

Perhaps if I can just bring you back, Dr Cleary, before you go ahead to that?-- Yes.

The memorandum from you to your program medical director, your program nursing director and program business manager, all of the cardiology program, which is CA3, that is attachment 3 to Dr Aroney's statement, predates the memorandum from the Director-General, MIC12, by some two weeks. Now, I am supposing that you were provided independently of MIC12 the information to which you refer; is that correct?-- That's correct.

All right?-- And I think the-----

Now, what person provided you with that information?-- I didn't read the complete memorandum but up higher in that memorandum on page 2, the Acting General Manager Health Services John Scott indicates that he met with - with people and that at that stage they discussed the situation, I think the - the date that is printed there is the date that was

available at that time. Certainly there was a conversation between - I believe it was Dr John Scott, I may be in error, I have no record of who the conversation was with, but certainly there was a conversation which - which was with a senior person within Queensland Health indicating that they were very concerned about the length of the category 1 waiting list at the Prince Charles Hospital as opposed to the PA Hospital and there was a clear opportunity for us to take up - for us to refer patients across to the PA Hospital for care.

COMMISSIONER: Doctor, can you explain to me, I got the impression this morning from Dr Aroney's evidence, and I might be mistaken about this, that someone who needs angiography normally needs it pretty quickly. It is not something which you expect to have category 3 patients for in your group; is that right?-- My understanding is that there are various - sorry, there are various groups of patients. Some patients do, as you say, Commissioner, require it urgently. There are also a group of patients who may be scheduled for angiography as a prelude to an operation which has been planned well in advance. And so, there are - there are certainly cases where - where patients would have their angiography scheduled in advance to quite some - sorry, quite some way in advance.

It is just that in paragraph 41 of your statement you tell us that QH has a standardised process for categorising patients, that Prince Charles uses those categories. You assume, as for the moment I'd accept you're entitled to assume, that PAH also uses Queensland Health categories. However, on or about January 2005 you became aware that PAH had been using a different categorisation process in cardiology. Does that mean that people who were regarded on the north side of Brisbane as needing treatment within 30 days were regarded on the south side of Brisbane as being unable - I'm sorry, being able to wait indefinitely?-- Perhaps I could clarify the - that. In about November of the prior year, which I - which would be 2004, there was a workshop involving all of the cardiologists in Brisbane and I wasn't able to be present at that. I was on annual leave. When I returned from leave, there had been an extensive discussion around how the different hospitals were categorising patients and that's when I became aware of the difference. My general recollection is that the Director of Cardiology used category 1 as patients who need an angiography within a couple of days, whereas at the Prince Charles and other hospitals, category 1 was needing a procedure within 30 days. Category 2 was someone who needed angiography within perhaps two weeks and category 3 was patients who need angiography within approximately four weeks, or perhaps longer. So the difference was in how they - what criteria were used to put patients into those - those categories.

Is what you're telling us then that Dr Buckland's memorandum to you produces an entirely incorrect impression of the situation because he's simply not comparing like with like when he says that - if I can find it again.

MS KELLY: MIC12.

COMMISSIONER: When he says that there are 229 category 1 patients at Prince Charles and zero at PA, that that bears no relation to the fact that PA Hospital had a significant number of patients who might well have been categorised as category 1 if they were - lived on the north side of Brisbane?-- That's entirely correct, Commissioner. The classification system resulted in the data that was provided being incorrectly interpreted.

So, what you would ask us to accept then is that Dr Buckland didn't know this, executive management at the PAH didn't know this, executive management at the Prince Charles Hospital didn't know this, District Manager at the PAH, the executive director at the PAH, Dr Garrahy at the PAH, none of these people knew that different systems were being used at the two hospitals?-- I can't comment on other people's knowledge, Commissioner, but, certainly, I wasn't aware of it. I don't believe that the staff at the Prince Charles Hospital were aware of it and, again, we tend to use the standard classification system across the state. I do note that there was a newspaper article around this time that Dr Buckland was quoted in where he made comments about the two different - the differences in the waiting lists at the two sites but I can't recall the content of that at this present time.

MS KELLY: And, in fact, Dr Cleary, you were advised repeatedly during 2003 and 2004 by the cardiology staff at Prince Charles Hospital that the Princess Alexandra figures were wrong. That's right, isn't it?-- No, I don't believe that is correct. I was advised - I should firstly say that the categorisation of patients is something that's at the discretion of the clinicians. The clinicians involved in treating and caring for the patients determine what categories patients go into. It seems-----

COMMISSIONER: But, Dr Cleary, at the moment it seems you were asked about things that you were told by the cardiac staff at the Prince Charles. Do you deny that you had such conversations?-- Yes, the conversations did occur but they were more in terms of, "We don't understand how the PA Hospital staff categorise their patients." Some patients who we would regard as requiring treatment, for example, AIC, the implantable defibrillators, who we thought needed treatment, when they were assessed by the staff at the Princess Alexandra Hospital, they were deemed not to require treatment. So there was a difference in, perhaps, clinical practice. PA on some occasions took into account matters that we didn't. As I understand it, our clinicians didn't take into account such as they put a higher emphasis on patients not smoking before they got on to the waiting list whereas at Prince Charles, that emphasis on preventing smoking before you get your surgery or your intervention wasn't - wasn't as high.

But, Doctor, I must say, I have some difficulty in following all of this. If I was told that there was this dramatic difference in the numbers on the waiting lists on one side of

the river as compared with the other and I was told by my cardiac staff that they couldn't understand how the categorisation was being done at the PA, if I were in your position, I'd want to know what was going on. I wouldn't just assume that it must be the same methodology being used at both hospitals?-- Indeed, I did make inquiries. We had regular meetings during this period with the staff from the PA Hospital and I did make inquiries at that time as to why there were the differences in the waiting lists. My explanation or the explanation provided to me at the time was it was - it was, again, the prioritisation process, that they considered these patients to be of a lower priority and therefore they were in category 3 whereas staff at Prince Charles considered those patients to be in a high priority and they were in category 2 or category 1.

Doctor, whatever the explanation, it came to your attention that things were done differently at the PA Hospital. That's right, isn't it?-- Yes.

And, therefore, you knew from the moment you got Dr Buckland's memorandum that the statistics he was providing to you were misleading because they suggested that PA had a - a greater capacity to deal with cardiac patients than the Prince Charles, which you knew just wasn't justified by those statistics?-- If I could just clarify my - clarify my understanding. My understanding was there was a different approach taken. In terms of the specifics of that approach and whether the waiting times were different, that certainly wasn't my perception. My understanding is that the clinicians at the PA regarded - for example, would regard someone who was still smoking and had other medical problems as being a category 3 patient and therefore should wait for 90 days or thereabouts whereas at Prince Charles, the clinicians would say, "Well, that's someone who should be in category 1 and should wait 30 days."

Exactly. So different systems were in use at the hospitals; therefore, it was utterly misleading to say, "Look, what a great job PA is doing. They have got zero category 1 whereas you have got 229 category 1 at Prince Charles." I mean, it's just a misuse of statistics, isn't it? It's not comparing oranges with oranges?-- Commissioner, I would agree, and at the time I raised my concerns - or earlier than this I raised my concerns. I wasn't able to find out why there was a difference apart from the approach that the clinicians took and that someone thought one patient could wait 30 days and another patient could wait 60 days or 90 days. It was only in January that after I'd had a conversation with the director of the unit there where he explained in some detail as to the classification that was used and I was - I was - I was surprised at that because my interpretation until that time had just been that category 1, 2 and 3 were still the 30, 90 and more than 90 day categories as used everywhere else in the state but just that the clinicians had a different approach as to how you classify people into those groups.

MS KELLY: So if, indeed, the Commissioners accepted the

evidence from Dr Aroney that advice had been provided to you at a long time prior-----

MR FITZPATRICK: Well-----

COMMISSIONER: Ms Kelly, I think you've made your point.

MR FITZPATRICK: Thank you, Commissioner. And can I just say, Commissioner, I haven't interrupted, perhaps I should have, but I can't find that evidence anywhere in Dr Aroney's statement that my client was specifically advised that the waiting lists at the Princess Alexandra Hospital were falsified.

COMMISSIONER: Look, for the reasons I raised earlier, Ms Kelly, I'm frankly not interested in looking for someone to blame. What has been explained to us by Dr Cleary is this utterly bizarre situation where different categories are being used at the state's two major cardiac hospitals. You know, if that's not a systemic problem, then I don't know what is. What you and Dr Aroney have usefully identified for us is a problem that needs to be addressed. I don't think it's particularly productive to say it's Dr Cleary's fault or Dr Buckland's fault or anyone else. It happened now. Now, let's move on and it seems to me perfectly apparent that one of the recommendations we are going to have to put in bold print and double underline is that these statistics at each hospital throughout the state could be maintained on the same consistent basis.

D COMMISSIONER EDWARDS: Consistent.

COMMISSIONER: That's the real point, isn't it?

MS KELLY: Well, there are more points than that, with respect, Commissioner.

COMMISSIONER: Well, perhaps you can follow those up after the afternoon break. We will be back at 3.30.

THE COMMISSION ADJOURNED AT 3.13 P.M.

THE COMMISSION RESUMED AT 3.37 P.M.

MICHAEL IAN CLEARY, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Yes, Ms Kelly.

MS KELLY: Commissioner, arising out of the difference in categorisation of patients from Princess Alexandra and Prince Charles Hospitals, there is an issue which you yourself raised yesterday and that is of the desktop surgery.

COMMISSIONER: Yes.

MS KELLY: At page 4778 to 9 of yesterday's transcript you asked that.

COMMISSIONER: I can remember my question.

MS KELLY: Yes.

COMMISSIONER: Where are you taking us with this?

MS KELLY: In response to your follow-up question as to whether patients had the - who were re-categorised had the further disadvantage of going to the bottom of the list, Dr Cleary answered that he was aware from his understanding that this occurred when a patient was transferred from one hospital to another.

COMMISSIONER: Yes.

MS KELLY: My question to Dr Cleary will be was it the case that patients who were category 1 patients according to the Prince Charles Hospital categorisation being transferred to Princess Alexandra were re-categorised as patient 3 - category 3 patients.

COMMISSIONER: Do you know that doctor?-- I can answer that question, Commissioner.

Yes?-- The answer is no. The process that we set in train was for one of, in relation to this specific issue that we were discussing before the break was generally a cardiologist from the PA Hospital would travel across to Prince Charles, review the Prince Charles medical records for patients that were on our waiting list and who were going to be treated at the PA, they would then ring the patient, and we thought that was a very good idea because it would be a way of reassuring the patient that an experienced cardiologist from the PA Hospital was ringing them and there was the general conversation with the patient about how they could offer that particular patient an angiogram sooner than the Prince Charles Hospital and could - and would they be interested in taking that opportunity. They then gave them a specific date for

their procedure.

But there was no downgrading of categories?-- No, these were all, all of the patients that were transferred were considered to be high priority and were transferred across in the category they were in, unless, for some clinical reason that category was changed such as they became ill.

Yes. And one would expect that would usually be an upgrading?-- Yes.

MS KELLY: Accompanying the transfer of patients and perhaps critical to it was a transfer of resources from Prince Charles to Princess Alexandra; that's right, isn't it?-- Not in this case, no. In this particular situation, again referring to that memorandum in that time, around January when that memorandum was sent, there was no transfer of resources from the Prince Charles Hospital to the PA Hospital. However, I understand that the Director-General made available additional resources to the Princess Alexandra Hospital to allow them to do somewhere between 10 and 20 additional angiography procedures per week. It did take the Prince Alexandra Hospital a period of time to - I'll use a loose term - ramp up, clearly they needed to bring on staff and additional resources and be able to rearrange their schedule to allow that to occur, and from my recollection it took a few weeks for that to occur, the first week after the - the particular support that the PA Hospital was providing at Prince Charles it took a few weeks for that to occur. My recollection is that there were seven or eight cases that went across in the first week and the numbers increased thereafter until such time as the category 1 waiting list at the Prince Charles was considered to be under control, and at that stage the transfer of further cases was stopped. There was also a very extensive discussion between the clinicians and the medical superintendents from the two hospitals about how to make this work in a very sensible and rational manner. Clearly we didn't want to move people who'd already been booked who'd already made arrangements for their procedure, so we tended to identify patients who hadn't been booked and we also - and I think it's attached in my - to my statement - had organised a process whereby we'd prioritised patients who would be considered for transfer once those higher priority patients were moved, then we moved to the lesser priority patients and so on. Some of that was done on the basis of geographic location of the patients, for example, category 1 patients who were living close to PA would be referred to PA before category 1 patients living close to Prince Charles, for example.

Thank you. Dr Cleary, it's the case, is it not, that the original impetus to transfer to Princess Alexandra Hospital was that was a submission made by that hospital to Queensland Health management in February 2002 which was represented and ultimately successful in February of 2003; is that right?-- Could I just clarify we're actually now moving on to a different issue?

Yes?-- Because that's a completely separate issue to the one that we've been discussing until now.

Yes?-- And so the transfer of cardiac services is covered in separate paragraphs in my statement.

Yes, all right, well do you want me to take you to those paragraphs for clarity?

COMMISSIONER: No, there's no need for that. Can you repeat the question please?

MS KELLY: It's the case, isn't it, that the original transfer of patients from Prince Charles Hospital to Princess Alexandra Hospital was - arose out of a submission made by Princess Alexandra Hospital to Queensland Health in February 2002 which was represented in February 2003 when it was ultimately successful; paragraph 21 of your statement?-- Thank you. That's my understanding, and I have attached a copy of that submission or properly called a business case to my statement.

Yes, all right. Can you turn to MIC3, that is, attachment 3, wherein you set out the Terms of Reference to that cardiac surgery services working party; that's right, isn't it?-- Yes, that's the cardiac services - cardiac surgery services working party that was established by Queensland Health corporately and I was a member of that group as you can see in the membership.

Yes. And at the fifth dot point under the heading "Role", the intention was, "To transfer resources and increase activity at PA from 1 January 2004"; that's right, isn't it?-- Yes, that's true.

Yes. And during the course of 2003 then, that working party first obtained from each of the hospital services the documents attached as MIC4 which was each hospital's assessment of the impact of the transfer?-- Yes, that would be correct.

All right. Now, you say that there were disparities at paragraph 27 between the two reports. Without, obviously I'm not assuming and won't suggest to you that you should have an intimate knowledge of the detail of each of those submissions, but are you able to recall in either submission whether there is a - on identification of the difficulty of transferring patients of separate categorisations between the hospitals?-- No, I don't believe that's considered that - the difference between the two submissions essentially came down to the amount of funding that would be transferred. The Princess Alexandra Hospital were seeking funding to build up a unit. The model of care they used at the Princess Alexandra Hospital was a more expensive type of model of care, for example, they used doctors to run their by-pass machines and so the costs at the PA Hospital were higher than treating the equivalent patient at the Prince Charles hospital. Some of that was because of the size of the Prince Charles Hospital and the efficiency gains you have with a larger organisation. In

terms of the principles, the principles that were being applied were to transfer those patients that lived in the southern zone, that is, people that live south of the Brisbane River and west to the care of the PA Hospital, categorisation wouldn't have been something that was considered at - in that context because you're looking at the actual patients who live in that drainage area obtaining their care closer to home at the PA Hospital and they would have been patients who were category 1 through to category 3. The two directors of cardiac surgery, when this process was being organised, had discussions and worked out what was a clinically appropriate mechanism for that transfer to occur. Some patients who clearly had a long history with the Prince Charles Hospital remained under our care whereas new patients who came into the system and who hadn't been seen before would generally be referred to the PA Hospital because that way their entire care could be provided for at that hospital. The group I'd have to say, given that there wasn't a universal support for this arrangement, worked very hard to make it, make it work and the clinicians in particular made sure that the patient care was optimised during the process.

Dr Cleary, further to that point, wasn't it the advice that you received at that time that the direct result of the interhospital transfers would be an increase in the need to perform procedures of 188 procedures per annum?-- I don't recall that specific advice, but my understanding is that we were transferring patients who were currently being treated at one hospital to another hospital and that there was an equivalent volume of work being undertaken across the State in terms of that transfer. If I could just refer-----

Can I ask you - sorry?-- ----- to - forgive me for my slowness - there is a, there is a table underneath paragraph 101 in my statement which identifies for that financial year, 2003/4 verses 2004/5, bearing in mind that the transfer occurred for intents and purpose in the middle of that period to 2003/4 was prior to the transfer, 2004/5, was after the transfer, and the change you will see there is that that last column is an indication of across the hospitals what additional work was undertaken on top of the work that had been done if you included the transfer. So if we just transferred 300 cases of cardiac surgery to PA, we would have expected we would be doing 1,890 cases. In actual fact, the following year we did 2,160 cases, so between the two hospitals, we did an additional 270 cardiac surgical procedures the following year. So I guess in terms of the population of Queensland, yes, there was a transfer, yes, I would agree, and you haven't asked me the question but yes, I would have to say that there wasn't universal support for that transfer, but for the population of Queensland for the end of that financial year, 2005, we performed in Queensland an extra roughly 300 cardiac operations.

Dr Cleary, if I can ask you to refer to attachment CA4 to Dr Col Aroney's statement; do you have that in front of you?-- No, I'm afraid I don't.

I'll hand that to you. If this could go on the monitor please? If you could scroll down to the second last paragraph please? Now, commencing with the words, "Based on the current demand"; do you see those words, Dr Cleary?-- Yes, yes.

All right. Now, just to inform you, this is a part of a submission which was prepared by Dr Galbraith, Tony Shields and Haley Middleton from Prince Charles Hospital cleared by John Robert, Cheryl Burns and you submitted through Dan Bergin, the central zone manager to Dr John Scott, and the date of it is 24 November 2003; all right?-- Yes.

The subject of it is "Emergency and Unplanned Activity Demand for Patients Presenting with Acute Coronary Syndrome and Existing Resource Availability for Treatment." So this postdates what Dr Aroney refers to as the first round of cuts which occurred in 2003; all right? Now, this then is a memorandum cleared through you, and I want you to read the second last paragraph, not aloud, of course. What does that paragraph mean?-- Well, from time to time, we would highlight things - and I think this needs to be seen in the context of the entire submission and the workings within Queensland Health - from time to time when we identify issues of concern, we would put together a briefing paper outlining those concerns and forward that into corporate office for their consideration. We do do from time to time model what our predicted demands might be and this was done in November 2003, I believe, that's correct, isn't it?

Yes?-- So that would be - and we prepare these submissions and then seek additional funding for the work that we believe we may need to do. During this period, and I guess this is one part of a jigsaw puzzle and that's why it's very difficult to interpret because often these submissions are forwarded seeking additional funding and the funding then becomes available and that's the context in which this was written. In terms of the overall budget change for 2003/4 and 2004/5, that's again outlined in my statement under paragraph 99. The reason I mention that is that throughout the year we seek additional funding, we seek approval for additional activity and these documents, the one you've alluded to, are put forward as documentary evidence to explain why we need the additional funding and what our potential demands are. Again, we've - we would generally receive additional funding on submission of those types of data.

But Dr Cleary, does it not mean that the transfer being proposed at this time in November 2003 would result in the need to perform an additional 188 procedures per annum plus a further 38 procedures per annum to address the long wait elective cases - long wait elective case; is that not what it says and does it not mean what it seems to say?-- Well, again, if I could take you back to my statement and underneath paragraph 101, during that transition period across the three hospitals, so PA, Royal Brisbane and Prince Charles, at the end of that financial year, we did an extra 147 angiography procedures and 385 additional angioplasty and stenting procedures. So within the context of the transfer, there

would have been difficulties, but across all of the hospitals in Brisbane - and I should say Townsville as well - we in Queensland did additional procedures in that coming financial year of the order of 550 - 540 cases. So yes, there is the - yes, there is the demand, that demand may have been being experienced at the Prince Charles Hospital but with the additional funding that was provided to all of the hospitals that financial year, we were able to do across the State an extra, as I said, roughly 450 cases. All those cases don't necessarily need to be done at Prince Charles if resources are made available to other hospitals. My recollection of the timing of the additional funding is a little bit hazy, but around this time PA was certainly provided with the additional funds that I mentioned earlier to do additional procedures and Royal Brisbane was also provided with funding to undertake an additional 10 procedures per week as well. It was later in the year, but again, I think seeing Prince Charles in isolation is probably not a true reflection of the capacity of Queensland Health as an organisation to respond to the needs of patients with cardiac disease in the community.

Pardon me, Dr Cleary, for persisting with this, but what I understand to arise from that document is that the transfer system was going to create in itself a need for an extra 188 further procedures; is that not right?-- Look, I would have to read the entire document again to see the context in which this was written, and that probably isn't an appropriate use of time because I recall it's probably six or eight pages, but I can only go back and say across the system there are pressures, there are pressures all the time in health, we - we are continuously lobbying is probably the wrong word but continuously seeking additional support for clinical services and this is one of the many documents that would go forward almost on a monthly basis seeking that sort of support. I also understand that Prince Charles isn't the only hospital that can do these procedures, and if Queensland Health corporately sees the benefit in providing more sustainable services in the Royal Brisbane Hospital or in the PA Hospital to support the community within Queensland, I mean, I would have to support that.

But doctor-----?-- I can't say that providing additional funds to PA or Royal Brisbane for cardiac services is not a good idea.

But Dr Cleary, you've already told us that Prince Charles can provide the cheapest service and you've told us that the need, the transfer created in itself the need for more services, so how was it to be to the benefit of the public of Queensland to initiate a transfer system which resulted in the need for more service and more expensive service?

MR FITZPATRICK: Well, Commissioners, as I understand Dr Cleary's evidence, he's not suggested that he was responsible for initiating this proposal for a transfer.

COMMISSIONER: I'm sure you right, Mr Fitzpatrick, but I have the impression that Dr Cleary's quite capable of answering the

question for himself and Dr Cleary, that's so, isn't it, what Mr Fitzpatrick just said?-- I'd be very happy to answer, yes.

Yes?-- My personal view, I personally found it difficult to support the transfer. My personal view, and I did make representation at the time, was that one - this was one approach to making the PA Hospital more sustainable, and I should probably talk about a very critical issue which is sustainability of the service at the PA Hospital, and I'd like to come back to that if I may, but the first issue is that my personal belief was that it would have been easier for growth funds in cardiology and cardiac surgery to have gone to the PA Hospital and for the Prince Charles Hospital's resources to remain unaffected, because what actually happened was there was a service transfer to the PA Hospital, there was a funding transfer to the PA Hospital. Within probably three months of that actual transfer occurring, additional funds flowed back from Queensland Health corporately into the Prince Charles Hospital which allowed us to expand our services, and again, if you look at those tables around paragraph 99, you can see that over this time, our cardiology budget has actually gone up, it's gone up from $25 million to $30 million which is a fairly large growth over a three year period.

Our activity - we are putting in 102 more implantable defibrillators, we're putting in - we had 1,300 more admissions to the hospital, so, yes, this transfer occurred. As I said, I would personally believe that growth funds could have gone to the Princess Alexandra Hospital and that we could have been left unaffected and not had to change our level of service and go through this process, but the overall effect of this is that there has been more service to the population of Queensland, better access to the community. One other thing I thought I would very briefly, Commissioner, if it is okay, go back to is the reason for this transfer wasn't - wasn't because of - even though I don't necessarily think it was universally supported, it was done because of the sustainability of the service at the PA Hospital. They had a service that was significantly smaller than the one at Prince Charles. The Director of Surgery there and some of the surgeons found it difficult to arrange cover, the commitment to being on call to the callbacks that occur, the cardiology service, and the demands there meant that sustainability of that service was certainly something that the doctors at the Princess Alexandra Hospital were worried about, and they raised that with Queensland Health corporately. So the reason for the transfer was to make sure that the PA Hospital had a sustainable and robust cardiac service. In terms of the numbers, I think the PA Hospital has gone from doing roughly 400 cardiac surgical procedures a year, to now something in the order of 900, and Prince Charles is still doing approximately 1,450 cases a year. So, again, the difference in size between the two hospitals is still significant and we have the capacity to be more efficient because of our size. I think the PA Hospital, as it's grown, has also become more efficient, and I would think that if there was any further growth there, which there undoubtedly will be, they will be able to do that with a lower cost than perhaps occurred with this initial transfer.

MS KELLY: Dr Cleary, is it your evidence that you made attempts to be heard that the transfer being proposed was not in the public interest but that you were not heard?-- Not at all. I think there are a large number of people who expressed the view - and you can see the members of that working party included Dr Greg Stafford, who is an eminent cardiac surgeon and Dr Galbraith - yes, Dr Galbraith is there. They are the directors of our service. They, as well as myself, made representation at that committee that it would be appropriate for growth funds to go to PA and for this transfer to be managed in a different way. But I guess - and I can't talk for those people that made the decision, but I could imagine that they were going to have to balance up issues of sustainability of a service that is at the Princess Alexandra Hospital versus the difficulties entailed in transferring a caseload from the Prince Charles to the PA Hospital and I think, you know, from my perspective that would be a very difficult decision to make. But, again, once that decision is made, we all got - we all made the best out of that and made sure that the patients got appropriate care and weren't disadvantaged.

See, I am looking in your statement and in the minutes, which are the working party minutes, and I can't find any - any dissent from the proposal to carry out the transfer?-- That would be because I don't - I would have to check but I don't believe there is a complete set of the minutes of that meeting. The minutes that were included were just those minutes that allowed me to identify that a decision was taken, and that decision was made by the General Manager Health Services at the time, Dr Buckland. So the minutes - or the documentation relating to this transfer, as you would imagine, included a number of meetings in Queensland Health, weekly meetings at the Prince Charles Hospital, to go through the very - the mechanics of how this would occur, and additional meetings which included the clinicians between the two hospitals. So the information I have provided is more of a summary, and really a way of identifying what some of the key decision points were, but not really the specifics of some of those. I - I can - we could make available some of those other documents if that would be necessary?

Thank you, Dr Cleary. Dr Cleary, the impact of the transfer was the institution of cuts 1 and 2 at least, as referred to by Dr Aroney, at Prince Charles Hospital. That's right, isn't it?-- I wouldn't be able to comment. I am not specific in my mind about the rationale for the words cuts 1 and 2. All I can refer to - and I think it is difficult trying to interpret that information - I have just tried to summarise it again in that area at the end of my statement.

Well-----

COMMISSIONER: Doctor, I don't think we need to trouble you with any more than this: the decision was made to make the transfer. That was contrary to your best view and the view you expressed at the time as to how it should be done, but when the decision was made, you, as was your duty, went along with it and gave effect to it as best you could, and that resulted in less money available to Prince Charles Hospital - not less in an absolute sense but money that would otherwise have come to the Prince Charles Hospital going to the PA. Do you remain of the view that that was the wrong decision, to make that transfer or to make that transfer the way it was done?-- I would support the later position, Commissioner. Very soon after the transfer occurred we had additional funds come back to the Prince Charles Hospital. We were then able to undertake not only additional surgery, but the surgery that probably Prince Charles is well positioned to do. There was specific funding for pulmonary thromboendartectomy surgery, and it is as complicated as the name suggests. One of our specialists is a world leader in this field and we're able to provide that service to Queenslanders but we also get referrals from all over Australia. So that was an area that was specifically funded.

Doctor, we really don't need that level of detail. The point, as I understand it, is simply this: your view was that if there is going to be the establishment of a better cardiac

service at the PA, that should be done with a fresh injection of funding, rather than funds being taken away from Prince Charles. That view didn't find favour at the time but, in the result, Prince Charles has received extra funding anyway?-- That's - that's very clear, Commissioner, thank you.

Ms Kelly, is there anything else?

MS KELLY: Yes, there is something else. In relation to Dr Aroney's resignation, Dr Cleary, evidence was given yesterday, prior to your arrival, by Dr McNeil of the Prince Charles Hospital, who is the chairperson of the Medical Advisory Committee, to the effect that credentialing and privileging of specialists was the responsibility of the subcommittee of the Medical Advisory Committee, and I want to take you to two documents which are attached, oddly, in my copies, to your - although they are appended, in theory to Exhibit 301B, that is your role of Executive Director of Medical Services statement.

COMMISSIONER: Ms Kelly, what does this go to? It has obviously got nothing to do with Patel or Bundaberg, so what systemic issue are you trying to highlight?

MS KELLY: The failure of the credentialing process to permit Dr Aroney to return on a voluntary basis after his resignation to perform services in respect of procedures he had invented.

COMMISSIONER: I don't think that goes to a systemic issue. You can move on to your next point.

MS KELLY: I have nothing further.

COMMISSIONER: Thank you. Does anyone else wish to cross-examine Dr Cleary before Mr Fitzpatrick re-examines?

MR ALLEN: Just one matter.

COMMISSIONER: Yes, Mr Allen?

CROSS-EXAMINATION:

MR ALLEN: Dr Cleary, John Allen for the Queensland Nurses' Union. In your first statement in relation to Bundaberg Base Hospital you mention at paragraph 44 that one of the key activities required to normalise the hospital's operations was re-establishing a management structure, and then over the page, paragraph 45, you talk about operational management under the revised structure. Could I - are you able to explain what steps were taken to restructure management? What was the structure as you found it, and the revised structure?-- Yes. The - under the ACHS accreditation process, there are seven key areas that the accreditation process looks at, such as leadership and management, improving

performance, human resource management, and those are streams that the ACHS group look at. In Bundaberg - the committee structure in Bundaberg was established around those themes, which are in the ACHS accreditation manual, but they were never meant to be used as committee functions, they were really streams that you would look at within an organisation, and some of those functions would rightly rest with an individual to manage rather than with a committee. So in terms of some of the very simple things that I was involved in at that time, having regard to the short time I was there, I was aware of how this type of arrangement causes diffuse accountability within an organisation in terms - by that I mean-----

Can I perhaps - are you - do I gather that the change to the management structure was the change to the committee structure?-- The change was making individuals accountable and responsible for certain things that had previously been managed by a committee.

Okay?-- For example, the Director of Corporate Services was designated the person to manage all matters in relation to human resource management and all matters in relation to information management. So that rather than have a number of - have a diffuse arrangement, everything that related to those two areas went to that individual. We also had the quality and safety agenda and, again, that was vested in the - sorry, the quality agenda was vested in the Director of Nursing Services and patient safety was vested in the Director of Medical Services. So they then had an accountability and a responsibility to manage those particular areas.

How did that differ in relation to those two last aspects from the structure as you understood existed beforehand?-- Many of those things would come to a committee and be considered by a committee, but there probably wasn't a single point of accountability for those particular aspects until you got to the district manager. And so in my personal experience when I was in Bundaberg, many matters that I believe should have been rightly dealt with by other individuals were often raised to the level of the district manager for a decision. Whereas I believe many of them should be vested in a particular person to actively manage. Human resource management, as one aspect, I found that there were multiple files kept in different locations, which you would normally call your personnel files, and there were confidential staff files kept in different locations. That probably reflected that diffuse accountability. Most organisations, and certainly all the ones I have worked within, would see all of that information being centralised into the Human Resource Management department, or personnel department, and that then means you have a centralised single point of access for all of these very important files. One of the difficulties I found was that you had to actually go to almost three offices to find all of the information, look at three different files which were often duplicate. So my belief was that by making, for example, the Executive Director of Corporate Services accountable and responsible for human resource management,

that they would take an active role in managing the process that needed to be in place to ensure it was efficiently run.

Okay. I am perhaps a bit more interested in the clinical aspects than those two particular positions you mentioned. So the Director of Medical Services role changed in that the Director of Medical Services became responsible for what matters?-- For patient safety, although I have to say that given the turnover in that position in that period were there for between two and six or eight weeks as the Medical Superintendent, it was difficult to - for them to take on that portfolio in a robust manner, but certainly patient safety issues would go to that particular person. Examples might be drug errors. Rather than go to a group of people who might look at it, there would be - you know, a patient safety issue would go to the Medical Superintendent to consider, to seek advice from other people on, and to make a decision. In my experience, by doing that you will in fact have someone who feels that they own the problem and will be accountable for it. I, in my other role, feel very accountable for patient safety. I have sleepless nights worrying about it.

COMMISSIONER: Doctor, I think you have gone a little bit past the question you were asked?-- Yes.

MR ALLEN: So prior to that change, as you understand it patient safety was a responsibility of a committee or various committees, and then ultimately the responsibility of a district manager?-- That's correct. There is, what I found, a very complicated flowchart that related to the safety - the patient quality and safety committees and what support they were provided, and I found that very difficult to follow, and it had lots of crossover. I believe you just need to centralise those things under senior people and have them manage them.

Okay. Can you just clarify again the change in the role of Director of Nursing?-- The Director of Nursing was going to take on the role of managing quality, and in Bundaberg at that time that meant they were going to take a lead role in moving the organisation towards ACHS accreditation. The good thing about ACHS accreditation is-----

COMMISSIONER: Doctor, I think you have answered the question, unless Mr Allen wants you to follow that up?

MR ALLEN: All right. And did part of that change involve really taking that away from the District Quality and Decision Support Unit?-- Or lifting it up, giving it an executive sponsorship so that that person could take the lead assisting the management, drive the process with the support of the district's quality unit.

All right. Which you describe in paragraph 59 as being, basically, a complete shambles, as you found it?-- No, I think there were some process issues in that area which could have been improved. We did have a review undertaken of two areas when I was in Bundaberg, that being one, and those

comments were made by the reviewer, and I wouldn't - I wouldn't disagree with it, but I think that there were process issues that could have been improved within a quality and safety unit.

Your statement obviously speaks for itself. Just in relation to paragraph 33 of your statement and the contracts which were arranged with seven VMOs to provide specialist surgical support, were they all doctors based in Bundaberg?-- No, those were very specific contracts with doctors at the Royal Brisbane Hospital. They had particular expertise in surgical treatment and had offered to assist. So they were - there were specific contracts for them which made provisions for how the patients would be treated, both potentially in the Royal Brisbane Hospital or in other hospitals.

Okay, so it was really a fairly unusual stopgap arrangement, given the particular circumstances at Bundaberg?-- Yes.

Not something which you would have expected a district manager to formulate under normal circumstances?-- No.

Okay. Yes, thank you.

COMMISSIONER: Mr Devlin?

MR DEVLIN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR DEVLIN: Ralph Devlin representing the Medical Board. Dr Cleary, just a few questions about credentialing and privileging just in the provincial setting. I take it you would expect an international medical graduate who is an SMO to be supervised in a provincial hospital by a Director of Surgery? If that person is an SMO surgery, you would expect them to be supervised by the Director of Surgery?-- In - I - I would say yes but it would depend on what the college - what the college's view was. There may be, for example, reason for someone to be supervised locally and by someone not locally, depending on the circumstances. For example, I spoke the other day about an orthopaedic surgeon at our hospital who travels to Bundaberg to provide support, but in general you would expect for someone, in the position that you describe, to be supervised by a more senior surgeon who has - who has a fellowship or equivalence with the College of Surgeons.

Therefore, would it be your expectation that in the case of a locum who becomes Director of Surgery, as we saw in Bundaberg with Patel, that the same arrangements would apply?-- Yes.

None of that was put in place, as you understand it?-- That's my understanding, yes.

Okay. Now, just say so if you don't feel that your own situation permits you to answer this with any accuracy, but can we have any confidence that that pattern of events is not repeated anywhere else in the State with the smaller hospitals?-- I don't think I have the capacity-----

That's fine?-- -----to answer that.

We will pass on. You mention the credentialing and privileging of international medical graduates could be individual cases done from Brisbane by an eminent, in this case, surgeon. Do I take it from what you say, then, that the credentialing and privileging is essentially a paper exercise?-- Yes, that's true. There is a paper process in which you assess a professional's - a doctor's credentials. The key to that is the Medical Board website, which will detail the person's qualifications and any other restrictions on their practice. In addition to that, if the person isn't - you would also look at the person's curriculum vitae and appropriate certificates, if that was required. If the person is not known, you would certainly be obtaining referee checks before you were going to consider the matter further, and then in terms of the privileging process, clearly you need to take into account what the delineation of the hospital is before you can grant someone privileges. I am sure that's been discussed extensively.

Yes.

COMMISSIONER: Doctor, when Mr Devlin asks you whether it is a paper process, though, I take it you are not agreeing or suggesting that it is the sort of process where a hospital can send a package of information to five different people who are the credentialers and ask each of them to review it independently? I assume it is the sort of process where, no doubt, the bulk of the work is in paper, in the sense you look at people's documentation, but as we all know, that sort of exercise benefits from getting together and talking it through and saying, "Well, it looks a bit weak in this area", or "he has had a really good report from someone else", and the members of the committee can benefit from that interaction. So whilst Mr Devlin suggests it is a paper process, it is a paper process that benefits from interaction between the committee members?-- That's very true, Commissioner, and I think in our - in my experience, having a committee that's worked together for a long period of time, also makes a significant difference because you become aware of the strengths and-----

Yes?-- -----weakness of some of the other people involved, and I think having that didactic interaction certainly is important.

And it may not be ideal to do it by telephone link-up but that's at least a feasible way, particularly if you are in a provincial area and you are getting input from, as Mr Devlin says, an eminent specialist in Brisbane?-- It may be feasible to do that. I, though, would agree with you certainly if you

were doing this for all of the staff in the hospital once every three years, for example, I think you would do that face-to-face.

Yes?-- And you would go to the meeting and you would actually talk to your colleagues and participate in that, but if there was something a month later that came up, you may be able to deal with that over the phone and using a paper system.

Well, let's take the specifics of this: Dr Patel arrived from the US, no-one in Australia has ever heard of him before, there is some checking of his referees and so on, but it is obviously very important to get someone started at the hospital as soon as possible. In those sort of circumstances, it would be feasible for a credentialing committee to get together on a phone link-up and share their ideas rather than a specialist from Brisbane having to get on a plane and fly to Bundaberg to speak with the other members?-- Yes, I would agree, Commissioner.

D COMMISSIONER VIDER: And just taking that point one step further, you are talking about special purpose registrants here, and that registration was specific to the title of the position description. Now, that meant that Dr Patel was registered to come here and work as an SMO surgery. That position description said he had to be supervised by the Director of Surgery. Now, are you of the opinion that had there been a local credentialing committee who understood the significance of that, they would have known that to accept him into that position they had to have a Director of Surgery who could supervise Dr Patel?-- Yes, I would agree, Deputy Commissioner.

And that didn't happen. He became the Director of Surgery and he didn't have anybody to supervise him?-- Yes.

And hence we're all here?-- If I could add that I personally think that the Medical Board, in publishing information on the internet, has made a great deal of information available to people like myself, and the information that's contained in that register is always noted, and where there are particular comments in them, we go to, I guess in these times, extraordinary length to make sure that we comply with them, or we go back to the Medical Board to seek clarification on them. I would like to think that we have always done that. I am sure that over recent times that's been particularly-----

Yes, we have had evidence of that.

COMMISSIONER: Certainly since March in particular?-- Yes.

D COMMISSIONER VIDER: Thank you.

MR DEVLIN: Thank you. Can I just go to another - my inquiry then about the credentialing and privileging process and how much practical input goes into that then. If it's to some degree a paper exercise, I gather from what you've said about the big city model, that your committee, at least some members of it, if not all, have had an opportunity to observe the candidate in the battle lines and observe the candidate's clinical skills. You're nodding, you're agreeing with me?-- Yes, that's - that's true.

Okay. Take the provincial model though, take the new arrival from overseas. Do you see that - does your experience tell you that the opportunity to see the candidate in the battle lines before credentialing might necessarily be reduced in the practical input into that process?-- Yes, it would be.

Have you got any ideas about how that might be improved?-- One of the things that we've been doing is supporting some of the specialists in - deemed specialists in country centres. And as an example, one of the deemed specialists who works in North Queensland travels to Prince Charles on a monthly basis, scrubs in with our cardiologists-----

Thank you?-- -----participates in procedures and we have a liaison with his local supervisor. There's certainly a great deal of benefit of that, not - not necessarily just for the individual but if you're in a town outside Brisbane and you've worked closely with other clinical staff in your speciality, you can actually pick up the phone and have a discussion, refer patients more easily. So, it improves the network as well as helps with the confirming of skills and abilities and I think that's been quite a useful process. We also have staff that travel to some of the other centres and do the reverse. That's generally at the request of one of the colleges or specialists societies. The Australian Orthopaedic Association has approached one of our staff to do that for a number of deemed specialists in orthopaedic surgery outside Brisbane and, again, that networking and building of a link between the provincial centres and major urban facilities I think is very important.

What we don't know and what you can't tell us, I suppose, from your own area of experience is whether it's uniform across the board both as to all the specialities and as to all the provincial hospitals?-- I would - I would hazard a guess and say that that wouldn't be the norm. In fact, I suspect that it's quite an unusual type of arrangement.

Do you see a need for uniformity in light of what we've learnt here?-- I do. I think there is a great deal that can be done in terms of working across networks, identifying people who do need that level of support and supervision - "supervision" is

probably the wrong word, but support and assistance with skills maintenance. Clearly, that's going to require some resourcing because we are going to put a burden on the clinical staff who are already working in the system to ask them to take on an additional supervisor role when I think it's fair to say that the clinical staff feel very over stretched. It would be a challenge but it would be something I think there would be support for.

And it really couldn't happen other than in Q Health, could it, in a practical sense?-- That's an interesting proposition. The director of - sorry, Dr - the surgeon who works at the Mater Hospital in Bundaberg whose name I've just forgotten. Dr de Lacy.

De Lacey?-- Dr de Lacy is the chairman of that private hospital's credentials and privileges committee. So another option where you have multiple hospitals in a town, and I think there are three hospitals in Bundaberg, would be to work with the private sector. Certainly the clinical staff in a smaller town work - work across private and public hospitals. And there may be an opportunity to have a - a credentialing and privileging group that could review those cases where people are seeking credentials and privileges across - across a number of facilities. The private hospitals, I think, wouldn't be - wouldn't disagree with that and it would certainly, to my way of thinking, bring an additional level of scrutiny into the system because you are going to have more peer review, there is a larger group of people who would be looking at practices and who can provide advice.

So you're really saying that Q Health could not within its capability - present capabilities go it alone. We have heard lots about the silo model. It really needs to reach out to the private sector as well to ensure that the appropriate level of surveillance of incoming IMGs is maintained?-- I would agree. If I was in Bundaberg, I would be approaching the chairs of the credentialing committee of the private hospitals and the managers of those private hospitals to seek to bring together a group that could look at the medical staff credentials and privileges across those facilities, and I don't know whether that would be acceptable to the other facilities but that would be, I think, a very reasonable approach, especially in towns like Bundaberg which are large and have multiple facilities.

Perhaps not tribally acceptable but practically necessary. Thank you.

COMMISSIONER: Just a couple of follow-ups from Mr Devlin's question. One is I had the impression from some of the evidence we have heard, particularly from Dr Brian Thiele, that often credentialing committees work a bit on a sort of seven degrees of separation basis, that the members of the committee may not have seen the particular surgeon in operation, assuming it's a surgeon for a moment, but the members of those committees will know people who have or know people who know people who have, and the specialists medical

world is small enough that, generally speaking, they can get informed feedback about a particular candidate even if he or she is from India or the United States or Europe or Africa. Is that your experience?-- That would be my experience, Commissioner. It's amazing it is not just within Australia that that network exists. It's across the globe. Whenever we have new staff joining us, it amazes me how well informed their colleagues become about their - their levels of skill and their areas of expertise before they've actually started and I think that's, again, something that we have seen over recent years with globalisation of the medical workforce.

The other follow-up question was simply this. One of the things we're considering as a response to the Patel situation is whether overseas trained doctors should have a mandatory period in a metropolitan hospital before going to the country not only so that their skills can be assessed but also so that they can develop the networks and the relationships that will provide them support in rural parts of the state. I guess that that's not necessary if you're going, say, to Rockhampton as the seventh surgeon and there'll be a Director of Surgery and at least a number of other surgeons to keep an eye on you. But if you're going to be sending an overseas trained doctor either as the only person in a particular field or as the head of that particular field, then they - they should need to be assessed in Brisbane before going out. How do you feel about those approaches?-- I think that's a very reasonable proposition and there are probably two parts to it. One is the technical skill that you may want to look at but also gaining an understanding of how the health system works.

Yes?-- I've been working in it for 20 years, since I was an intern at the Gold Coast, and I would venture to say there are huge areas in which I don't understand how the system works. To go into a community or into, you know, a one-doctor town for example and not really have a good feel for how the system works I think is a very risky - risky approach. But I at one stage looked after the aerial medical retrieval service for the state - for south-east Queensland rather and the number of times you would get phone calls from registrars who were working in our emergency department saying, "I have just had a call from Murgon. I don't know where it is but there is a patient up there that's sick, what should I do?" and they're doctors working in major provincial centres. I'm probably a little bit verbose but we ended up putting a map on the wall to show people where these towns were so they could get an understanding.

Yes, yes?-- I guess I use that as an example of even the simplest things that we take for granted, like where's Murgon. For people coming in from overseas, they have a very limited understanding of distance and the tyranny of distance and the difficulty and what's actually available to you to go and work in that type of environment and how do you get help.

Mr Diehm.

MR DIEHM: Yes, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Doctor, my name is Geoffrey Diehm and I appear for Dr Keating. Just regarding, again, 301A, your statement touches upon or deals with your time in Bundaberg. Could I ask you a couple of questions specifically about the credentialing and privileging matters that you've referred to there. In paragraph 52 you tell us that you managed to locate documentation relating to credentialing and privileging and you talk about it being documentation which is issued and processed consistent with Q Health policy. We have in evidence before the Commission here both a Queensland Health policy document and guidelines issued in 2003 concerning credentialing and privileging and also a short document that was created in 2003 at Bundaberg being the local policy document about credentialing and privileging. Is that the documentation that you're referring to that you found?-- That would be the documentation in part. Certainly, I was aware of the Queensland Health policy and the local procedure which operationalised that policy was a document that I located. The other - the other documents that are relevant are the minutes of some of the credentials and privileges committee meetings that occurred between the two districts, that being the Fraser Coast and Bundaberg.

Yes?-- And my recollection is that there were three sets of minutes that I perused while I was in Bundaberg.

Yes. And those were minutes that showed that there had been credentialing and privileging undertaken for physicians, obstetricians and pediatricians?-- That's correct, yes.

Now, you say that you found this documentation after an extensive search. Was it difficult to locate?-- It was, and in my experience you would generally have a folio that was the credentials and privileges committee meeting in terms of reference, minutes of the meeting and any related documentation. We certainly found the Queensland Health document or I found the Queensland Health document - or was provided with the Queensland Health document and the local procedure, but the - but the minutes of the meetings that had occurred were in a separate folio and I ended up actually speaking with the Medical Superintendent from - sorry, the Executive Director of Medical Services from Hervey Bay to gain an understanding of where I might find them and my recollection is that they were in a different area, a different folio.

You were no doubt labouring under the difficulty that you're walking into somebody else's offices and trying to understand their filing system and find where they put documents, Doctor?

COMMISSIONER: I think there was an affirmative answer to

that?-- Yes.

MR DIEHM: Yes, yes.

COMMISSIONER: And also, the difficulty that, frankly, there had been a bit of a Stalinist style purge of the administration at Bundaberg following the Patel incident so that people who would know where to find things just weren't there to help you?-- Although, having said that, the administrative staff were the - the administrative support staff were there. My feeling was they were very competent, very professional staff and they were able to locate documents very quickly.

Yes.

MR DIEHM: Thank you. Now, the balance of the information that you recollect concerning paragraph - or contained in paragraph 52 about what had happened with respect to credentialing and privileging and why other things hadn't happened is information that you got from the Director of Medical Services and Fraser Coast; is that right?-- Some of that information I gleaned from the minutes. As I think I mentioned yesterday, my recollection was that in one set of minutes it made reference to the fact that obtaining support from the College of Surgeons was difficult and that that had meant that it was difficult to credential and privilege the surgical staff. But the remainder of the information would be information that I - sorry, would be - would be matters that I formed a view about while I was up there having regard to all the information that came across my desk.

All right. Did you speak to the Fraser Coast Director of Medical Services concerning the problems as that person perceived them with respect to the credentialing and privileging process?-- I did speak to the - to the person concerned. When I had that discussion I didn't express any particular personal views. I was seeking information and trying to understand how the process was working and what arrangements were in place. At that stage I hadn't seen minutes of the meetings and I was finding it difficult to locate some of that material. Certainly, that person provided me with information about general matters in terms of which groups of specialists had been considered by the committee and then I subsequently found the minutes.

Doctor, is it your understanding as a result of this process that the problems that Bundaberg had experienced with respect to credentialing and privileging were mirrored at Fraser Coast?-- I'd find it difficult to comment on that because I wasn't particularly - at the time I was in Bundaberg, wasn't looking at those minutes to determine what was happening in Bundaberg. I would imagine though that the credentialing process had not occurred for the surgical staff in Fraser Coast at that time because of the reasons that you've identified.

Where you say - said there that you weren't looking at these

things with a view to finding out what had happened in Bundaberg, did you mean what had happened in the Fraser Coast?-- My apologies, yes.

Yes, thank you. Now, did you glean from your investigations into these matters, and I understand the purpose behind your investigations, but did you glean from that that the position was that in Bundaberg at least there hadn't been any credentialing of any surgeon since about 2001?-- That would be my general impression. I hadn't found any documentary evidence of a surgeon being credentialed from the files that I looked at. I wasn't - I wasn't looking at all of the files however. I was looking at particular files as issues were raised in the - either by the Commission, who had offices in Bundaberg at the time and who requested information, I would generally peruse those files before they would be provided or after they were provided and - so, I hadn't done an extensive review of all of the surgical specialists or the anaesthetists or the pediatricians, so it was only those files that were ones that I would look at as they were being provided to other - other groups, be they the Commission or other interested parties.

In so far as there were general practitioners operating out of the Bundaberg Hospital, did you gain the appreciation that those doctors had been credentialed and privileged through a zonal committee?-- Yes. In fact, the doctors that worked not particularly at Bundaberg but those that worked at Childers, Gin Gin - I think it would be Childers and Gin Gin, had been credentialed through the zonal process, which I think works particularly well for rural Medical Superintendents or practitioners in those sorts of hospitals and there is in fact a different arrangement for those. The credentialing of those staff was certainly found on the district's credentials and privileges files.

All right. Now, in paragraph 53 you make the observation that given, subject to the limits that have already been mentioned, the credentialing and privileging process had not been undertaken, the District Manager had provided interim privileges for the surgical and other staff. Now, that was a process, was it not, that had been undertaken on the advice of the Director of Medical Services to the District Manager?

COMMISSIONER: Or don't you know?-- I'd find it difficult to comment. I have a recollection that on some of the files that I perused there were notations from the Medical Superintendent but I don't believe that would be something I could comment on in terms of its universality.

Yes.

MR DIEHM: Where interim privileges are granted by the District Manager in accordance with Queensland Health policy, it's not the practice, is it, for the privileges to specify in any detail the nature of the medical service that that practitioner might provide?-- No, I disagree with that. It probably is a - is a hospital specific arrangement. I know

that where I work is - is unusual but in that it provides a suite of fairly complex services. But we specify for a cardiologist, for example, whether they have adult cardiology rights, paediatric cardiology rights, whether they can do angiograms, angiograms plus stenting procedures, whether they can put in septal defect closure devices, whether they can put in defibrillators and whether they can put in pacemakers.

COMMISSIONER: That's interim privileging as a result of the formal credentialing process?-- Yes, Commissioner.

MR DIEHM: Is that something you're able to do in hospitals of the kind you're referring to there because you have immediate access to other specialists who can assist in the interim privileging arrangement to be that precise?

COMMISSIONER: Mr Diehm, do you mind if I ask your question in a slight different way?

MR DIEHM: No.

COMMISSIONER: It wouldn't surprise you in a rural or regional hospital which doesn't have the number of specialists who are at the Prince Charles Hospital if there just wasn't the scope to credential with the level of specificity that you're talking about?-- No, that would be quite reasonable. I think in a different environment the level of specificity would vary but I am aware that, for example, in Bundaberg, one of the - one of the orthopaedic surgeons is proficient in joint replacement surgery. The other orthopaedic surgeon didn't have a great deal of experience in that field and so the orthopaedic association had indicated that one of these doctors was certainly well able to provide joint replacement surgery. So even in Bundaberg, you could get to the level within some of those areas to specify some of those particular things.

As I understand as a result of a formal credentialing process rather than a situation where the District Manager is granting interim privileges?-- Yes, yes.

The very fact that there was input from the orthopaedic association suggests that it went for a full credentialing if I can put it that way?-- Yes.

You wouldn't expect the District Manager or the Director of Medical Services at Bundaberg to be able to do that - that sort of thing off their own bat without having the relevant experts available to advise them?-- That's correct. You would need to gain expert advice. Wherever you were working, you'd need that expert advice before you could make - put in place specific arrangements such as that unless the Medical Board or in the case of an international medical graduate who has had contact with the college or society, where you could take that information from any reports that they'd already written.

MR DIEHM: Thank you, Commissioner. Or, indeed, unless the

practitioner seeking the privileges themselves disclose that - their limitations?-- Yes, and that's something that happens not infrequently.

Yes. Doctor, in the second sentence in paragraph 53 you say that there was, however, very little evidence that credentials were reviewed and you have made reference to the interim privileges being granted by the District Manager. Is that an observation to the effect that there were some inadequacy in the way in which interim privileges were granted or are you saying or is that an observation that there wasn't a proper review done as is contemplated by a formal credentialing and privileging process?-- My perception would be that for interim privileges there would be some level of documentation, be that an application form for privileges with attached certificates-----

COMMISSIONER: No, Doctor, I think you're missing the point of the question. Your statement says, "There was very little evidence that credentials were reviewed." Do you mean reviewed when the interim privileges were granted or reviewed after the interim privileges were granted?-- I see, thank you, Commissioner, I apologise. No, it was when the credentials - sorry, when the privileges were granted.

MR DIEHM: When the interim privileges were granted?-- When the interim privileges were granted.

What you were alluding to was you would expect ordinarily that there would be an application for privileges and that there would be some documentation associated with that?-- Yes.

Did you find none?-- It was variable. Certainly the general practitioners or medical officers who worked in the provincial, in Gin Gin or Childers for example, that level of documentation was apparent. My recollection of Dr Patel's personnel and related files was that that documentation wasn't apparent. But I would need to again review those files before I could provide any certainty around that.

Well, Doctor, again, appreciating that you were only there for 20 days, undoubtedly very busy in the time that you were there, it's possible, is it not, that there was in fact a process in place being followed whereby each of the practitioners, including Dr Patel, had made an application, a written application, for privileges and that there was documentation associated with each of those applications even though the formal step of a final review by a committee had not been able to be undertaken, but that you, simply because of time constraints or other logistical difficulties in finding the documents, were simply unaware of them?-- I'd find it difficult to agree with you. It certainly would be possible, but during the time I was there, I had a very close - I examined many of the personnel files very closely. I held personally Dr Patel's files in my office in a secure cabinet and I became very familiar with the contents of those over that period. There were other doctors whose files I reviewed from time to time and, again, my impression was that

that documentation wasn't contained within those files. The independent review - the review that was undertaken by the HR professional and who made some comments which I've recounted in my statement also found - found there were some limitation to the documentation available when he did his review.

Are you, as you can recall it, of the understanding or belief that with respect to Dr Patel - I'll speak specifically of him for the moment - that there was no documentation concerning an application for clinical privileges by him?-- From my recollection, there wasn't an application contained in his HR personnel files, but again, before being absolutely certain of that, I would really want to peruse those files again.

COMMISSIONER: And nor do you recall finding such an application somewhere else?-- No, I don't recall it in other locations.

MR DIEHM: Or seeing any correspondence to or from Dr Patel concerning a clinical privileges process to him?-- Again, I'd need to look at the files before I could be confident of an answer, however, I am aware that there were letters written to some of the clinical staff and I did come across those in my perusal of the files and I was told by the administrative staff who worked in the medical administration area that they had written to the doctors and asked for them to provide their materials but that the response had been - had been poor and they hadn't received completed applications, so I think there had been attempts in terms of writing to various medical staff asking them for the material but that that material hadn't been forthcoming.

Doctor, in paragraph 54 you tell us that, "Having reviewed the local processes, you provided detailed documentation of how the activity was managed at Prince Charles Hospital together with relevant local procedures along with a recommendation that a new local process be implemented." In short, what were the changes to the documented process at Bundaberg that you were recommending be followed?-- In summary, I think one of the major - major concerns I had was that there was no register of who had been privileged who had been written to, who had provided partial information, so it was difficult to find a-----

COMMISSIONER: Well, doctor, that's one point is having a register of-----?-- Having a register.

-----accreditation; what other recommendation?-- Of having a standard set of letters that would go to people so that you could identify what the specifics of the credentials and privileges were. Also having a committee that - and I discussed this with the district manager that took over from me - having a committee that potentially worked across the private and public hospitals, and they could then draw on the information that I provided in terms of the Terms of Reference and the processes that were in place. Certainly the procedure that I identified when I was in Bundaberg would have been, in my opinion, would have been an adequate procedure.

COMMISSIONER: Would have been an adequate, not inadequate?-- An adequate procedure had it been followed, and so my perspective is that the process wasn't followed but there was clear documentation on what the process should have been.

All right. Yes.

MR DIEHM: Thank you. I have no nothing further, thank you Commissioner.

COMMISSIONER: Thank you.

MS FEENEY: No thank you, Commissioner.

COMMISSIONER: Mr Fitzpatrick - oh, I'm sorry, Mr Mullins.

MR MULLINS: I thought I had nothing but I have one matter briefly arising out of Mr Diehm's cross examination.

CROSS-EXAMINATION:

MR MULLINS: Doctor, my name is Mullins, I appear on behalf of the patients. Just on a credentialing issue, we understand that Dr Patel wasn't credentialed or privileged when he first arrived at the hospital; that was your understanding?-- That's my understanding and yes, that's my understanding.

Yes. And the credentialing and privileging documentation that my learned friend referred to, which is Exhibit 279, suggests that there should be a review if, at the end of a contract, for example, or the end of a probationary period or in some circumstances if there is a poor outcome or there are poor outcomes; that's your understanding as well of the process?-- Yes.

If during the course of the first 12 months of a surgeon's time at a hospital there were poor outcomes and complaints about those, would that make it even more important that at the conclusion of the first 12 months that there be a review of the privileges and credentialing?-- Yes, I think that would be a fair comment.

And if the surgeon had not been credentialed and privileged in the first instance, then that would be almost unforgivable not to credential and privilege the surgeon at the end of the first 12 months if the surgeon was going to remain at the hospital?-- I think it would be important to make that review process a robust one. Perhaps I should say it would be something where that's a very difficult process, I think if someone is having outcomes that aren't universally good, then you certainly do need good information before you take that matter forward, but it may then be that you identify other practices that aren't appropriate. For example, if it's a high infection rate, then I would have thought the infection control nurse should be involved looking at the procedures, looking at everything related to that patient - sorry, that doctor's patients to see if there are ways to improve it or if there are system issues, and notwithstanding the specifics of Dr Patel, but I think you would look at the system issues

before you looked at individual issues. But having excluded there's any systematic difficulties with outcomes, then I think you would be looking at the specific surgical - the specific in this case surgeon, and from my perspective I'd be gaining an external perspective, someone who is an experienced surgeon to come and look at that because I don't believe I'm as a - I guess I was trained in emergency medicine so I can talk a little bit about that, but in terms of surgery, I'd be wanting an expert who I believe was able to make informed comment on the outcomes before you would want to move forward.

And you'd expect to do that as part of the review of the credentialing and privileging process?-- Yes, if there are concerns about particular clinicians, either the committee or the chair of that committee could seek further information and various committees monitor different outcomes, some of them, some of them are easier to monitor, infection rates, so I think you can certainly look at that through the committee, yes.

Thank you Commissioner.

D COMMISSIONER VIDER: Doctor, a yes or no answer will suffice to this question, but do you think as we move forward with the emphasis on patient safety and clinical outcomes, that will help drive a change in the culture that will make the acceptance of privileging and that might be putting limitations about what a practitioner can do or cannot do will be easier?-- I believe so. I believe that's already happened, that a number of clinicians that I've spoken with have said that since March this year, they now understand why credentialing and privileging is so important and that in - on future occasion they'll be much prompter with their responses.

Yes. Thank you.

COMMISSIONER: Thank you. Mr Fitzpatrick, it's entirely up to you, of course. I don't feel that anything that's arisen from cross-examination requires a response in re-examination, but I'd leave it entirely to your judgment as to anything you wish to cover.

MR FITZPATRICK: Thank you Commissioner. I was going to be brief.

COMMISSIONER: Yes.

MR FITZPATRICK: And I had two matters only with the Commission's leave, and both regrettably relate to the cardiac issue, Commissioners.

COMMISSIONER: Yes.

RE-EXAMINATION:

MR FITZPATRICK: Dr Cleary, could I ask you please to focus on paragraph 35 of your statement pertaining to cardiology matters?

COMMISSIONER: The one that's the size of the 70s phone book.

MR FITZPATRICK: It is, Commissioner. Do you have that, doctor?-- Paragraph 35?

Yes. Doctor, that is a paragraph which deals with some information received about the differences in wait for cardiac cases at the PA Hospital and your hospital. Now, Dr Aroney gave evidence to the Commission this morning that throughout the whole of the 2004 year, you were - that is, when the transfer of patients was going on between the two hospitals - you had express knowledge of the differences in classification approach at the two hospitals; can I ask you to comment whether you agree with that proposition or not?-- I would disagree with that. To be distinct and respond, my assumption was that the classification was the same as in the category 1 was 30 days, category 2 was 90 days and category 3 is more than 90 days, but that the criteria used between the two hospitals differed. So that at one hospital you might be a category 1 but for other reasons you'd be a category 2 at the other hospital, and that difference of clinical opinion is not unusual. We had occasion some years ago to take on additional workload from another hospital, 40 per cent of the patients that were referred to us were deemed by specialists to be different from - so the criteria, the listing was different, so it's not unusual for changes at the margin, but to summarise, I assume that the classification was the same but that the criteria used by the clinicians was different. As it turns out, the criteria used by the clinicians were different and the classification was different.

Yes.

COMMISSIONER: Doctor, if I can just ask you this quite specifically about that point: looking at the Thomas Ayre Report, and that's dated January 2004; is that when you received it?-- Yes, that's correct.

All right. In the final paragraph of that report, page 15, it actually urges a review of the ICD waiting list criteria to be undertaken in collaboration with other public providers. Now, I realise that that's criteria limited to one cardiac procedure, but reading that and the reasons given in the body of the report for making that recommendation suggest that at least - well, as early as January 2004, it was well known that different criteria were being used at different hospitals?-- For this - this particular procedure, that was well - that was known.

Yes?-- The waiting - the classification was the same but the criteria were different. We had experiences where patients that we believe needed to have or that the clinicians at the Prince Charles believed needed to have an implantable defibrillator who were subsequently reviewed by other hospitals and deemed not to require that, so there were certainly criteria - differences in the criteria used to list people.

Doctor, I feel I should ask you this because some people might say look, when you're told that there's a zero category 1, two category 2 patients at the PA compared with almost 300 - over 300 patients in those categories at the Prince Charles, it must have been obvious to blind Freddie that different criteria were being used, otherwise there is just no logical reason why people's hearts on the south side of the river are so much stronger than people's hearts on the north side of the river, that you'd have such a dramatic disparity. It must have been apparent to you surely that these statistics were not comparing like with like?-- Yes, I did, I had that belief.

Yes?-- But I had no evidence that there was a difference in the criteria and that was a difficulty that I had in like yourself, it didn't look right, it didn't make sense, but I couldn't get to the root of the difference.

Well, that then just goes on to the next step in the process: Dr Aroney claimed, and you deny it, that you were aware of the exact nature of the problem, that you know the truth of the matter now seems to be you knew that there was some problem and you don't seem to have done anything to sort it out whilst Dr Buckland was issuing directives based on the assumption that the north side had a sort of many thousand per cent worse incident of heart disease than the south side. What was actually done to resolve this impasse or was it just allowed to drift on for 12 months until you happen to find out that different tests were being used?-- There were, during the course of this - or during the transfer of cases from the two hospitals, there were a number of meetings where we talked about what the criteria were, and again, it was difficult for me to distill from that anything apart from one hospital took a holistic approach to considering the patients, and one hospital took a perhaps a less holistic approach. In retrospect, I think I would agree with you, I should have been more - more robust in my examination of the waiting list.

Yes.

MR FITZPATRICK: Thank you Commissioner.

And doctor, having regard to what you've just said to the Commissioner, does it - is it your evidence that you first came into possession of the evidence, the black and white data about the different classification approaches between the two hospitals in January of this year as you've said initially in paragraph 41 of your statement?-- Yes, it was around that

time that I became aware of it. It was also around that time that we started to improve our collection of information relating to patients on the waiting list, and that probably also allowed me to look more closely at it.

All right. Dr Cleary, would you look please at annexure 17A to your cardiac statement? In that I think is a briefing prepared by you to Dr Scott in October last year?-- Yes, that's correct.

Relating to a number of patients, nine - anyway, who were said to have died whilst on the waiting list for - whilst in the process of transfer to your hospital; is that so?-- That's correct, yes.

Now, there is, after page 5 to that briefing, a number of patient summaries, one for each of the patients detailing the case; do you know who prepared those summaries?-- Yes, I prepared those summaries. There were certain difficulties in preparing this document in that I only had access to dates at which patients were said to have died and dates of birth, I didn't have access to names, and given that a lot of these patients weren't from - hadn't been treated at the Prince Charles, it was difficult to identify the specific patients. However, to the best of my ability, I believe we identified the majority of those patients mentioned by the Member of Parliament and but it may not be absolutely correct because I - we were never able to obtain a list from the Member of Parliament who mentioned this of the patient's specific names.

All right.

COMMISSIONER: Doctor, the suggestion made by Professor Aroney in his evidence this morning is that some of the dates of death given by you are out by a couple of days. Do I take it from what you've said that there was no deliberate misstatement of the facts, that you stated the facts as best you could lining them up with the dates and so on provided in the Member of Parliament's speech?-- Yes, Commissioner, I personally reviewed what material we had locally. Sometimes that was a faxed letter and an ECG and a booking form. On occasions there was more detail because the patient may have been the previous patient of the Prince Charles and I tried in reviewing these files as I identified them to identify dates and the process that was put in place, and certainly to the best of my ability at the time having regard to the sometimes limited information available.

But there was no deliberate falsification?-- No.

MR FITZPATRICK: Well, Dr Cleary, in the case of patients A and B, do you accept that the dates of death of those patients are inaccurately stated by three days? Do you accept that they are wrong?-- I would have to check. If there was further information that was provided in terms of the specific patients, but certainly to the best of my ability those dates are correct.

COMMISSIONER: Or may it be the case that the person you have identified as patient A and patient B is simply different people from the ones that Dr Aroney had in mind?-- Yes. I don't - I still do not know - I still can't link my patient A to a particular name. All I know is the only information I was provided with was deaths - was dates of death and dates of birth, and we then tried to track back from that. If there is more specific information, I could go back and conduct a further review.

I don't think that's necessary.

MR FITZPATRICK: Thank you, Commissioners. That's all I have.

COMMISSIONER: Mr Andrews, any re-examination?

MR ANDREWS: No, Commissioner.

COMMISSIONER: Doctor, I am very sorry that you have had to come back for a second occasion. I am sure you understand the reasons why that was necessary, but we do appreciate your time and your giving us the benefit of your knowledge, not only in relation to Bundaberg but also in relation to the Prince Charles Hospital and particularly the cardiac issues. We are grateful for your assistance in those matters and you are excused from further attendance?-- Thank you very much. I - yes.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews?

MR ANDREWS: There are potentially four matters - four witnesses, whose at least statements may appear tomorrow. The first witness to be called at 9.30 is Ms Wendy Edmond. Her statement is available in the precincts in hardcopy. It has been emailed. Dr Russell Stitz has today - his statement has today been provided. It has been emailed and a submission which was made by Dr Stitz will soon be emailed to the parties. Dr Jayasekera may be available tomorrow afternoon, if not he will be available on Friday afternoon by telephone.

Mr Kerslake's statement is proposed to be tendered at 2.30 and

Mr Perrett, who represents him, would like to be here when it is tendered. The parties were, about 10 days ago, asked whether anyone wanted Mr Kerslake to be present for cross-examination. As a result of some replies and a number of failures to reply, it is assumed that Mr Kerslake is not required for cross-examination.

COMMISSIONER: I am sure if anyone has a different view, they will let you know as soon as possible. Very well, we will adjourn then till 9.30 tomorrow morning.

THE COMMISSION ADJOURNED AT 5.22 P.M. TILL 9.30 A.M. THE FOLLOWING DAY